Warrington

Joint Strategic Needs Assessment (JSNA)

Physical Activity

2015

June 2015
The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.
Executive Summary

Introduction and Overview

Scope of the chapter

This chapter will examine physical activity both as a concept and in a Warrington context. It will look to define what constitutes physical activity, what its benefits are, what risks are associated with not doing enough physical activity, and who might be at increased risk.

The chapter will then place these ideas into a Warrington context, as far as possible, by describing the levels of physical activity in various sections of the population and comparing this to estimates of the levels actually achieved in Warrington. It will then look at the services that are provided to give Warrington residents opportunities to participate in physical activity and what resources these services utilise. This chapter will also identify gaps in knowledge or services that need to be addressed.

This chapter should also be read alongside the Warrington Sport & Physical Activity Profile 2014 (Warrington Borough Council, 2014) which contains detail on policy and socio-economic context, and levels of participation in physical activity by people in Warrington.

What is physical activity and what are the benefits?

The World Health Organisation (WHO) defines physical activity as “any bodily movement produced by skeletal muscles that requires energy expenditure” (WHO, 2015). WHO recognises that regular moderate intensity physical activity – such as walking, cycling, or participating in sports – has significant benefits for health, such as reducing the risk of cardiovascular (heart) diseases, diabetes, colon and breast cancer, and depression. Also, adequate levels of physical activity will decrease the risk of a hip or vertebral fracture and help control weight.

How does physical inactivity affect health?

Physical inactivity is the fourth leading risk factor for global mortality (6% of deaths globally). Moreover, physical inactivity is estimated to be the main cause for approximately 21-25% of breast and colon cancers, 27% of diabetes and approximately 30% of ischemic heart disease burden (WHO, 2015).

According to the NHS Atlas of Risk (NHS Choices, 2013), in 2007, 5.4% (25,200) of all deaths in England were attributable to physical inactivity. Of these, 65.5% (16,500) were due to ischaemic heart disease, 21.4% (5,380) due to stroke, 8.4% (2,110) due to bowel cancer, 2.1% (520) due to breast cancer, and the remainder were due to complications of diabetes.

Results of a 12 year European study, recently published, and undertaken by researchers in the University of Cambridge (2015), suggests that a lack of physical activity could contribute to twice as many deaths as obesity. By increasing the level of exercise even by a small amount (equivalent to a 20 minute brisk walk a day) could help to reduce the risk of premature death by between 16 to 30%.

Recommended amounts of physical activity

In 2011 the Department of Health launched Start Active, Stay Active (DH, 2011), a physical activity guideline based on evidence from Loughborough University and the British Heart
Foundation National Centre Technical Report (Bull, 2010). For all age groups, the Chief Medical Officer recommends a reduction in the amount of time that individuals spend being sedentary, although individual physical and mental ability needs considering when interpreting these guidelines. The guidelines are broadly in line with the WHO recommendations on physical activity for similar age groups (WHO, 2010), and generally, they recommend the following for different age groups:

- **Under 5 Years (Walking):** Children of pre-school age should be physically active daily for at least 180 minutes (3 hours), spread throughout the day, most likely in the form of unstructured play.
- **Children and Young People (5 – 18 year olds):** These individuals should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Additionally, on three days each week they should engage in activity that strengthens muscle and bones.
- **Adults (19 – 64 year olds):** These individuals should engage in daily activity. Over the course of a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – this gives the readily appreciated 30 minutes on at least 5 days a week. Additionally, on two days each week they should engage in activity that strengthens muscles.
- **Older Adults (65+):** These individuals should engage in daily activity. Over the course of a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – this gives the readily appreciated 30 minutes on at least 5 days a week. Additionally on two days each week they should engage in activity that strengthens muscles. For older adults who are at risk of falls, these individuals should engage in physical activity to improve balance and co-ordination on at least two days a week.

**Recommendations on physical activity for pregnant women**

Guidance from The Royal College of Obstetricians and Gynaecologists (RCOG, 2006) suggest that:

- All women should be encouraged to participate in aerobic and strength-conditioning exercise as part of a healthy lifestyle during their pregnancy.
- Reasonable goals of aerobic conditioning in pregnancy should be to maintain a good fitness level throughout pregnancy without trying to reach peak fitness level or train for athletic competition.
- Women should choose activities that will minimise the risk of loss of balance and foetal trauma (examples given within the guideline).
- Women should be advised that adverse pregnancy or neonatal outcomes are not increased for exercising women.
- Initiation of pelvic floor exercises in the immediate postpartum period may reduce the risk of future urinary incontinence.
- Women should be advised that moderate exercise during lactation does not affect the quantity or composition of breast milk or impact on foetal growth.

There are a number of conditions that require medical supervision while undertaking exercise in pregnancy. Additionally, there are a number of warning signs that exercise should be terminated contained within the guidance. In general, however, the RCOG advocate a maximum heart rate of 60–70% for women who were sedentary prior to pregnancy and the upper range of 60–90% of maximum heart rate for women wishing to maintain fitness during pregnancy. This is factored by maternal age in the guidance. When starting an aerobic exercise programme, the guidance advocates that previously sedentary women should begin
with 15 minutes continuous exercise three times a week, increasing gradually to 30-minute sessions four times a week to daily.

**Levels of exercise undertaken in England**

The following information has been extracted from the publication “Statistics on Obesity, Physical Activity and Diet” (HSCIC, 2014a) which uses several sources for its data. In 2012, based on data from the Health Survey for England, estimates show that:

- 67% of men and 55% of women aged 16 and above met the recommendations for aerobic activity.
- 52% of men and 45% of women in England reported that they had taken part in sports/exercise at least once during during the past four weeks prior to interview.
- 46% of men and 37% of women made walks of at least moderate intensity for 10 minutes or more on at least one day in the past four weeks prior to interview.
- More women (26%) than men (19%) were classed as inactive (defined as less than 30 “equivalent” minutes of exercise per week).
- Men were more likely to be sedentary than women for six hours or more on both weekdays (31% and 29% respectively) and weekend days (40% and 35% respectively). (Average total sedentary time combines both time spent watching the television and other sedentary time).

Regarding physical activity among children, key points are:

- 81% of 5-10 year olds had taken part in sports activities outside of school time in the last four weeks prior to interview, and 95% of 11-15 year olds took part in sport in or outside school. Based on the Taking Part Survey 2012/13, these results have remained stable since 2008/09.
- In the last week, prior to being interviewed, 67% of 5-10 year olds took part in sport outside of school, and 89% of 11-15 year olds took part in sport either in or outside of school. For those aged 5-10 years this is a significant decrease since 2008/09 in which the rate was 75%; there was no significant change for 11-15 year olds.
- 55% of pupils in years 1-13 of participating schools took part in at least 3 hours of high quality PE and out of hours school sport in a typical week. Among the three types of schools that were surveyed, 64% of pupils in primary schools, 46% of pupils in secondary schools and 64% of pupils in special schools reported participating in at least three hours of high quality PE and out of hours school sport in a typical week. (The PE and Sport Survey 2009/10).

National indicators to monitor levels of activity and inactivity are available on the Public Health Outcomes Framework (PHE, 2015a) and allows local area monitoring to be benchmarked against regional and national averages:

1.16 Utilisation of outdoor space for exercise/health reasons.

2.13 Proportion of physically active and inactive adults:

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2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer's recommended guidelines on physical activity.

2.13ii Proportion of adults classified as "inactive".
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Latest published data (March 2013 to February 2014) on the Public Health Outcomes Framework shows that in England 17.1% of people used green space for exercise/health reason, an increase on the previous year (15.3%).

In 2013, 56.0% of people in England took the recommended amounts of physical activity per week, the same as in 2012. However, 28.3% of people in England are classed as inactive and took less than 30 “equivalent” minutes of exercise per week, very similar to 2012 (28.5%).

Key Issues and Gaps

- The Warrington Children and Young People Survey (Warrington Public Health, 2014) highlights that boys tend to do more physical activity than girls; however very few pupils reach the Chief Medical Officer’s guidelines for physical activity for children.

- Nationally available data by local authority, sourced from the Active People Survey (PHE, 2015a), indicates that 54.8% of Warrington residents are physically active and meet the Chief Medical Officer’s guidelines. Those considered inactive (less than 30 equivalent minutes of activity per week) is 27.2% in Warrington.

- In the Warrington Health and Wellbeing Survey (Warrington Public Health, 2013), 75% of residents achieve levels of activity in line with the Chief Medical Officer’s guidelines (results not to be compared with data from the Active People Survey due to different methodologies for both surveys).

- The Warrington Health and Wellbeing Survey also highlights that the amount of physical activity decreases with age; men tend to be more active than women; and those in the more deprived areas tend to exercise less.

- Data from LiveWire leisure services shows that young adults and those age groups up to the age of 54 make up the highest numbers of members; however only 30% of members visited leisure services during October to December 2014.

- The Active Warrington Partnership has developed a number of schemes and projects to encourage people to take part in physical activity, in order to realise their aim - by 2016 Warrington will be the most active borough in the North West.

- The use of parks and green spaces in Warrington for exercise and health reasons has increased over the past 2 years.

- With the establishment of the Active Warrington Partnership in 2012, a lot more additional data is now collected, and as the Active Warrington Strategy progresses more information will become available. However, we still have some data gaps around usage of leisure facilities in Warrington, for example for LiveWire services, for private gyms and leisure facilities. Not having the complete picture makes it hard to identify the unmet needs of the population.

Recommendations for Commissioning

Updates to previous recommendations:

- To establish a baseline of current leisure service use, understand the footfalls in each leisure centre, and understand the profile of leisure centre users by gathering and analysing data by age, gender and where they live. **This information is being gathered.** As well as recording the data for leisure services data is also recorded from across
**The Active Warrington Partnership, although this data will relate only to services being delivered by partners within the network only.**

- To identify if equitable access to leisure services are being achieved through the analysis of data relating to the use of Warrington’s Wellbeing card scheme, because data sourced from the Active People Survey suggests that this may not be the case. **The Active Warrington Partnership has embarked on a much wider programme of inclusivity that will come into effect 2015/16. This recommendation to be carried forward.**

- Explore potential for analysing the local use of green spaces for exercise or health reasons. **The Active Warrington Partnership has collected data on the number of projects and sessions delivered in Warrington parks and open spaces during 2013/14.**

- Once the baseline of leisure service and green space activity has been established, a wider review of physical activity to be undertaken to ensure that the delivery is suitable for the needs of the town, and that those in need are effectively targeted. **A Warrington Sport and Physical Activity Profile was produced in 2014 by Warrington Borough Council’s Customer Insight Team.**

- Further partnership work needs to be supported to encourage the use of green spaces. For example by achieving an outdoor based activity programme such as walking or cycling programmes. **The Active Warrington Partnership now promotes recreational running and cycling projects and have introduced initiatives like Park Run to Warrington. They also now collect data around running, cycling and walking, and have released a publication which details activity under these three areas.**

- Develop a volunteer network across the neighbourhoods to maximise the quality of referrals into core Health Improvement services. This could also assist in brief interventions and the ‘Every Contact Counts’1 public health initiative taking place in the more deprived areas of Warrington. **A volunteer network has been developed within the Wellbeing Service which works towards outcomes defined in a Service Plan. Volunteers who are recruited can be matched into neighbourhood teams. All volunteers undertake the ‘Every Contact Counts’ training, and the overarching theme of the volunteer network is to cascade public health messages, and to help reduce inequalities by closing the gap.**

- To develop a physical activity programme to encourage older people to take part in physical activity and active recreation. **This recommendation is still in development. Livewire are engaged in programmes of activity with the elderly in residential care but we are lacking a robust programme of engagement for the elderly which is clear in the Active Warrington Monitoring and Evaluation. This recommendation to be carried forward.**

**Recommendations based on current JSNA chapter:**

- To identify if equitable access to leisure services, physical activity sessions and events, and sport facilities is being achieved.

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1 The NHS Future Forum recommendations to the Department of Health include the ‘Every Contact Counts’ initiative, in which “Every healthcare professional should make every contact count – use every contact with the public to help them improve their health” (NHS Future Forum, 2011).
To encourage older people to take part in physical activity and active recreation. A physical activity programme is currently being developed.

To determine current activity levels of children and young people across the borough to inform a physical activity programme that improves uptake of physical activity, with a particular focus on girls.

To build upon, where possible, the LiveWire data currently available on customers and members of its leisure services. Non-personalised data on age, gender, and postcode (or other area identifier), particularly for customers as well as members, will help to provide a fuller analysis of customers and usage of services.

To collate the amount of data available from different sources to form a comprehensive picture of physical activity in Warrington. To bring in new sources of information where possible, eg from private gyms.

1) Who is at Risk and Why?

There are certain population groups who may be less likely to undertake physical activity, either because there may be specific barriers to participation or due to circumstances related to their situation. This section aims to describe some of these key groups and the associated barriers, and aims to highlight that these groups may need additional support, or need services delivered in a different way, to meet their individual needs.

1.1) Black Minority Ethnic Groups (BME): ‘The health of minority ethnic groups’ survey (Joint Health Surveys Unit, 1999) measured participation in physical activity among the main minority ethnic groups in England. Compared with the general population, it found that South Asian and Chinese men and women were much less likely to participate in physical activity (of any kind, whether it be sport and exercise, walking, heavy housework or DIY). Bangladeshi men and women were the most inactive – they were almost twice as likely as the general population to be classified as sedentary. Koshoedo and colleagues (2009) identified a number of barriers for engaging black and minority ethnic groups in physical activity, grouping them into personal, socio-economic, cultural and environmental barriers.

1.2) Carers: It is possible that, similar to other health needs for carers, physical activity takes second place to caring responsibilities. However, there is a paucity of published information on this issue for both adult carers and young carers that needs to be addressed both locally and nationally.

1.3) Children: In 2012, the Health Survey for England (HSCIC, 2013a) estimated that only 21% of boys and 16% girls, aged 5 – 15, were classified as meeting the government’s recommendations for physical activity (at least 1 hour of moderately intensive physical activity per day). Boys experienced a significant reduction since 2008, who at the time 28% met the recommendations. The proportion of girls meeting the recommendations has also reduced since 2008 but not significantly (19%).

Perceived barriers to participation for adolescents has been considered in a number of studies. A systematic review by Rees and colleagues (2006) identified the following barriers: not feeling competent (in the activity), negative reactions from peers to their choice and skill at chosen activity, feelings of inertia and conflicting interests, self-consciousness, parental constraints, safety and cultural issues, time and facilities, and a dislike of structured activities and those organised by adults. Please also see the JSNA chapter on Children’s Healthy Weight.
1.4) **Homeless People**: It has been argued that homeless people tend to undertake large amounts of low-intensity physical exercise, through more than 10,000 daily steps of walking. However, as may be expected, given their circumstances, most do not take part in more intensive exercise (Randers et al., 2011). Several initiatives across the UK attempt to address the issue of promoting elements of a healthy lifestyle. For example, the Booth Centre in Manchester encourages people to participate in new sports and outdoor activities as part of their Healthy Lifestyles Programme.

1.5) **People with Mental Health Conditions**: Research suggests (Ussher et al., 2007) that individuals with mental health problems tend to be more sedentary than the general population, with walking being the most common activity. This UK study also found that respondents reported very little confidence in their ability to exercise when feeling sad or stressed, and they reported low levels of social support toward exercising. Approximately half the respondents in this study expressed a belief in the health benefits of exercise, enjoyment of exercise, and a desire to be more active. The research identified a number of barriers to physical activity including feeling too tired, illness, bad weather, time, feeling unsafe outdoors, being afraid of getting injured, feeling self-consciousness, and being unsure what to do.

1.6) **Older People**: Physical activity levels decline with increasing age. It is estimated that, in England in 2012, 51% of men and 42% of women aged 65-74 meet the recommendations for physical activity (HSE, 2013b). There has been an increase since 2008 in the proportions of men and women in this age group undertaking recommended levels, 46% and 37% respectively.

A small (n=230) UK study (Davis et al., 2011) has highlighted the variability in the physical activity levels of older adults. Younger participants (70 - 74.9 years) were significantly more active (5,660 steps per day) than older participants (80+ years) (3,409 steps per day). Also, men performed significantly more minutes of moderate to vigorous physical activity than women. Additionally, the study identified some factors that appear to modify physical activity levels in older people. For example, normal weight participants were significantly more active (5,368 steps per day) than overweight (4,532 steps per day) and obese (3,251 steps per day) groups. Those performing many journeys (over 11 journeys per week) were significantly more active (5,838 steps per day) than those performing few (less than 7 journeys per week) (3,094 steps per day). Physical activity was significantly greater in the mornings than afternoons and evenings. Sundays were significantly less active (3,331 steps per day) than Saturdays (4,193 steps per day) and weekdays (4,623 steps per day). Light activity was significantly higher in spring than in winter.

Barriers to physical activity in older people have been found to include pre-existing health problems, lack of companion with whom to exercise, unpleasant or unsafe environment in which to exercise (lack of green space and broken paving stones etc.), lack of pavement (walking is a key exercise for this age group) in rural areas, fear for safety (violence and accidental injury), traffic safety and pollution (Dawson et al., 2007).

1.7) **People with Learning Disabilities**: The Improving Health and Lives Learning Disabilities Observatory provides information on the health and wellbeing of people with learning disabilities, and is a collaboration between Public Health England, the Centre for Disability Research at the University of Lancaster, and the National Development Team for Inclusion.

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3. An enhanced physical activity questionnaire was introduced for adults in the 2008 Health Survey for England, and results for 2008 and 2012 have been revised based on the new recommendations for physical activity
4. https://www.improvinghealthandlives.org.uk/
Turner and Robinson (2011) state that “there is evidence that people with learning disabilities take less exercise than the general population and that their diet is often unbalanced, with an insufficient intake of fruit and vegetables. In addition, people with learning disabilities often find it hard to understand the consequences of their lifestyle on their health”.

1.8) People with a Physical Disability: People with physical disabilities are less likely to engage in regular moderate physical activity than people without disabilities, yet they have similar needs in terms of health promotion and prevention of disease. The report, *Improving the life chances of disabled people*, produced by the Prime Minister’s Strategy Unit, states that “Using the widest survey definition, it is estimated that there are about 11 million disabled adults in the UK – one in five of the total adult population – and 770,000 disabled children. Many of these people would not define themselves as disabled. The majority of these people experience low level impairments – wheelchair users, blind people and deaf people make up an important minority” (Prime Minister’s Strategy Unit, 2005).

The National Institute for Health and Care Excellence (NICE) commissioned the charity, KIDS, to produce a briefing on disabled children and young people with regard to physical activity, active play and sport from which many children with disabilities are routinely excluded (Scott, 2010). It examines the health benefits of play, national policy, and the barriers that disabled children and young people face in accessing play and leisure opportunities. It also includes recommendations on making play, sport and leisure activities more inclusive. The English Federation of Disability Sport (EFDS) is the national body responsible for developing sport for disabled people in England. It provides research, publications, and information on best practice, available at [http://www.efds.co.uk/](http://www.efds.co.uk/).

1.9) People Living in More Deprived Neighbourhoods: According to the 2006 Health Survey for England (HSCIC, 2008), there is a clear association between participation in physical activity and household income. This association is apparent for both men and women, with those in the lowest income quintile (fifth) more likely to be in the low participation group than those in the highest income quintile. Those with the highest income were also most likely to participate in active sport: 89% of those earning over £50k had done so at least once in the previous 12 months, while for those whose income was less than £10k the figure was 61%. Barriers to participation have been identified (Withall et al., 2011); factors such as cost, the fear of ‘walking in alone’, accessibility of facilities, and appropriate communication strategies may be of particular importance to increasing recruitment of low income groups.

2) The Level of Need in the Local Population

2.1) Children and Young People

2.1.1) Children and Young People Survey: Warrington Public Health Team commissioned a large scale survey of children and young people in primary and secondary schools in Warrington in spring/summer 2014. There were 926 year 6 (aged 10/11 years) respondents from 28 (out of 68) Warrington primary schools, and 1,251 year 8 (aged 12/13 years) and 1,302 year 10 (aged 14/15 years) respondents from 10 (out of 12) Warrington secondary schools. A broad range of topic areas were covered in the questionnaire, including physical activity.

When asked how much pupils enjoy physical activities:

- In years 8 and 10, a significantly higher proportion of boys than girls said they enjoyed physical activities a lot or quite a lot.
• This difference becomes more extreme the higher the year group; by year 10 only 52% of girls compared to 80% of boys said they enjoy physical activity a lot or quite a lot. See chart 1.
• 8% of year 10 girls said they don't enjoy physical activity at all, and a further 40% said they only enjoy it a little.
• Warrington was broadly in line with national figures, although more year 6 girls in Warrington (86%) said they enjoyed physical activity a lot / quite a lot, compared to national (80%), but less year 10 girls in Warrington (52%) did so (national 58%).

Chart 1: Percentage of Children enjoying Physical Activities

![Chart 1: Percentage of Children enjoying Physical Activities](image)

Percentages calculated from valid answers (i.e. invalid answers are excluded from denominator)

Chart 2 shows the percentage of children who consider themselves to be fit or very fit.

Chart 2: Percentage of Children who consider Themselves Fit/very fit

![Chart 2: Percentage of Children who consider Themselves Fit/very fit](image)

Percentages calculated from valid answers (i.e. invalid answers are excluded from denominator)

When asked how fit pupils thought they were:

• In year 6 a significantly higher proportion of boys (71%) than girls (57%) said they thought they were fit or very fit.
• In year 8, there was a small but not significant difference between the proportion of boys and girls (49% and 42% respectively) who thought they were fit or very fit.
In year 10 there was a large significant difference between boys and girls; 48% of boys and only 24% of girls thought they were fit or very fit. Answers were broadly in line with national figures, except fewer year 6 girls in Warrington (57%) answered fit / very fit, compared to 66% nationally, but more year 8 girls in Warrington (42%) did so compared to 35% nationally.

Pupils were asked how many days they got out of breath and/or sweaty for a total of at least an hour while doing physical activity, in the last 7 days. The Chief Medical Officer guidelines for children and young people is moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. The data was therefore grouped to show a category of “every day”. However, there are no nationally comparable figures available for the categories shown in chart 3.

There is relatively little difference between the year groups. In general, more boys than girls were in the 4-6 days and every day; and more girls than boys in the none and 1-3 days.

- No days: 33% of pupils overall. There is relatively little variation between year groups, and a difference between girls and boys only in year 10 (30% boys and 38% girls).
- 1 - 3 days: ranges from 39% (year 8 boys) to 50% (year 6 and year 8 girls).
- 4 - 6 days: ranges from 11% (year 10 girls) to 20% (year 8 boys).
- Every day: very few pupils reached the Chief Medical Officer guidelines (5% overall). The proportion ranged from 2% to 8%, with a slightly higher proportion of boys than girls in each year group.

Chart 3: Percentage of Children who got Out of Breath

<table>
<thead>
<tr>
<th>In the last 7 days, no. of days got out of breath/sweaty for at least 60 minutes (Warrington CYP Survey 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None 1 to 3 days 4 to 6 days every day</td>
</tr>
<tr>
<td>Boys</td>
</tr>
<tr>
<td>Y6</td>
</tr>
<tr>
<td>30%</td>
</tr>
<tr>
<td>Y8</td>
</tr>
<tr>
<td>33%</td>
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<tr>
<td>Y10</td>
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<tr>
<td>30%</td>
</tr>
</tbody>
</table>

Percentages calculated from valid answers (i.e. invalid answers are excluded from denominator)

2.1.2) National Child Measurement Programme (NCMP): The NCMP has been run annually since the 2006/07 academic year. Almost all children in reception year (aged 4/5) and year 6 (aged 10/11) are weighed and measured. Participation rates in Warrington have been consistently higher than nationally or in the North West. National indicators are based on this data, and monitor the proportion of obese children, and the proportion of “all excess weight” (i.e. the overweight and obese categories combined).

Reception (aged 4/5):

- Prevalence of obesity, and prevalence of overweight/obesity in Warrington has been consistently lower than England and the North West, except in 2011/12.
• In 2013/14, Warrington obesity prevalence was 7.8%, compared to 9.5% in England and 9.9% in the North West.
• In 2013/14, at 20.2%, Warrington overweight/obesity prevalence was at its lowest level since 2007/08 (2006/07 data was considered unrobust due to it being the first year of collection). Comparative figures were 22.5% in England and 23.6% in the North West.
• Whilst the obesity prevalence in Warrington (7.8%) is low compared to the North West and England, it still means that approximately 1 in 13 reception children are obese. See chart 4 for further details.

Chart 4: Reception Children Overweight/Obese

Year 6 (aged 10/11):

• Prevalence of obesity, and prevalence of overweight/obesity in Warrington has been consistently lower than England and the North West, except in 2011/12.
• In 2013/14, Warrington obesity prevalence is 16.2%, compared to 19.1% in England and 19.8% in the North West.
• In 2013/14, Warrington overweight/obesity prevalence is 31.3%, compared to 33.5% in England and 34.4% in the North West.
• Whilst the obesity prevalence in Warrington (16.2%) is low compared to the North West and England, it still means that over 1 in 6 Year 6 children are obese. See chart 5.

Chart 5: Year 6 Children Overweight/Obese
Further information can be found in the Children and Young People Healthy Weight JSNA Chapter

2.2) Adults

Please also refer to the Warrington Sport & Physical Activity Profile 2014 (WBC, 2014) which contains detailed analysis on sports participation in Warrington from the Active People Survey (Sport England) among other things.

2.2.1) Levels of Activity: Data in the Public Health Outcomes Framework (PHE, 2015) and sourced from the Active People Survey from Sport England, highlights that 54.8% of people in Warrington are physically active\(^5\) (latest data presented as at 2013). This is a small reduction since 2012 in which levels were 57.6%. Warrington’s current value is lower than England (56.0%) although not significantly lower.

Warrington Public Health Team commissioned a local Health and Wellbeing Survey in 2013 in which respondents were asked to quantify the amount of moderate\(^6\) and vigorous physical activity they do in an average week. Overall, 76% of residents are achieving the Chief Medical Officer’s (CMO) recommended amount of physical activity.

Please note these results should not be compared with those on the Public Health Outcomes Framework as definitions of physical activity are different between the two surveys\(^7\).

The following analysis is based on the Warrington Health and Wellbeing Survey. As may be expected, prevalence of activity decreases with age; 81% of 18-39 year olds are active, this compares with 69% of those aged 65 and over. On average, males are more active than females; 79.9% of men meet the CMO’s recommendations, compared with 72.9% of women. Women are significantly worse than the Warrington average for all people (76.4%), men are significantly better. See chart 6 for further detail.

\(^5\) Based on the Chief Medical Officer recommendations of at least 150 minutes of moderate activity, in bouts of 10 minutes or more, per week

\(^6\) Moderate intensity activity is defined as any activity that causes you to get warmer and breathe a little harder

\(^7\) The CMO guidance states that everyday activity such as active travel, heavy housework and occupational activity counts towards the 150 minute guideline. This definition differs from that used in the Sport England Survey, which excludes occupational activity and housework. Thus figures are not comparable with Sport England findings or those reported in the Public Health Outcomes Framework (which uses Sport England data).
Level of physical activity is associated with deprivation; 69.6% of residents in quintile 1 are active to recommended levels. This compares with 80.3% of residents in quintile 5. The distribution by age band, sex and deprivation is illustrated in chart 7.

When looking at physical activity by ward it can be seen in map 1 that a significantly higher proportion of males in the south and west of the borough, and Poulton South in the centre, do the recommended amount of physical activity, compared to Warrington’s average of 76.4%.

A significantly lower proportion of females in Latchford East, and in several wards in the north west of the borough, do the recommended amount of physical activity, when compared to Warrington overall.

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8 Local areas of Warrington divided into 5 groups, based on how they rank on a national deprivation scale (using the Index of Multiple Deprivation (IMD) 2010); quintile 1 is most deprived, quintile 5 is least deprived
Map 1: Physical Activity by Ward

Ward Key:

1 = Appleton
2 = Bewsey & Whitecross
3 = Birchwood
4 = Burtonwood & Winwick
5 = Culcheth, Glazebury & Croft
6 = Fairfield & Howley
7 = Grappenhall & Thelwall
8 = Great Sankey North
9 = Great Sankey South
10 = Hatton, Stretton & Walton
11 = Latchford East
12 = Latchford West
13 = Lymm
14 = Orford
15 = Penketh & Cuerdley
16 = Poplars & Hulme
17 = Poulton North
18 = Poulton South
19 = Rixton & Woolston
20 = Stockton Heath
21 = Westbrook
22 = Whittle Hall

Source: Warrington Health and Wellbeing Survey
2.2.2) Levels of Inactivity: It is estimated that there are 12.5 million people in England who are classed as physically inactive (UKactive, 2014). The Chief Medical Officer defines physical inactivity as participation in less than 30 minutes of moderate intensity physical activity per week, in bouts of 10 minutes or more.

The North West has been ranked as one of the most inactive region of England (UKactive, 2014). Warrington compares well with other North West local authorities (ranked 3rd out of 23) and nationally is ranked 60th out of 152 local authorities, where 1st is best performing.

However latest data (2013) highlights there are still 27.2% of Warrington residents who are classed as inactive and take less than 30 "equivalent" minutes of exercise per week (PHE, 2015a). This is lower than the England average of 28.3% but not significantly different. The percentage of inactive residents in Warrington has also increased slightly since the previous year (26.2%).

The Warrington Health and Wellbeing Survey shows that inactivity increases with age; 8.2% of 18-39 year olds do less than 30 'equivalent' minutes of exercise a week compared to 23.1% of those aged 65 and over. Women, all ages, are significantly higher (15.4%) when compared to the Warrington average for all people (13.3%). Men are significantly lower (11.2%). Chart 8 shows the breakdown by gender and age group.

Please note: results from the Warrington Health and Wellbeing Survey, shown below, should not be compared with the data above taken from the Active People Survey by Sport England due to differing methodologies.

Chart 8: Physical Inactivity by Gender and Age Band
The proportion of people who are inactive increase the more deprived the area, as can be seen in chart 9. This is across all age bands. Quintile 1 (the most deprived area of Warrington) is significantly higher for all people (19.9%) when compared to the Warrington average of 13.3%. Quintile 5 (the least deprived area) is significantly lower at 9.5%.

When looking at physical inactivity by ward, ie less than 30 ‘equivalent’ minutes of exercise per week, map 2 shows that a significantly lower proportion of males in Appleton, Hatton, Stretton & Walton, and Lymm are inactive compared to Warrington’s average of 13.3%. A significantly higher proportion of females are inactive in Burtonwood & Winwick, Poplars & Hulme, and Orford, when compared to Warrington overall.
Increasing physical activity in those aged 40 – 79 years can help to prevent some deaths. Calculations, using the Health Impact of Physical Inactivity Tool (PHE, 2013a), estimate that the following amount of deaths, seen in table 1, could be prevented in 40 – 79 year olds in Warrington if levels of physical activity were increased.
Table 1: Increasing Physical Activity and Preventable Deaths

<table>
<thead>
<tr>
<th>% Warrington Population More Active (ages 40-79, 2010 MYE)</th>
<th>Estimated Numbers of Preventable Deaths (all causes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>13</td>
</tr>
<tr>
<td>50%</td>
<td>62</td>
</tr>
<tr>
<td>75%</td>
<td>112</td>
</tr>
<tr>
<td>100%</td>
<td>162</td>
</tr>
</tbody>
</table>


2.3) Burden of Ill Health That May Result From Low Physical Activity

2.3.1) Ischaemic Heart Disease and Stroke: Physical inactivity increases the risk of heart disease and stroke by 50% (World Heart Federation, 2015). Health is improving in Warrington but there is still stark variation. The town has seen a fall over the past decade in death rates from all causes, and cardiovascular diseases (CVD), which includes things like coronary heart disease, stroke, diabetes and kidney disease. However, All Cause and CVD mortality rates remain significantly higher than the England average. Premature deaths (under the age of 75 years) from CVD for 2011 to 2013 in Warrington were 58.6 per 100,000 population, compared to 50.9 per 100,000 for England (PHE, 2015a).

As described in the CVD chapter of the JSNA, CVD is the biggest cause of reduced life expectancy within Warrington, and premature CVD mortality rates are currently 13% above the average for England. Ischaemic Heart Disease (IHD) is the biggest contributor locally to the comparatively higher rates of CVD deaths. IHD death rates consistently exceed the average for England by over 20%. There is also a strong association with socio-economic deprivation. Analysis shows that the vast majority of ‘excess’ all-aged CVD deaths in Warrington occur amongst people living in local areas that are ranked amongst the 40% most deprived in England.

2.5.2) Cancer:

Bowel Cancer: There were 400 new cases of bowel cancer diagnosed in 2010–2012, giving an incidence rate\(^9\) of 75.8 per 100,000 population (HSCIC, 2015). This rate is lower than England (77.2) and the North West (79.5), although not statistically significant. For people aged under 75, Warrington’s incidence rate of 49.9 per 100,000 is slightly higher than the England average (48.5) and slightly lower than the North West (50.7) but again no significant difference is observed.

Breast Cancer: Warrington had an incidence rate of 194.1 per 100,000 females, the 6\(^{th}\) highest cancer incidence rate nationally (out of 326 local authorities) during 2010 to 2012; in total there were 575 new cases diagnosed (HSCIC, 2015). This resulted in an incidence rate that was significantly higher than both England (163.6) and the North West (164.6). The trend in the rate of incidence has shown year on year increases since 2007 to 2009. When looking at women aged less than 75 years, Warrington had an incidence rate of 162.0. This was 17\(^{th}\) highest nationally. Again, Warrington women had an incidence rate that was significantly higher than England (139.1) and the North West (140.0).

2.5.3) Diabetes: In 2013/14 there were 10,434 adults aged 17 and above diagnosed with diabetes in Warrington, equivalent to 6.16% of the population registered at a Warrington GP Practice (aged 17 and over). The level of diagnosed cases was slightly lower in Warrington than the national average of 6.21% (HSCIC, 2014b). Latest data (2013/14) shows that of the

\(^9\) The incidence rate is the number of new cases of the disease over a period of time, per 100,000 head of population
diagnosed cases in Warrington, 64.1% of patients have well controlled blood glucose, and Warrington is ranked 57th best performing out of 211 Clinical Commissioning Groups (1st is best) (PHE, 2014a).

2.5.4) Obesity: Based on the Active People Survey, in 2012 (latest available data), 70.0% of Warrington residents were classed as overweight or obese\(^{10}\) (PHE, 2015a). This is statistically significantly higher than the England average of 63.8%, but classed as similar to the North West average (66.0%). Breaking this down further, 48.3% of Warrington residents are overweight and 21.7% obese.

The local Health and Wellbeing Survey, undertaken in 2013, showed that obesity prevalence in Warrington followed the pattern of deprivation, with higher levels in the more deprived areas. However, the percentage of adults who are overweight did not follow this pattern. When considering all excess weight, there was a distinction between the 60% most deprived areas (quintiles 1, 2 and 3) which had a substantially higher proportion of adults with excess weight, than the 40% least deprived areas (quintiles 4 and 5).

Adverse health effects of obesity include heart disease, diabetes, asthma, heart failure and hypertension. Reported prevalence rates of all of these conditions are either higher in Warrington than nationally (although the differences may not be statistically significant), or the same (HSCIC, 2014b).

2.5.5) Bone Health: A systematic review (Howe et al., 2011) of 43 randomised controlled trials (over 4,320 participants) has concluded that there is a relatively small, statistically significant, but possibly important, effect of exercise on bone density, compared with control groups. Exercise has the potential to be a safe and effective way to avert bone loss in postmenopausal women.

However, bone density is only part of the issue, as the majority of fragility fractures (the main outcome for poor bone health – predominantly hip fractures) are linked to falls. Exercise has been shown to reduce the rate of falls and the number of individuals having falls (Gillespie et al., 2009) for elderly people living in the community, providing that the exercise being participated in entails two or more of these components; strength, balance, flexibility, or endurance.

Another study (Cameron et al., 2010) has shown that exercise is effective in reducing falls in subacute hospital settings, but its effectiveness in nursing care facilities remains uncertain.

Hip fracture rates in the 65+ age group have a similar picture both locally and nationally at 577.7 and 568.1 per 100,000, respectively, for 2012/13 (PHE, 2015a).

2.5.6) Mental Health and Wellbeing: In 2013/14, according to the GP Patient Survey, 4.5% of respondents (aged 18+) in Warrington reported a long-term mental health issue. This compares to 4.8% in England (PHE, 2015b). Warrington has a higher proportion of people on the disease register for depression than the national average, 7.2% and 6.5% respectively in 2013/14 (HSCIC, 2014b), although prevalence in Warrington has reduced in recent years from a high of 13.4% in 2010/11.

There is increasing recognition (Whitelaw et al., 2008) of the link between physical activity and mental health and wellbeing. Many GP practices now prescribe exercise, either free or at reduced cost, as a way to treat depression (NHS Choices, 2014).

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\(^{10}\) Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m\(^2\)
3) Current Services in Relation to Need

3.1) LiveWire Leisure: Leisure, libraries and lifestyles services transferred from Warrington Borough Council, in May 2012, to LiveWire, which is a Community Interest Company.

The following information comes from LiveWire’s quarterly monitoring spreadsheets (2015) and gives some indication of usage of facilities.

Within Warrington, there are 6 leisure facilities managed by LiveWire, and in 2014, over 2.7 million visits were made to these facilities. When looking at visits by activity, after discounting ‘other’ which has the highest percentage (30.4%), the top 3 activities for 2014 were pool usage (27.1%), the fitness suite (11.7%) and the sports hall (8.7%), together accounting for nearly half of all visits. Of the 2,747,831 visits made in 2014, 30.4% (835,842) were visits made by members.

Customer profiling regarding age and gender has not been included here as data is only available by percentages per quarter, not numbers per quarter. Therefore, it has not been possible to calculate the numbers of people in different age groups or by gender for the whole of 2014. It is also uncertain on what numbers the percentages were based; they are not necessarily based on the total number of visits per quarter. Furthermore it is hard to draw any firm conclusions from the data, even just by looking at the latest quarter, as age and gender were recorded as ‘unknown’ in over 50% of the records.

In terms of membership of leisure facilities, latest available data (October to December 2014) shows that LiveWire had 21,776 ‘live’ members, comprising 46% males, 50% females and 4% unknown.

Membership across the 6 leisure centres and aquatics shows that young adults and adults up to the age of 54 account for the highest number of members. For the 3 months ending December 2014, 16 – 24 year olds represented 15.6% of members followed by 25 – 34 years (14.7%), 35 – 44 (13.5%), and 45 – 54 (12.7%). Together these top 4 age groups represent just over half (56.5%) of memberships. There are some slight variations when looking individually at leisure centres and, for aquatics specifically, the younger age groups aged up to 13 years account for the largest memberships (73.2%).

However please bear in mind that members may not necessarily visit the leisure centres, and as stated earlier less than a third of visitors for 2014 were members.

To ensure that there is an opportunity for equitable access to leisure services within Warrington, concessionary membership is available for those who are in receipt of certain benefits. The latest data from LiveWire (for the period October to December 2014) shows that of the 21,776 ‘live’ members, 8,106 (37.2%) were on concession.

Table 2 gives a breakdown of ‘live’ members and those on concession by each leisure centre. Orford Jubilee has the greatest proportion of its members on concession, just over half (52.1%). Concessionary members at Orford Jubilee also account for 41.8% of all concessions across Warrington. This is to be expected as Orford Jubilee is based in one of the most deprived areas of Warrington, as can be seen in map 3.

Maybe more of a surprise is that Woolston leisure centre has the next highest proportion of members on concession, 42.0%, as this leisure centre is based in one of the less deprived areas of Warrington. Looking further into this, the large proportion of concessions may possibly be explained due to Woolston leisure having the highest proportion of people aged 65 and over who are members (14%) compared to other leisure centres (the next highest is
Orford Jubilee with 11.8%). Concessionary membership is available to those aged 60 and over. Those in receipt of carers allowance or caring for an adult full time are also eligible for discounts, and seeing that 20% of the population in Rixton and Woolston ward is aged 65 and over, and the ward is ranked 9th highest out of the 22 Warrington wards for the proportion of older people, this too may contribute to the high number of concessions.

Table 2: ‘Live’ Members and Concessions by Leisure Centre, Oct to Dec 2014

<table>
<thead>
<tr>
<th>Leisure Centre</th>
<th>No. of 'live' members</th>
<th>No. of 'live' members on concession</th>
<th>% of members on concession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orford Jubilee</td>
<td>6504</td>
<td>3389</td>
<td>52.1%</td>
</tr>
<tr>
<td>Woolston</td>
<td>3198</td>
<td>1343</td>
<td>42.0%</td>
</tr>
<tr>
<td>Birchwood</td>
<td>2510</td>
<td>966</td>
<td>38.5%</td>
</tr>
<tr>
<td>Great Sankey</td>
<td>2197</td>
<td>738</td>
<td>33.6%</td>
</tr>
<tr>
<td>Broomfields</td>
<td>2327</td>
<td>696</td>
<td>29.9%</td>
</tr>
<tr>
<td>Culcheth</td>
<td>1047</td>
<td>299</td>
<td>28.6%</td>
</tr>
<tr>
<td>Aquatics</td>
<td>3993</td>
<td>675</td>
<td>16.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21776</td>
<td>8106</td>
<td>37.2%</td>
</tr>
</tbody>
</table>

Source: LiveWire, 2015

Map 3: Location of LiveWire Leisure Centres

For future JSNA chapter updates, it would be useful to be able to have access to numbers of actual customers, rather than just members, by age and gender in order to conduct analysis on customers using the leisure facilities. If the amount of ‘unknowns’ are able to be reduced, 

Source: Livewire, 2015 (http://www.livewirewarrington.co.uk/leisure/our-locations); ONS – deprivation by LSOA
this will give a more robust data set. Postcode or lower super output area of where customers, and members, live would help to further profile usage by leisure centre.

3.2) Wellbeing Service: The aim of the Wellbeing Service is to improve the health and wellbeing of local people over the age of 16 by encouraging and supporting healthy lifestyle choices and to reduce health inequalities by helping people to make changes they want in their lives by offering practical advice and signposting into appropriate services. The service:

- Identifies and engages with individuals from deprived communities or groups.
- Uses the Health Trainer approach to support individuals to make changes in their behaviour to achieve a positive impact on their health. This includes working with individuals to agree health related behaviour change, identifying the barriers, facilitating appropriate use of other services and opportunities in the community, agreeing a Wellbeing Plan, providing personalised support to achieve goals, and following up individuals.
- Supports individuals to make more effective and timely use of health and wellbeing services in Warrington, and other services, as appropriate. The Wellbeing Service works in conjunction with other key providers and services being offered across Warrington. Cross-referrals between the different services take place in order to ensure that people receive the relevant support they require. These include:
  - Lifestyle Services.
  - Healthy Weight Services (eg. Healthy Weight Programme, MEND).
  - Job Centre Plus.
  - Housing Associations.
  - Support for Carers.
  - Community Services.
  - GPs, Primary Care.
  - Neighbourhood Service Teams.
  - Sexual Health/Mental Health Services.

A befriending project is currently being developed which will provide an opportunity for clients of the Wellbeing Service and the Wellbeing volunteers (befrienders) to be matched together. A volunteer befriender will spend time with a client, offering them support whilst encouraging them to develop their independence and self confidence.

The integration of additional services, such as Reach for Health (exercise on prescription referral programme), Stay on Your Feet (falls prevention and exercise on prescription for those aged 65+) and Weight Management (group and one to one based education programme), provides the ability to harness both objectives and resources to individuals most in need.

The introduction of the Wrights Foundation GP referral and British Association for Cardiovascular Prevention & Rehabilitation (BACPR) qualifications have provided an additional referral route for low risk referrals, whilst providing more availability for the medium to high risk referrals. A referral criterion is set out by both the Wrights Foundation and BACPR education bodies.

3.3) Exercise Referral Scheme (Reach for Health): Reach for Health (RFH) is an exercise referral scheme (for those aged 16+) operated in Warrington by the Local Authority. It is aimed at people with health problems who need support to be more active. The programme is specifically designed for an individual’s needs by Reach for Health trained advisers.
In 2013/14, 2,188 patients were referred to the Reach for Health service. Of these:

- 1,657 (76%) started the exercise programme
- 947 completed it (43% of those referred initially)
- 71% of clients going through the service had a long term condition.

The percentage of people still exercising, having gone through the referral scheme, was 84% at 3 months and 79% at 12 months. This is a ratio of approximately 3 referrals for each one successful outcome (an individual remaining moderately active at 12 months), compared to the 17 to one ratio in the review by Williams et al. (2007).

However, the percentage of clients referred to the RFH who live in the 20% most deprived areas remains below the service target set. The target set is 40% of referrals made should be from clients residing in the 20% most deprived areas. In 2013/14 this percentage was 22%.

3.4) Stay On Your Feet: This service is specifically aimed at those aged 65 years and over. It is an 8 week programme aimed at improving physical activity levels, muscle strength and balance.

In 2013/14, 77% of clients completed the exercise programme demonstrating improvement in 2 or more of the following: muscle strength, balance, posture and flexibility. This compares to 84% in 2012/13.

3.5) Weight Management Service (Diet, Exercise and Nutrition Advice): The healthy weight service offers an effective and safe approach for patients. It incorporates healthy eating advice, exercise, behavioural techniques and cooking skills over a 4, 8 or 12 week programme. It also offers a drop-in service.

There were 1,348 referrals to the weight service between April 2013 and March 2014 (compared to 1,349 in 2012/13). Results from 2013/14 show that:

- 314 participants completed the course (at least 75% attendance).
- 21% of clients achieved a weight loss of between 0-5%, and 21% of clients achieved a weight loss of 5% or greater.
- 81% of clients displayed a positive change in dietary behaviour.
- 70% of clients displayed a positive change in wellbeing.

Further information on healthy weight is contained in the Healthy Weight JSNA Chapter.

3.6) Active Warrington Partnership: The partnership comprises several local organisations and has the following vision and aim:

1. ‘Each year, Warrington will become more active and healthier’.
2. By 2016 Warrington will be the most active borough in the North West.

In order to achieve this vision and aim the partnership has developed schemes and projects to enable people in Warrington to access, take part in and support the delivery of more sport and physical activity.

In 2013/14, 127 activities for families were developed in leisure facilities or parks and open spaces. These activities were either existing projects which were expanded, or new opportunities that were created. Parallel activities have also been created allowing parents or
carers to do one activity while their children do another at the same facility or event. In 2013/14 there were 4 parallel activities which engaged a total of 382 people.

All partners have actively promoted opportunities to engage Warrington residents in swimming, cycling, running and walking, and in 2013/14 the following numbers of people were engaged:

- Swimming 328,334
- Cycling 932
- Running 8,803
- Walking 3,684.

The Annual Report 2013-14 (Active Warrington, 2014) highlights some of the key achievements of the partnership, a couple of examples shown below.

Bewsey and Dallam were identified as an area with low levels of engagement and participation in sport and activity, closely linked to lack of facilities and providers in the area. A project, aimed at increasing provision and engaging people in different age groups to take up sport and physical activity, was made possible by a grant from Sport England’s Community Sport Activation Fund totalling £229,176. The project started in March 2014 and will run for 3 years, and has the aim of getting 5,000 people more active. Already there are new running groups, group exercise programmes and multi-sport activity sessions taking place at community venues in the area.

The Park Run national initiative launched in Warrington in January 2014 with 419 runners taking part. Since then over 5,000 runners have attended the free Saturday morning timed sessions. The project is coordinated and delivered solely by volunteers with support from the Active Warrington Team. The runs are also well represented by Warrington running clubs who turn up in club colours each week.

3.7) Green Spaces: Warrington residents have access to a wide range of open or green spaces across the borough of Warrington, which provides the opportunity for outdoor recreation activities. Warrington also has six Green Flag\(^{11}\) parks (Warrington Hall & Gardens, Risley Moss, Lymm Dam, Alexandra Park, St Peters Park and Bewsey Park), and a number of other Green Flag sites. There are opportunities to walk parts of the Trans Pennine Trail at Sankey Valley and Black Bear Park (which also leads to the Mersey Way). There are two areas which are sites of special interest; Lymm Dam (sandstone geology) and Rixton Claypits (Site of Special Scientific Interest). There are a number of parks which also offer the opportunity to utilise sports facilities such as football and rugby pitches, running tracks and bowling greens.

Latest published data (March 2013 to February 2014) on the Public Health Outcomes Framework (PHE, 2015a) shows that, in Warrington, 20.5% of people use green space for exercise/health reasons. This compares to the England average of 17.1%, although Warrington is not statistically significantly higher. There has been a year on year increase in Warrington, from a low of 5.8% in 2011/12, to 16.0% in 2012/13, and now 20.5% as it currently stands.

Data collected by the Active Warrington Partnership shows that, in 2013/14, there were 96 sessions and 20 events organised in parks and open spaces to increase activity levels. In 2014/15 this increased to 281 sessions (+192.7%), and events were maintained at 20 for the most recent year. During 2014/15, 7,763 people participated in sessions/events in parks and

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\(^{11}\) The Green Flag Award, first launched in 1996, is the standard for parks and recognises well-managed, high quality sites that meet the needs of the community
open spaces. The number of people participating increased approximately 4 times in the second part of the year (October 2014 to March 2015) compared to the first six months.

4) Projected Service Use and Outcomes in 3-5 Years and 5-10 Years

As we are not confident of the level of physical activity being undertaken throughout Warrington, it is not appropriate at this stage to conduct projected analysis on service use. Extra data that would be considered useful includes further detail of customers and members using Livewire services, and membership/visitor attendance of private gyms would add to a more complete picture. However, it is recognised that there have been improvements to pull together the different strands on such a wide reaching subject.

The work of the Active Warrington Partnership and their aim of Warrington being the most active borough in the North West by 2016 has seen a tremendous amount of work being undertaken in communities in the past couple of years to achieve this aim.

5) Evidence of What Works

5.1) Evidence from Policy

Nationally, physical activity has been identified as a key measure in both the primary and secondary prevention of the conditions identified earlier due to inactivity. The cross-government ‘Moving More, Living More’ (HM Government, 2014) is a campaign for a more active nation as part of the 2012 Olympic and Paralympic Games legacy. Although over 1.5 million more people are doing sport once a week than when London won the bid in 2005 to host the Olympic and Paralympic Games (HM Government, 2014, p7), there is still plenty of work to be done, with a large proportion of people remaining inactive. Working together with partners and stakeholders, the Government has set out areas for action to increase physical activity in the population. The main report is accompanied by a series of annexes setting out the benefits of physical activity, the national framework for delivery, work already in hand, a series of case studies, and international best practice.

The government’s aim of increasing the number of adults taking at least 150 minutes of physical activity a week and reducing the number taking less than 30 minutes per week, year on year, has seen slow progress. But it is hoped that with the development of a national physical activity framework (PHE, 2014b), using an evidence-based approach to tackle the levels of inactivity across the country, this will help to promote increased levels of activity among the population. The framework, ‘Everyday active, every day’, developed by Public Health England along with national and local leaders, has four areas for action, including changing the social ‘norm’ to make physical activity the expectation, developing expertise and leadership within professionals and volunteers, creating environments to support active lives, and identifying and up-scaling successful programmes nationwide.

Public Health England have also produced a ‘Healthy people, healthy places’ briefing on obesity and increasing physical activity and active travel (Cavill and Rutter, 2013). The briefing outlines the regulatory and policy approaches that can be taken to help modify the environment to encourage a more active lifestyle.

A report produced by the Health Select Committee (House of Commons, 2015) on physical activity and diet and how it impacts on health highlights the need to consider physical activity in its own right, independent of other issues such as obesity, and has investigated existing evidence on what works in order to draw together recommendations for the next Government.
The paper discusses and makes recommendations on a number of things such as individual interventions, like highlighting the benefits of exercise to a person’s health, and population-level interventions, for example redesigning environments to encourage physical activity. The Committee examines the role of local authorities in encouraging uptake in activity, against a background of financial pressures, and the need to ensure local authorities have the resources to take forward the agenda on physical activity. The Committee recommends cross-government working to ensure strategies that are devised incorporate the full range of ‘elements’ – public education, regulation, fiscal measures, changes to the school curriculum – are just some examples. They recommend that the new government introduces an audit to measure progress against NICE Quality Standards for physical activity and diet, as there is currently little assessment of how far NICE guidelines have been implemented. They also highlight the need to promote physical activity in a primary care setting.

The role of doctors in helping people become more active is further emphasised by the Academy of Medical Royal Colleges (2015). Their report outlines not only why doctors should take a leading role but how they should do that.

5.2) Evidence-Based Practice Interventions

5.2.1) Exercise Referral Schemes: A review by Williams et al. (2007) found that 17 referrals are required for every one successful case (one previously sedentary individual becoming moderately active), with as few as between 12% and 42% of individuals completing a 10-12 week programme. Moreover, the findings from this study indicated that exercise referral schemes have a small effect on increasing physical activity in sedentary people. The key challenge, the authors conclude, if future exercise referral schemes are to be commissioned by the NHS, is to increase uptake and improve adherence by addressing the barriers described in these studies.

The National Institute for Health and Care Excellence (NICE) (2006) recommend that “practitioners, policy makers and commissioners should only endorse exercise referral schemes to promote physical activity that are part of a properly designed and controlled research study to determine effectiveness”. NICE also determined that there was insufficient evidence to recommend the use of exercise referral schemes to promote physical activity, other than as part of research studies where their effectiveness can be evaluated. NICE have published new recommendations that replace the above (NICE, 2014a). This guideline focuses on exercise referral schemes that try to increase physical activity among people who are inactive or sedentary and are otherwise healthy or who have an existing health condition or other risk factors for disease. Details of the new recommendations can be found at this link: https://www.nice.org.uk/guidance/ph54.

Pavey et al. (2011) published a systematic review in the British Medical Journal which found that considerable uncertainty remains as to the effectiveness of exercise referral schemes for increasing physical activity, fitness, or health indicators, or whether they are an efficient use of resources for sedentary people with or without a medical diagnosis.

More recently, Duda et al. (2014) undertook a trial to compare standard provision exercise referral with an exercise referral intervention grounded in Self Determination Theory. The authors concluded that “Significant gains in physical activity and improvements in quality of life and well-being outcomes emerged in both the standard provision exercise referral and the SDT-based intervention at programme end”.

5.2.2) Children and Young People: NICE have published evidence-based guidance on the promotion of physical activity for children and young people (NICE, 2009), aimed at promoting physical activity, active play and sport for pre-school and school-age children in family, pre-school, school and community settings. As well as setting out priorities at a national level, it
also contains recommendations for local authorities and its commissioning partners on how to increase physical activity in this cohort. Following on from this, NICE published an audit on how this guidance was implemented in Oxfordshire (NICE, 2012a), in which the key learning points were:

1. Increase awareness of NICE guidance on promoting physical activity in children and young people across schools.
2. Develop with partners a coordinated strategy to improve physical activity in children and young people which encompasses the recommendations in the NICE guidance. Partners should work with the Partnership Development Managers and School Games Officers to develop and implement the strategy.
3. Work with sports partnerships to develop links between schools and sports clubs and to make school facilities available outside of schools hours.
4. Encourage schools to develop a school travel plan, to integrate the plan with travel plans of other schools and to involve children and young people, parents, the local community and external agencies in implementing the plan.

A briefing published by Public Health England (PHE, 2013b), which draws together existing datasets and an academic literature search, highlights that when children are physically active, this is associated with improved mental health and wellbeing including happiness and higher levels of self-esteem, and lower levels of worry, anxiety and depression.

5.2.3) Adults: NICE have a number of evidence-based public health guidelines to promote physical activity of adults. These include:

- NICE Quality Standard 84 (NICE, 2015). Physical activity: encouraging activity in all people in contact with the NHS.
- NICE Pathway. Physical activity overview (NICE, 2014b). This pathway also includes recommendations for schools.
- NICE Pathway. Walking and cycling overview (NICE, 2014c).
- Public Health Guideline 53 (PH53) Managing overweight and obesity in adults – lifestyle weight management services (NICE, 2014d). This guideline covers encouraging adults to be physically active.
- Local Government Briefing (LGB8) Walking and cycling (NICE, 2013a).
- Public Health Guideline 41 (PH41) Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation (NICE, 2012b).
- Local Government Briefing (LGB3) Physical activity (NICE, 2012c).
- Public Health Guideline 13 (PH13) Intervention guidance on workplace health promotion with reference to physical activity (NICE, 2008a).
- The effectiveness of public health interventions for increasing physical activity among adults (Health Development Agency, 2005).

The NICE Physical Activity Return on Investment Tool (NICE, 2014e) has been developed to help decision making in physical activity programme planning. Users can evaluate a range of interventions in their geographical area and models the economic returns that can be expected in different payback timescales.

A study by Martin et al. (2014) investigated the relationship between active travel and psychological wellbeing. The authors explored associations between wellbeing and (i) travel mode choice, (ii) changes in time spent commuting by specific travel modes and (iii) switching to more active travel modes. The authors found a positive association between active commuting and wellbeing and concluded that "the positive psychological wellbeing effects identified in this study should be considered in cost-benefit assessments of interventions seeking to promote active travel".
Malik et al. (2014) carried out a systematic review of workplace physical activity interventions to identify types of interventions and their outcomes. The purpose of the study was to a) identify the types of interventions offered by workplaces to encourage uptake in physical activity by their staff, b) examine the characteristics of those interventions, c) assess whether they had a positive impact on activity levels, and d) assess the methodological quality of studies. The authors concluded that although some results showed that workplace interventions can be successful, overall results were inconclusive. They conclude that more research is needed to fully examine the effectiveness of interventions, and to be able to highlight which ones are best promoted in the workplace.

5.2.4) NICE Brief Interventions: Brief Intervention is a widely adopted proactive mentality within primary care, where practitioners identify and signpost inactive adults into a suitable form of physical activity, whether that is provided on an advisory basis or through a more structured form of referral. The information provided is relevant to the patients/clients’ needs and interests. NICE advocate the use of brief interventions and make a number of recommendations regarding their implementation (NICE, 2006). Updates on recommendations 1 – 4 in the public health guidance can be found in NICE guidelines PH44 (2013b).

5.2.5) Targeted Intervention: Consultation with previous and existing service users, coupled with consultation with people who declined to attend programmes, enables the service to evaluate the suitability and attractiveness of the programmes provided. This helps to inform future programme design.

A successful targeted intervention, Warrington Women’s Wellness programme, was based on a multiple behavioural intervention approach to tackling health-harming behaviours. This evaluated programme, designed following in-depth insight work with women from areas of deprivation, aimed to introduce participants to a range of physical, educational and motivational activities, with the intention of building confidence and inspiring action. Although a largely structured programme, the approach was flexible rather than prescriptive. Introduction to exercise through a variety of physical activities helped address barriers to participation. Consequently, many participants, with the support of other group members, developed confidence in going on to access leisure services. The evaluation of this intervention found that, following participation in the programme, nearly three quarters of individuals were doing 20 minutes or more of vigorous exercise at least once a week compared with only one fifth of individuals doing so prior to participation. Post-programme, all respondents reported doing 20 minutes or more of moderate exercise a minimum of four times a week, compared with less than a third pre-programme. Since the first pilot programme it has been run in various parts of Warrington and they run one a year.

A pilot project called My Best Move, sponsored by NHS London and delivered by Intelligent Health (NICE, 2013c), involved training GPs and other health professionals in the London region to encourage their patients with long term conditions to become more active. The training was aimed at engaging GPs and focused on how physical activity can help treat many conditions, thereby leading to better patient outcomes, and the relevancy to the role of the GP. The project monitored the impact of the training on GPs’ knowledge and confidence in recommending activity to their patients. Results showed a significant improvement in not only the importance that GPs and healthcare staff placed on the role of physical activity, but also their confidence in speaking to their patients about increasing their activity. Future phases of ‘My Best Move’ are to include more in depth evaluation, and to explore how patient outcomes might be measured.
5.3) Wider Determinants

NICE have addressed the issue of wider determinants of physical activity by examining the effect of the environment on physical activity (NICE, 2008b). These recommendations are aimed at professionals who have responsibility for the built or natural environment, including local transport authorities, transport planners, those working in Local Authorities, and the education, community, voluntary and private sectors. The recommendations from NICE include:

5.3.1) Strategies, Policies and Plans

- Involve all local communities and experts at all stages of the development to ensure the potential for physical activity is maximised.
- Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life. Ensure local facilities and services are easily accessible on foot, by bicycle and by other modes of transport involving physical activity. Ensure children can participate in physically active play.
- Assess in advance what impact (both intended and unintended) the proposals are likely to have on physical activity levels. For example, will local services be accessible on foot, by bicycle or by people whose mobility is impaired? Make the results publicly available and accessible. Existing impact assessment tools could be used.
- New evidence (NICE, 2014f), since publication of the original guidance, highlights that implementing community design policies, which aim to create ‘liveable’ developments to promote physical activity, results in environments more supportive of walking. Furthermore, the degree of actual compliance with these policies suggests increased levels of walking for transport purposes, although recreational walking appears not to increase. Please note Evidence Updates are intended to increase awareness of new evidence – they do not replace current NICE guidelines and do not provide formal practice recommendations.

5.3.2) Transport

- Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads. (This includes people whose mobility is impaired.) Use one or more of the following methods:
  - re-allocate road space to support physically active modes of transport (for example, by widening pavements and introducing cycle lanes).
  - restrict motor vehicle access (for example, by closing or narrowing roads to reduce capacity).
  - introduce road-user charging schemes.
  - introduce traffic-calming schemes to restrict vehicle speeds (using signage and changes to highway design).
  - create safe routes to schools (for example, by using traffic-calming measures near schools and by creating or improving walking and cycle routes to schools).
- Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity. These routes should offer everyone (including people whose mobility is impaired) convenient, safe and attractive access to workplaces, homes, schools and other public facilities (such as shops, play and green areas, and social destinations). They should be built and maintained to a high standard.
5.3.3) Public Open Spaces
- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity. They should also be accessible by public transport.
- Ensure public open spaces and public paths are maintained to a high standard. They should be safe, attractive and welcoming to everyone.
- New evidence (NICE, 2014f), since publication of the guidance, suggests that improving the features and amenities of a community park may lead to increased use and physical activity. Furthermore, upgrading and maintaining community playgrounds could increase levels of physical activity among local school children, although the effect may be restricted to those with a lower BMI. The maintenance of public playgrounds isn’t specifically mentioned in the existing recommendation, and it is possible that this evidence could have a potential impact on guidance when next reviewed.

5.3.4) Buildings
- Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes. (Campuses comprise two or more related buildings set together in the grounds of a defined site.)
- Ensure new workplaces are linked to walking and cycling networks. Where possible, these links should improve the existing walking and cycling infrastructure by creating new routes (and not just links to the new facility).
- During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them.
- Ensure staircases are clearly signposted and are attractive to use. For example, they should be well-lit and well-decorated.

5.3.5) Schools
- Ensure school playgrounds are designed to encourage varied, physically active play.
- Primary schools should create areas (for instance, by using different colours) to promote individual and group physical activities such as hopscotch and other games.

5.4) Black and Minority Ethnic Groups
A study into suitable weight management design (ESRO, 2010) identified that, within the black minority and ethnic groups (BME), both male and female representatives desired a programme that was culturally relevant.

6) (Target) Population/Service User Views
The Leisure Warrington User Survey 2010 (WBC, 2010) highlighted that there were two key drivers for usage of leisure facilities: convenience of facility and value for money.

Within the local Health and Wellbeing Survey (2013), respondents were asked their reasons that prevented them being more involved in physical activity. They were given a number of options to choose from, and they could choose more than one. Two of those options specifically refer to location and value for money.

Data shows that the more deprived areas in Warrington tend to have more people who give these reasons for not exercising, compared to the less deprived areas.
In quintile 1, the most deprived area, 7.3% of people said there was nowhere nearby they could go for exercise. This quintile had the highest response for this answer, and the percentage of people who gave this as a reason lessened as the level of deprivation in Warrington improved (3.4% in quintile 5).

A similar pattern was seen for value for money, with 22.0% of people in quintile 1 stating that a reason for not exercising more was it was too expensive, compared to 8.3% in quintile 5.

Other key reasons for not exercising also came out of the results. Looking at Warrington as a whole, when asked what prevented people from doing physical activity the largest response was “not enough time” (35.1%) particularly for people aged under 40, especially women (49.8% of women and 45.9% of men). Women were more likely than men to give reasons such as “not enough energy”, “no childcare” and “no one to come with me”.

Please note numbers are small once broken down by gender and reason, and caution should be used when interpreting these results.

Wellbeing Service

The following shows a number of testimonials from local people who have use the Wellbeing Service:

“My Mentor is very good at her job. She is thoughtful and very patient. She has a positive approach which helps me with my problems. Makes me think there is still light at the end of the tunnel. She is a lovely human being, a true diamond. Thank you."

“Thank you for everything you do for us. We wouldn’t all be here if it wasn’t for you!!”

“The Mentor was fantastic with me and even though she wanted to refer me I felt I could cope after seeing her”

“Without your help I really don’t think I would be here today. Thank you, forever in your debt”

“I have recommended the Wellbeing Service to some of my friends and can’t thank them enough for the help they gave me.”

“I do appreciate the help, support and guidance given by your Service and the decency and respect given by your staff, thanks you”.

“Without this Service there really wouldn’t be much help out there. You helped me so much and I’ve stayed well”.

LiveWire Services

The following shows a number of testimonials from local people who have use LiveWire services:

“Why Weight has changed my whole view on why I eat certain food ie sweet stuff and how I had allowed an event that took place in my early childhood to dominate my attitude to food. It has taught me about self-worth, how to turn negative events into something positive. I now look forward to healthy meals especially lunches and I now have lots of ideas how to make meals interesting”.
“In the last year since starting adult lessons as a complete beginner, I was anxious about the 
water and could not swim very far at all. Now I am swimming three strokes competently and 
find swimming really relaxing. I have also been whale shark snorkelling!”

“I love coming to yoga. I am currently on long term sickness from work and coming to this 
class makes me feel so much better. I have even started to improve at it which makes me 
want to come more and more.”

8) Unmet Needs and Service Gaps

With the establishment of the Active Warrington Partnership in 2012, a lot more additional 
data is now collected, and as the Active Warrington Strategy progresses more information will 
become available.

However, we still have some data gaps around usage of leisure facilities in Warrington, for 
example for Livewire services, for private gyms and leisure facilities, and not having the 
complete picture makes it hard to identify the unmet needs of the population.

9) Recommendations for Commissioning

- To identify if equitable access to leisure services, physical activity sessions and events, 
and sport facilities is being achieved.

- To encourage older people to take part in physical activity and active recreation. A 
physical activity programme is currently being developed.

- To determine current activity levels of children and young people across the borough to 
inform a physical activity programme that improves uptake of physical activity, with a 
particular focus on girls.

- To build upon, where possible, the Livewire data currently available on customers and 
members of its leisure services. Non-personalised data on age, gender, and postcode (or 
other area identifier), particularly for customers as well as members, will help to provide a 
fuller analysis of customers and usage of services.

- To collate the amount of data available from different sources to form a comprehensive 
picture of physical activity in Warrington. To bring in new sources of information where 
possible eg from private gyms.

10) Recommendations for Further Needs Assessment

A Sport and Physical Activity Profile has recently been produced for Warrington to establish 
the current levels of physical activity and to consider what future action is needed to meet 
Warrington’s goals. The profile, along with this JSNA chapter, provide a thorough picture of 
physical activity in Warrington.

Looking forward, a recently developed facilities and pitch strategy, and the possible 
development of a parks strategy, will provide further information to inform future JSNA 
chapters.
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