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This document is produced as part of Plymouth’s Joint Strategic Needs Assessment
EXECUTIVE SUMMARY

The development of the Needs Assessment was overseen by the Physical Activity Needs Assessment Steering Group. The Group was chaired by Sarah Ogilvie (Specialty Registrar in Public Health) who also produced this report for Plymouth. The author would like to thank Members of the Group for their considerable input and support throughout the process, in particular:

- Neil Minion (Advanced Practitioner in Public Health, Plymouth City Council) for conducting the evidence review and contributing significantly to the write-up of this chapter (Chapter 5)
- Louise Kelley and Martin Lees (Sports Development Unit, Plymouth City Council) for contributing significantly to Chapters 11 and 12 (mapping current provision for physical activity)
- Liz Slater (Leisure Partnership Manager, Plymouth City Council) for contributing to the mapping, particularly with regards to the Leisure Management contract (Chapters 11 and 12)
- Sarah Lees (Consultant in Public Health, Plymouth City Council) for guiding the process followed

In addition, special thanks are given to:

- Simon Hoad (Senior Public Health Analyst, Plymouth City Council) for his considerable input in providing data for the needs based chapters (Chapters 6-8)
- Key partners and organisations across the city, with a role in physical activity, who contributed to this Needs Assessment

Link to Plymouth’s JSNA: http://www.plymouth.gov.uk/jsna
1.1 Being physically active is important for our health and wellbeing. There is now an abundance of evidence linking physical activity to health outcomes (Table 1, page 11 of main report). In addition, from evidence collated by the All-Party Commission on Physical Activity (2014), we know that:

- **Active children do better** – physical activity increases cognitive outcomes and school attainment, and improves social interaction and confidence (Department of Health 2014).

- **Active people do better** - physical activity reduces the risk of all-cause mortality by 30%, of heart disease by 20-35%, of diabetes by 35-50% and of dementia by 40-45% (Department of Health 2014).

- **Active workplaces do better** – physical activity programmes in the workplace have resulted in reductions of absenteeism between 30% and 50% (Davis et al. 2007).

- **An active population drives a stronger economy** - UK Active (2014) estimates that just a 1% reduction in the rates of inactivity each year for five years would save the UK around £1.2 billion.

1.2 Physical inactivity has been identified as the fourth leading risk factor for global mortality causing an estimated 3.2 million deaths globally (World Health Organization 2015). Addressing physical inactivity will reduce the burden of preventable death, disease and disability, and support people and their communities to achieve their potential.

1.3 Locally, Plymouth City Council is committed to increasing levels of physical activity and reducing sedentary behaviour across the city through a combination of direct provision, working in partnership with relevant organisations and maximising available resources.

1.4 The purpose of this Physical Activity Needs Assessment was to gather local intelligence regarding the physical activity needs of the Plymouth population and to establish whether current provision for physical activity meets this demand. More specifically the objectives of Plymouth’s Physical Activity Needs Assessment were to:

- review existing evidence, policies and guidance regarding physical activity at the local, regional and national level
- examine existing datasets to identify need and levels of participation in physical activity
- map current provision for physical activity across Plymouth
- outline key findings, gaps in current provision and recommendations to address local physical activity needs in Plymouth and inform related policy and commissioning

1.5 For the purposes of this Needs Assessment, an inclusive definition of physical activity was adopted which recognises that physical activity can take many forms including sport, exercise, recreational and occupational activity, ‘active travel’ (e.g. walking and cycling as a means of transport), and heavy domestic activity including gardening and housework. This aligns to the national position on physical activity.

1.6 The process followed was based on a rapid health needs assessment. A comprehensive needs assessment takes longer and typically generates new or primary data. It would require more detailed investigation of the local population to understand motivators and barriers to being more physically active. A rapid assessment does not generate primary data and concentrates on collecting data that already exists. This approach still provides sufficient intelligence for decision...
makers to improve existing service provision to better meet local need and can be completed within a shorter timescale.

1.7 A small and focused Steering Group was established compromising the following members:

- Sarah Ogilvie - Specialty Registrar in Public Health, Office of the Director of Public Health, Plymouth City Council
- Neil Minion - Advanced Public Health Practitioner, Office of the Director of Public Health, Plymouth City Council
- Sarah Lees – Consultant in Public Health, Office of the Director of Public Health, Plymouth City Council
- Ruth Harrell – Consultant in Public Health, Office of the Director of Public Health, Plymouth City Council
- Louise Kelley – Sports Development Manager, Homes & Communities, Plymouth City Council
- Martin Lees - Community Sports Manager, Homes & Communities, Plymouth City Council
- Liz Slater - Leisure Partnership Manager, Joint Commissioning and Adult Social Care, Plymouth City Council

Additional input was provided by Simon Hoad (Senior Public Health Analyst, Office of the Director of Public Health) with regards to assessing local need. A final draft was agreed by the Steering Group in May 2015. This was then circulated within Plymouth City Council for additional internal consultation and sense checking before it was circulated to key stakeholders across the city for comment.

1.8 Conducting the Physical Activity Needs Assessment for Plymouth was not an easy task. In terms of assessing need, currently available data regarding levels of physical activity both locally and nationally is fairly limited although additional local data was captured recently which helped to inform the assessment of need. The assessment of need covered: Plymouth’s geography and demography; key health needs related to physical activity; the physical activity profile of children and young people; and the physical activity profile of adults in Plymouth.

1.9 The mapping exercise was conducted by gathering information from key stakeholders (providers and/or commissioners). Initially, a table-based template was used to capture information about current provision (e.g. type of provision, audience, location and cost) and this was then incorporated into the text of the document. There is a high volume of activity across the public, private, community and voluntary sector in Plymouth which caters for different population groups, differing interests and ability levels. Moreover, the methods by which members of the public will access and discover these activities are equally diverse. Consequently, the attempt to map current provision across the city only provides a 'snapshot' of present activity and is unlikely to be fully comprehensive. This is reflected in the report’s recommendations.

1.10 The findings and recommendations of this Needs Assessment are grouped into overarching recommendations and then by the population groups we know are least likely to be physically active or who make up a significant proportion of the Plymouth population:
**Overarching recommendations:**

1) Gather local insight regarding barriers and facilitators to being more physically active through qualitative methods and greater consultation with local people.

2) Develop a greater understanding of the role of the voluntary and community sector and how they can help to promote active lifestyles in the city through supporting local communities and capacity building.

3) Avoid referencing ‘sport’ and use the term ‘physical activity for all’.

4) Promote initiatives which encourage people to be more active, every day. This will include greater emphasis on social and recreational activities that might not require formal commissioning, are more appealing to a wider audience and are more sustainable in the long-term.

5) We should be innovative and creative with our opportunities such as taking activities to people in the community and better use of community assets and non-traditional facilities or spaces. Plymouth has an abundance of green space and blue space that could be better utilised by a broader population group.

6) Physical inactivity and sedentary lifestyles should not be seen in isolation but two health behaviours that often go hand-in-hand with others e.g. tobacco use and poor diet.

7) Where there is evidence of multi-level need, such as in the North West of the city where some residents experience a lack of facilities and significant health needs, then these areas should be considered as a priority for action.

8) Efforts should focus on the early years and families to ensure that we create active lifestyles for life.

9) The ageing population, the current and future physical activity needs of the over 65s and the growing number of retired people living alone (particularly women) should be considered as priority groups in relation to improving mobility, core strength, mental health and wellbeing and tackling social isolation and helping people to live independently for longer.

10) Any commissioned activity should adhere to the latest guidance/evidence base. For example, there have been recent academic challenges made against the impact of exercise referral schemes as an example of best practice.

11) Commissioning decisions should reflect consideration of whether or not a universal or more targeted offer is most appropriate for the identified groups that are least likely to be physically active in Plymouth. A universal offer may be more appropriate for LGBT people, for example. In addition, inactive residents in the city may be likely to fit into more than one of the population groups and therefore barriers are likely to be exacerbated for these individuals.

12) Ensure more effective monitoring of residents’ use of facilities and uptake of opportunities, activities and programmes to better inform need in the city and commissioning going forward.

13) Ensure appropriate evaluation of any commissioned activities related to physical activity, particularly with regards to reach, user profiles and accessibility.

14) No activity should be commissioned without clear evidence that it meets the needs of the population of Plymouth.

15) Every offer to residents of the city should take account of the groups identified as least likely to be physically active and this should inform future investment and commissioning.

16) There should be better linkage among opportunities taking place locally to avoid duplication, play to the strengths of each provider and ensure a diverse offer to Plymouth residents. This should be reflected in more joined-up and collaborative commissioning of opportunities related to physical activity.

17) Local opportunities should link more effectively with local and national campaigns, such as Change4Life, and ensure lasting legacy. Thrive Plymouth provides a clear mechanism with which to do this.

18) Campaigns may be more effective if targeted at those who are receptive to making small lifestyle changes.
19) There should be a move towards positive framing of health-related messages which promote active lifestyles as ‘the norm’.

20) The possibility of extending the capacity for health champion training should be explored so that more people are better able to signpost residents into local opportunities and ensure that every contact counts.

21) Local champions or leaders from each social group are needed in order to bring about significant change. The mentoring of local leaders, particularly with regards to developing their motivational skills, will be key.

22) Health advice should be integrated into every health and social care contact and in all care pathways – from pharmacists and physiotherapists to dental nurses and care assistants – including information on support for physical activity.

(1) General access to opportunities for physical activity (page 87 of main report)

Key findings and gaps in provision:

(1.1) The city is well served by public transport links although these routes do not always provide direct access to all existing opportunities for physical activity (e.g. at particular times of the day). Currently the routes and timetables are subject to commercial viability.

(1.2) The proportion of car owners in Plymouth is slightly below the national average, and is significantly lower in the South and West of the city.

(1.3) When reviewing opportunities for physical activity, accessibility and associated barriers (e.g. timing and cost) should be a key consideration, particularly when looking to promote active lifestyles among residents living in the South West, South East and North West localities. Plans are already in place to improve access to green space, play space and blue space across Plymouth. These plans will ensure that city green spaces are accessible by public transport and within short walking distances.

Recommendations:

(1.4) Easy and low cost access to physical activity via public transport, walking or other means should be a key consideration when promoting active lifestyles among residents in the South West, South East and North West localities as car ownership is lower than anywhere else in the city.

(1.5) Any commissioned activity relating to physical activity should include consideration of accessibility for Plymouth residents, including public transport routes, associated costs (direct or indirect) and timing of activities.

(1.6) Wherever reasonably practical, the delivery of physical activity opportunities should be delivered in local communities.

(2) Green space and play space (page 88 of main report)

Key findings and gaps in provision:

(2.1) Despite being a city, Plymouth has an abundance of green space and play space where people can relax, enjoy nature, take children to play, or take part in sport or recreation.

(2.2) Green spaces are diverse, free and easily accessible for the majority of the population.

(2.3) The city has a clear strategy in place to remove existing deficiencies in access to green space and play space, and to ensure that new development encompasses good access. Importantly, all new or enhanced green spaces will be designed to be accessible so that everyone in the community can enjoy them. The number of neighbourhoods where there is currently a deficiency of green space or play space will be reduced by 2023.

(2.4) Through implementation of the Green Space Strategy, Plymouth residents should not have to walk more than 400 metres to their nearest green space and not more than 600 metres to their nearest play space. In addition, all city green spaces will be accessible by public transport.

(2.5) It is not possible to accurately assess people’s use of green space in Plymouth due to the informal nature of the activities taking place.

Recommendations:
(2.6) Barriers to use and opportunities for greater use among local residents should be explored. For example, in the winter months, use may be reduced due to concerns over safety (e.g. a young woman jogging after work) and families may be more likely to use city spaces at the weekends.
(2.7) Initiatives to get everyone active everyday should utilise Plymouth’s abundant green space and play space, particularly as this space is diverse, free and easily accessible for the majority of the population.

(3) Blue space (page 93 of main report)

Key findings and gaps in provision:
(3.1) Plymouth is an Ocean City in a unique location. Plymouth’s ‘blue spaces’ (including the Plymouth Sound and Tamar) and associated water-based recreational activities offer significant opportunities for people to be physically active, particularly in the summer months.
(3.2) The Plymouth Hoe open space is exceptionally well used.
(3.3) The majority of the population live within one mile of water (sea or rivers) and identify ‘blue space’ as an important recreation resource. In addition, swimming is the main activity that people in Plymouth want to do more of and sailing and gig racing are popular activities.
(3.4) It is not possible to accurately assess people’s take-up of the water-based offer in Plymouth. However, there are known barriers to informal and formal water-related recreation activities including access, cost and timing of activities (seasonal, tidal and time of day). Water-based offers also require a basic swimming competence.
(3.5) There is currently no strategy which looks specifically at promoting use of ‘blue space’ and water-based activities in Plymouth.

Recommendations:
(3.6) Efforts should focus on addressing barriers and promoting use of water-based opportunities among the population groups we know are least likely to be physically active and who are least likely to make use of blue spaces. Evidence from Sport England suggests that swimming is the main activity that people in Plymouth want to do more of.
(3.7) Consider the development of a strategy to promote use of blue space and water-based activities in Plymouth with focus on barriers, particularly among population groups who are the least active and the least likely to take up the existing offer.
(3.8) Future commissioning should consider the water-based offer to residents of Plymouth, with particular regards to the early years, to ensure that interest and healthy lifestyles are developed early in life. A current priority for the city is to offer a ‘second chance to swim’ scheme so that any child who did not learn to swim in primary school gets another opportunity to learn this essential skill. Barriers to participation, particularly in terms of lack of swimming gear, should be addressed to make this an affordable option for Plymouth families.

(4) Indoor and outdoor sport and recreation facilities (page 94 of main report)

Key findings and gaps in provision:
(4.1) Plymouth has a variety of formal and informal sport and recreation facilities, operated by a range of providers, within a reasonably small geographical area. In particular, the flagship Plymouth Life Centre is now considered to be one of the busiest sport and recreation centres in Britain, and draws in residents from across the city.
(4.2) The majority of grass pitches, sports halls and artificial pitches are located on educational sites and therefore access for wider public use needs to be further explored. MoD facilities offer additional potential but access is currently restricted.

(4.3) Supported by local insight data (see page 95 of the main report), the North West corner of Plymouth is underprovided by built sport facilities. In addition, Ernesettle was identified as a neighbourhood with low use or no use of particular facilities and activities. This is particularly significant as we know that residents in the West of the city are more likely to experience poor health and Ernesettle has a greater proportion of residents with disability and/or long-term limiting illness.

(4.4) Neighbourhoods in the Plympton locality do not have easy access to all-weather pitches for sport and active recreation.

(4.5) A formal indoor and outdoor sport and recreation offer has restricted appeal to the population. Given the abundance of green and blue space in the city, it is important to recognise the potential for greater provision through informal facilities (e.g. public parks) and non-traditional facilities (e.g. church halls and community halls). These spaces can provide locality based provision and thereby enhance accessibility.

(4.6) The Plymouth Plan will set out a planned approach to the future provision of sports and recreation facilities and opportunities, which will build upon the Council’s wider Playing Pitches and Leisure Facilities evidence base. This will then help to direct investment to where it can have the greatest impact. This will include consideration of significant new population hubs in line with planned development for the city (including Derriford and Seaton and Sherford new town to the East of the city).

Recommendations:
(4.7) Explore access to grass pitches, sports halls and artificial pitches on educational sites for wider public use.
(4.8) Explore access to MoD facilities for wider public use.
(4.9) Focus efforts to address the lack of built facilities for sport and active recreation in the North West of the city.
(4.10) Explore low use or no use of facilities and activities for sport and active recreation in Ernesettle - less formal opportunities may be more appropriate and should be suitable for residents with disability and/or long-term limiting illness.
(4.11) Review Plympton residents’ access to all-weather pitches for sport and active recreation and explore alternatives.
(4.12) Explore the potential for greater provision through informal facilities (e.g. public parks) and non-traditional facilities (e.g. church halls and community halls) to meet unmet demand in the city.
(4.13) Direct investment in new facilities where it will have the greatest impact.

(5) Active design (page 97 of main report)

Key findings and gaps in provision:
(5.1) The promotion of physical activity levels in Plymouth can be enhanced through planned infrastructure for a healthier city.
(5.2) Plymouth City Council has recently invested in walking and cycling infrastructure with additional schemes to be delivered going forward.
(5.3) One of the main challenges for the city, particularly in terms of promoting active travel (e.g. cycling to work), is its topography.

Recommendations:
(5.4) Enhance the promotion of physical activity levels through planned infrastructure for a healthier city.
(5.5) Continue to invest in walking and cycling infrastructure and initiatives.
(5.6) Identify opportunities to address the challenge of Plymouth’s rugged and hilly nature.
(6) Events related to promoting physical activity in the city (page 97 of main report)

Key findings and gaps in provision:

(6.1) Organised events across Plymouth, both big and small, can act as a catalyst for people to become more physically active e.g. Race for Life.

Recommendations:

(6.2) Organisers of events should ensure that key organisations in the city are aware of planned events with advanced notice and should factor in a legacy element for increased community participation.

(6.3) Utilise opportunities to link with national events. For example, Plymouth links with Wimbledon and promotes the use of free tennis courts across the city as part of Great British Tennis Weekend.

(7) Plymouth City Council commissioned or provided services & activities (page 98 of main report)

Key findings and gaps in provision:

(7.1) Plymouth City Council (PCC) provides and commissions a number of services and activities supporting the physical activity agenda.

(7.2) This Needs Assessment should help to highlight to commissioners and providers the range of activity that takes place so that current provision can be reviewed to ensure alignment to need and avoidance of duplication.

Recommendations:

(7.3) Ensure future commissioning of PCC services and activities supporting the physical activity agenda is aligned to need and avoids any unnecessary duplication of the ‘offer’ to Plymouth residents.

(7.4) Ensure wherever possible that commissioned activities have the potential to provide long-term behaviour change.

(7.5) Ensure future commissioning requires providers to build in appropriate evaluation and data capture to provide greater understanding of individuals’ use of facilities and uptake of activities or programmes.

(7.6) Undertake qualitative research to gather local insight to inform commissioning going forward.

(8) Women and girls (page 102 of main report)

Key findings and gaps in provision:

(8.1) 50.5% of Plymouth’s population are female, with similar proportions of males and females across all age groups. There is some minor variation across neighbourhoods with a higher proportion of females in Elburton & Dunstone (although <10% difference).

(8.2) The recent survey of Plymouth schools identified that 19% of Year 8 and Year 10 pupils live mainly or only with their mother which may influence barriers to participation.

(8.3) Nationally, we know that women are less active than men in virtually every age group. For girls, participation begins to drop even more from the age of ten to 11 (national picture). Levels of inactivity are also higher among girls from the lowest economic group compared to the highest.

(8.4) Locally, whilst activity levels were generally low, there was no difference between males and females responding to the Wellbeing Survey. Women were only slightly more likely than males to report that they wanted to be more physically active (74% vs 69%). This contrasts with Sport England data for Plymouth which suggests that whilst physical activity rates have increased, 46% of Plymouth men compared to 29% of Plymouth women participate in sport at least once a week reflecting the regional and national picture. This may be due to the method of data collection: the Sport England survey focuses on sport and the local survey encompasses all forms of physical activity including housework and gardening.
Plymouth women have lower life expectancy than the England average.

Females are expected to have a higher prevalence of mental health problems in Plymouth than males. Evidence suggests that there is an approximately 20% to 30% lower risk for depression and dementia for adults participating in daily physical activity.

National evidence tells us that the barriers for women and girls are extremely varied and differences can be seen between different groups e.g. by ethnicity or social class. For example, Muslim women are unable to go swimming if there are male lifeguards. Lack of confidence, self-esteem and body image issues can prevent women and girls from exercising (national picture), in addition to concerns about safety (e.g. jogging after dark). For girls, social determinants, such as parental support, can also influence participation. Environmental factors such as poor access to suitable facilities and the lack of opportunity to exercise in a female only facility/class contribute to poor participation levels. Females’ perceptions of femininity, and their opinion that being sporty was not an aspirational female characteristic, have been identified as barriers to participation.

Sport England has launched a national campaign to persuade more women to adopt lifelong sporting habits (https://www.sportengland.org/our-work/equality-diversity/women/). This Girl Can is a related national campaign developed by Sport England and a wider range of partnership organisations which focuses on addressing judgment as a barrier to participation (http://www.thisgirlcan.co.uk/). A promotional video is currently being played on national television and there is national advertising (e.g. posters at bus stops).

Locally we know that the majority of Year 8 and Year 10 girls in Plymouth enjoy being physically active (only 7% of boys and girls reported that they did not enjoy activities at all). Walking and jogging were the most popular activities among both girls and boys and 20% reported riding a bicycle in their own time at least weekly.

Evidence from Sport England suggests that girls in particular can be more influenced by sporty mums than sporting heroes or big sporting events, yet 42% of Plymouth pupils responded that they ‘rarely or never’ play games or sports or do other physical activities with their parents or carers (and girls were slightly more likely to report this than boys).

Girls were more likely to believe they were ‘unfit’ or ‘very unfit’ than boys. In addition, boys reported that they were more likely to exercise on at least three days in the week before the survey than girls.

Locally, the top five barriers to physical activity for girls were: “I don’t have enough time”, “I am shy in front of other people”, “I’m not comfortable about how I look”, “It costs a lot to get there or take part”, “I know what I want to do but I don’t know where to go”. The barriers were not significantly different to the barriers for boys with the exception of barrier 3. Interestingly this is being addressed through Sport England’s This Girl Can campaign for women. Related to this, nearly two thirds of girls surveyed in Plymouth wanted to lose weight and over half responded that they worry ‘quite a lot’ or ‘a lot’ about the way they look.

Using the Sport England mosaic profiling tool, we know that ‘Retirement Home Singles’ make up the greatest proportion of the Plymouth population. These are predominantly women, aged 66+ years, living in sheltered accommodation. They are much less active than the average adult population but their activity levels are more consistent with other segments in this age range. They are likely to be doing less sport than 12 months ago, mainly due to health or injury, 10% take part in ‘keep fit/gym’, 7% swimming and 3% bowls (for a full profile see Appendix 9 of the main report).

At the Plymouth Life Centre 65% of indoor bowlers are male. Whilst the Plymouth Life Centre has seen a significant increase in bowling activity since opening in March 2012, the gender profile of those participating has not changed.

**Recommendations:**

Local initiatives should build on women’s desire to be more physically active (willing audience – identified through Wellbeing Survey). Year 8 and Year 10 girls also felt that
Initiatives to encourage women and girls to be more active should adopt a family-based approach to encourage active lifestyles for life, with focus on parental support and addressing time and cost as barriers to participation.

Mother–daughter activities should be promoted which address barriers to participation (e.g. cost, time including time of day, personal safety) and self-confidence. Consideration should be given to lone parents who are more likely to be mothers as barriers to participation are likely to be greater for this group.

Targeted work is needed with girls aged 10-11 where activity levels fall off significantly – this should be based on greater understanding of the barriers for this age group.

We need greater knowledge of provision tailored specifically for girls outside of school-based opportunities.

Efforts are needed to tackle the findings that Year 8 and Year 10 girls felt unfit and wanted to lose weight – this should focus on confidence building and highlighting the benefits of maintaining a healthy weight.

More opportunities should be created for girls from low income and/or BME backgrounds.

Improvements in teacher training, particularly at primary level and a more diverse and inclusive offer (which moves away from the current focus on competitive sport in PE to a broader range of activities to meet the needs of a wider group of children especially girls), is needed.

There should be a varied ‘offer’ for the city that addresses key barriers to participation for women and girls with particular emphasis on addressing low self-confidence.

Walking and jogging appear to be popular activities among pupils in Plymouth. The current offer in the city includes specific running groups for both women and girls. These could be further promoted.

A key area of engagement will be opportunities for retired women who live alone, particularly as this is a growing social group who are more likely to experience social isolation.

Local activity should align with national campaigns run by Sport England and other partnership organisations.

Local work should continue the movement created by the This Girl Can campaign.

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(9) Children and young people (page 102 of main report)

Key findings and gaps in provision:

(9.1) The city has the eighth lowest proportion of children and young people (aged under 18) of the 16 Southwest County and unitary authorities (2012).

(9.2) Due to an estimated 35,000 to 40,000 students residing in the city, the proportion of 18-24 year olds (13.2%) is higher than that found regionally (8.8%) and nationally (9.3%).

(9.3) The age profile of the Plymouth neighbourhoods is variable, with Greenbank & University standing out as an outlier because the 16-24 age group make up 57.3% of the population. Barne Barton has the highest proportion of 0-15 year olds.

(9.4) According to Mosaic profiling: the North West locality has a greater proportion of families with many children, living in areas of high deprivation and who need additional support; Plympton has a greater proportion of active families with teens and adult children whose prolonged support is eating up household resources; Central & North East has a greater proportion of forward-thinking younger families who sought affordable homes in good suburbs which they may now be out-growing.

(9.5) The School Wellbeing Survey (involving 820 boys and 970 girls from Year 8 and 899 boys and 1060 girls from Year 10) found that: 91% of pupils responded that they are White UK; 55% of pupils responded that they live with their mother and father; 19% responded that they live mainly or only with their mother; 8% responded that they are a 'young carer'; 7% responded that being a young carer takes up at least an hour of their time each
Plymouth has a greater proportion of children living in poverty than the England average. We know from the Plymouth Report 2014 that there were a total of 395 looked after children (children in care) in Plymouth (as of 31 March 2014; rounded to the nearest five), with a higher rate (77 per 10,000 children aged under 18 years) compared to the England average (60 per 10,000). There were also a total of 3,402 children starting a children-in-need episode (referred and subsequently accessed to be in need of social care in Plymouth throughout 2013/14). The rate of children-in-need of 665.1 per 10,000 children was 1.8 times that of the national rate (372.6). There were also a total of 501 children who became the subject of a child protection plan through the same period, with a higher rate (97.9 per 10,000 children) compared to the England average (42.1 per 10,000 children). In this Needs Assessment, we have not been able to specifically cover these children, although we recognise that they are a vulnerable group and will have specific needs/barriers when it comes to physical activity. We recognise that this is a gap in our current knowledge and something that will need to be addressed in the future (see recommendations).

Plymouth has higher rates of teenage pregnancy than the England average. Keyham and Greenbank & University are priority neighbourhoods for promoting healthy weight among reception school children. Ernesettle and Ham & Pennycross are priority neighbourhoods for promoting healthy weight among children in Year 6. Ernesettle has the lowest proportion of children in Reception with excess weight but the highest proportion of children with excess weight in Year 6.

35% of boys and 61% of girls responded that they would like to lose weight (School Wellbeing Survey 2014). 20% of boys and 53% of girls responded that they worry ‘quite a lot’ or ‘a lot’ about the way they look.

5.3% of parents with young children were considered to be socially isolated in 2014 (Health Visitor Survey 2014). Stonehouse has the highest proportion of families recorded as being in social isolation compared to Colebrook, Newnham & Ridgeway which has 1.4%.

The percentage of families where ‘one or more parents smoke’ was 26.2% (Health Visitor Survey 2014). This ranged from 4.0% in Woodford to 45.7% in Morice Town (an eleven-fold difference).

24% of Year 8 and Year 10 pupils said they have smoked in the past or smoke now (School Wellbeing Survey). 44% of smokers responded that they want to give up smoking; 30% said that they don’t want to give it up.

59% of pupils responded that the amount of sleep they normally get is enough for their health. 15% said it isn’t enough (School Wellbeing Survey 2014). 55% responded that they are ‘quite a lot’ or ‘a lot’ satisfied with their life at the moment. 45% responded that they feel confident in their own abilities and 47% feel in control of what happens in their life.

Levels of activity among Year 8 and Year 10 school pupils in Plymouth (2014):

- 67% responded that they enjoy physical activities ‘quite a lot’ or ‘a lot’. Boys were more likely to report this than girls although it is not known if this is significantly different.
- Only 7% of pupils responded that they don’t enjoy physical activities at all.
- 35% of pupils responded that they think they are ‘fit’ or ‘very fit’. 23% of pupils responded that they think they are ‘unfit’ or ‘very unfit’.
- 67% of pupils responded that they exercised enough to breathe harder and faster on at least three days in the week before the survey (again boys were more likely to have done so than girls). 7% of pupils responded that they didn’t exercise enough to breathe harder and faster at all in the week before the survey.
- 81% of pupils responded that they do at least one of the physical activities listed at least ‘weekly’. 46% of pupils responded that they go for walks in their own time at least ‘weekly’, while 36% said they go jogging and 20% ride a bicycle.
- 42% of pupils responded that they ‘rarely or never’ play games or sports or do other physical
activities with their parents or carers (girls were slightly more likely to report this than boys). 26% of pupils responded that they play games or sports or do other physical activities with their parents or carers ‘once a month’, while 31% said they do so ‘once a week’.

- 27% of pupils responded that they travelled to school by car or van on the day of the survey.
- 48% of pupils responded that they walked to school on the day of the survey.
- 43% of pupils responded that they don’t cycle.

(9.16) Main barriers to physical activity (boys and girls):
- 44% of pupils responded that they don’t have enough time to do as much exercise or sport as they want.
- 37% said they are shy in front of other people.
- 33% said it costs a lot to get there or take part.

(9.17) Top five barriers to physical activity for boys:
- “I don’t have enough time”
- “It costs a lot to get there or take part”
- “I know what I want to do but I don’t know where to go”
- “I am shy in front of other people”
- “Transport to get there is a problem”

(9.18) Top five barriers to physical activity for girls:
- “I don’t have enough time”
- “I am shy in front of other people”
- “I’m not comfortable about how I look”
- “It costs a lot to get there or take part”
- “I know what I want to do but I don’t know where to go”

(9.19) Nationally identified barriers to participation:
- Children and young people’s opportunities to be active can be affected by environmental, economic and social factors, and perceptions about safety and accessibility.
- Weather conditions – and their perception of what type of conditions make it suitable to be outside – can also affect the opportunities they take.
- Parents’ and service providers’ fears of injury can be barriers to participation, although the fear of risk may not necessarily correspond to reality.
- Bad school experiences have also been identified as barriers to being more physically active or participating in sport (e.g. no sport they like, being told they are no good at sport, sport means getting red/sweaty, fear of being laughed at).
- Sport outside of school can be considered too structured, competitive or serious.
- If no-one in the child or young person’s friendship circle organises sport, it is left to individuals, which can be isolating.
- Children and young people tend to prefer social events.
- Some see sport as physically painful or stressful.
- Sporting environment seen as unpleasant or intimidating.
- Some children and young people report not feeling fit enough to participate.
- Friends and family can often take precedence over other activities.
- Self-image is typically defined by other activities.

Recommendations:

(9.20) Ensure physical activity is encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

(9.21) Early years’ settings are key – early engagement has huge potential within the broader family setting to change culture and behaviours particularly around healthy lifestyles for healthy weight.

(9.22) In addition to a universal offer, priority neighbourhoods for promoting healthy weight are Keyham, Ernesettle, Greenbank & University, and Ham & Pennycross.
| (9.23) | The finding that Ernesettle has the lowest proportion of children with excess weight in reception yet the highest proportion of children with excess weight in Year 6 needs to be explored. We know that parents in this area are more likely to have a disability or long-term limiting illness. |
| (9.24) | Map the physical activity offer to young families provided by Plymouth's children's centres. |
| (9.25) | Review current training for early years' staff to ensure increased physical activity is promoted in the early years. |
| (9.26) | As Barne Barton has the highest proportion of 0-15 year olds, efforts could be targeted here in addition to city-wide efforts to get more children and young people moving more often. |
| (9.27) | Active schools should be the norm. A whole school approach is needed across the breadth of the school day. Fundamental to achieving this are improvements in teacher training particularly at primary level and a more diverse and inclusive offer (the current focuses on competitive sport in PE should be complemented by a broader range of activities to meet the needs of a wider group of children). |
| (9.28) | Whilst formal provision of PE is delivered within national framework, this should not deter those who promote physical activity to work with schools and colleges with regards to the extracurricular offer. |
| (9.29) | Increase the number of schools in Plymouth that are actively engaged in Change4Life clubs. |
| (9.30) | School-based healthy weight interventions may be more effective if targeted at boys or girls separately given that girls in Plymouth are much more likely to want to lose weight and are more likely to worry about their appearance than boys, and the locally identified barriers are different. |
| (9.31) | The offer to pupils from BME groups and/or pupils with learning disability or long-term limiting illness and/or pupils who are young carers should be greater explored to ensure that it is meeting need. |
| (9.32) | School-based interventions should address pupil's self-confidence as a barrier to greater participation and ensure that there is a varied offer to pupils to cater for different interests and instil good habits for life. |
| (9.33) | Pupils should be better signposted to opportunities across the city, particularly where access and cost are not barriers to take-up. |
| (9.34) | The finding that exercise improves sleep with associated benefits for school attainment should be promoted to parents in attempts to encourage children to be more physically active on school nights. |
| (9.35) | Aim to ensure that all children leave primary school being able to swim – where this is not happening currently, introduce a ‘second chance to swim’ scheme so that any child who did not learn to swim in primary school gets another opportunity to learn this skill. |
| (9.36) | Walking, cycling and jogging are popular activities among school pupils and should therefore be promoted, particularly as activities that parents or carers can also participate in. These should be promoted alongside addressing safety concerns e.g. through wider provision of 20mph zones. |
| (9.37) | Continue to support Bikeability cycle training for children to keep them safe on the road. |
| (9.38) | Explore community access to primary and secondary schools across the city and address barriers to greater use e.g. avoidance of block bookings. |
| (9.39) | Whilst there is a larger than average 18-24 year old population, there is good provision of sporting opportunities at the colleges and universities in the city. Potential for greater involvement in non-sporting opportunities should be explored, in addition to the role of the colleges/universities and students in increasing participation in physical activity by the wider community. Of note, the 16-24 age group make up 57.3% of the population of the Greenbank & University neighbourhood. The offer to female students, particularly those... |
from low income backgrounds and/or BME groups, should be further explored to ensure that current provision is meeting need.

(9.40) The North West locality should be well served by accessible, free or low cost opportunities for low income families and lone parents with multiple children.

(9.41) Stonehouse (South West locality) would benefit from group-based, low cost opportunities for families who feel socially isolated.

(9.42) As nearly a third of school pupils are likely to come from families where one or more parents smoke, and 24% of Year 8 and Year 10 pupils smoke now or have smoked in the past – family-based opportunities could address smoking cessation and physical activity together or be provided at the same time. Morice Town is a priority neighbourhood.

(9.43) A need for family-based opportunities during the working week has been identified.

(9.44) Maintain a discounted entrance fee for children, young people and families to city leisure services.

(9.45) Opportunities for physical activity for young families should be promoted in the Central & North East locality.

(9.46) The offer for teen parents needs to be explored to ensure it is meeting need. Teen parents and particularly lone teen parents are likely to face additional barriers to participation, including time, cost and low self-confidence.

(9.47) Understand the needs and barriers to physical activity for looked after children (children in care) and children-in-need.

(9.48) Given that time was the main barrier to school pupils being more physically active - and that this is also the main barrier for adults in the city - opportunities to be more physically active need to be built into everyday life e.g. through education and work settings, active travel (mainly walking as this is free) and through family-based low cost or free weekend activities.

(9.49) Non-sporting opportunities for children and young people in the city should be greater promoted.

(9.50) The Plymouth Fairness Commission made a specific recommendation to ensure that every young person in the city should be able to access free recreational and cultural activities within one bus ride.

(9.51) Interventions aimed at children and young people should acknowledge the influence of peers in terms of encouraging or discouraging physical activity.

(9.52) Opportunities should be fun and designed with children and/or young people and/or families.

(9.53) Ensure that professionals make every contact count with children and young people in terms of promoting active, healthy lifestyles for life.

(10) Adults of working age (page 106 of main report)

Key findings and gaps in provision:

(10.1) The proportion of the working-age (16-64 year old) population (65.7%) is higher than that regionally (62.1%) and nationally (64.1%).

(10.2) Plymouth has lower life expectancy for both men and women compared to the national picture, and higher levels of adults smoking (and smoking-related deaths). For 2011-12, Plymouth also had a higher proportion of patients aged 18+ years on the depression register compared to the South West and England average.

(10.3) Levels of participation decline gradually between the ages of 25 and 45 years (national picture).

(10.4) Participation declines with lower socioeconomic class, although Plymouth adults in Social-economic Classification (SEC) 5-8 are more active (34%) than the South West (31%) and national average (29%) for this group. Peverell & Hartley has the highest proportion (16.2%) of ‘higher managerial, administrative and professional occupations’ compared to 2.9% in Devonport. Stonehouse has the highest proportion (11.8%) of ‘never worked and long-term unemployed’ compared to 1.6% in Woodford. Locally, the Wellbeing Survey
found that unemployed people (79%) and managerial/clerical workers (76-83%) were more likely to report that they wanted to be more physically active.

(10.5) Based on the Active People Survey 7 (2012-13), 54% of adults in Plymouth (aged 16+ years) want to do more sport, compared to 54.7% regionally and 57.5% nationally. Of ‘active’ Plymouth adults (i.e. they have participated in at least one session of the sport, at any intensity or duration, in last 28 days), 34.2% would like to do more, compared to 35.5% regionally and 36.4% nationally. Of ‘inactive’ adults (i.e. those who have not participated in the sport in last 28 days), 19.8% would like to do more, compared to 19.4% regionally and 21% nationally. For Plymouth residents, the sport they would like to do the most is swimming.

(10.6) 69.5% of adult Plymouth residents are satisfied with local sports provision compared to 64.1% regionally and 60.3% nationally (Active People Survey 2012-13).

(10.7) Using the Sport England mosaic profiling tool, we know that ‘Sports Team Lads’, ‘Comfortable Mid-Life Males’ and ‘Pub League Team Mates’ make up a significant proportion of the Plymouth population (see Appendix 9-12 of the main report for detailed profiles). These are typically sporty males.

(10.8) Nationally identified barriers:
- Time is the most commonly cited barrier to participation in physical activity.
- Complex household routines (especially for those with young children) are a barrier to physical activity.
- Work commitments, lack of leisure time, caring for children or older people and not having enough money are major barriers to being more physically active.
- For many people, it is a combination of circumstances that prevent them from walking or cycling for everyday travel - these include the logistics of organising and travelling with children, pressures of time and other commitments, and concerns about safety.
- Motor traffic is a major deterrent for many cyclists (potential and current) and pedestrians in rural areas – and for children in all areas.
- Fear of violence or robbery is another deterrent - many potential walkers restrict their journeys on foot because of their perception that empty streets, particularly at night, are dangerous.
- There is a perception that walking and cycling are not things to do as a matter of routine.
- Traffic volume and speed act as barriers to walking and cycling (for recreation, as well as for transport purposes).

(10.9) We know there is reasonably high satisfaction with current facility provision across the city, particularly with the opening of the Plymouth Life Centre. Locally, lack of time was the most commonly cited barrier to being more physically active (48% of respondents to the Wellbeing Survey). Lack of money (31%) and lack of motivation (29%) were also commonly cited local barriers. Of relevance, the Plymouth Fairness Commission highlighted the escalating cost of living.

Recommendations:
(10.10) Given that Plymouth has a greater than average working-age population and levels of participation decline gradually between the ages of 25 and 45 years, adults of working age are a priority group.

(10.11) There is a desire among unemployed people and managerial/clerical workers in Plymouth to be more active which should be acted upon.

(10.12) Promoting physical activity in all workplace settings and opportunities in Plymouth would reach a large audience and would help to overcome some of the barriers to participation, including time, cost and issues around childcare. This would also enable participation to be translated into everyday activity.

(10.13) Work is already taking place to implement the Workplace Wellbeing Charter across the city and this should take priority. Workplace health is also the current focus of the Thrive Plymouth campaign to address health inequalities. Local businesses should continue to be
supported to take part and to work towards excellence, particularly with regards to supporting action to increase physical activity in the workplace.

(10.14) All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

(10.15) Given that swimming is one of the main activities that Plymouth adults would like to do more of, opportunities to facilitate participation should be promoted, particularly among employees.

(10.16) All employees should be encouraged to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work. This includes suppliers and visitors. The introduction of a travel plan or sustainable transport policy will help to get companies to think about how to encourage more sustainable and active travel.

(10.17) Physical activity through active travel and workplace health should be integrated into every level of economic growth and infrastructure planning.

(10.18) Active lifestyles should be integrated into local workforce development programmes and training for staff and should ensure that every contact counts.

(10.19) New workplaces should ensure that they are linked to walking and cycling networks.

(10.20) Transport strategy should be re-focused over time to provide long-term continuity of resources to incentivise and facilitate walking and cycling as regular daily transport.

(11) Older adults (page 107 of main report)

Key findings and gaps in provision:

(11.1) The city currently has the third lowest proportion of people aged 75 years and over compared to the national average, although the largest population increase will be seen in 75+ year olds.

(11.2) From 1991-93 to 2010-12, life expectancy at birth of males in the city increased to 78.3 years (+5.0 years) whilst life expectancy for females increased to 82.1 years (+3.1 years).

(11.3) During the period 2008-09 to 2012-13, the rate of hospital admissions for falls in adults aged ≥65 increased by 31.6 per 10,000 population. The rate of hospital admissions for falls in adults aged >75 increased in Plymouth by 62.8 per 10,000 population. Morice Town and the East End have the highest rate of emergency hospital admissions for fall-related injuries across all ages and in the over 75s.

(11.4) The directly age and sex standardised rate of primary hip replacement per 100,000 population for Plymouth and the South West is significantly higher than the England average.

(11.5) The estimated number of people with dementia in Plymouth is predicted to reduce for the 65-69 age group but increase in the over 69s by 2020.

(11.6) The proportion of adult social care users who have as much social contact as they would like is higher for Plymouth when compared to the England and the South West average.

(11.7) Levels of physical activity decline with increasing age for both men and women.

(11.8) Plymouth’s older population is increasing meaning that a larger proportion of the population will be sedentary. Of the Plymouth neighbourhoods, Elburton & Dunstone has the greatest proportion of adults aged 65 and over. This is the most sedentary age group (spending around 10 hours or more each day sitting or lying down) with higher rates of falls, obesity, heart disease and premature mortality compared with the general population.

(11.9) The Plymouth Wellbeing Survey 2014 found that older residents were the most likely not to have engaged in any physical activity in the past seven days (25%) compared to 14% of 35-59 year olds and 11% of 18-34 year olds.

(11.10) Participation in sport also declines with age, with only 13% of 55+ year olds in Plymouth participating in sport at least once a week compared to 21% regionally and nationally. Participation for this age group has decreased by 2% from 2005-06 to 2012-13.

(11.11) Older people in Plymouth are also less likely to report that they want to be more
physically active than younger people.

(11.12) Using the Sport England mosaic profiling tool, we know that ‘Retirement Home Singles’ make up the greatest proportion of the Plymouth population. These are predominantly females, aged 66+, living in sheltered accommodation. They are much less active than the average adult population but their activity levels are more consistent with other segments in this age range. They are likely to be doing less sport than 12 months ago, mainly due to health or injury, 10% take part in ‘keep fit/gym’, 7% swimming and 3% bowls (for a full profile see Appendix 9).

(11.13) National evidence suggests that the main barriers to participation are:

- lack of time
- cost – especially of gym membership
- health and physical limitations
- fear of injury
- feel unsafe going out alone and after dark
- lack of (very) local opportunities
- lack of companion
- poor weather
- lack of interest
- don’t enjoy being active
- don’t look the part
- don’t need to – because active and busy already

(11.14) Residents aged 60+ completing the Wellbeing Survey 2014 were more likely to report physical or other health barriers to being more physically active.

Recommendations:

(11.15) We need a better understanding of the offer to older people across the city.

(11.16) Efforts should focus on tackling sedentary behaviour in the 65+ age group. This should link with work around falls prevention, dementia and initiatives to tackle social isolation among older people and help them to live independently for longer.

(11.17) Given that residents are generally happy with the level of social care contact they receive – health and social care professionals should use this contact to opportunistically promote key messages and local activities that meet the needs of the individual.

(11.18) The competency and skills of health and social care staff to support older people, including integration of key skills around physical activity for older adults, should be improved.

(11.19) Interventions that promote moderate-intensity physical activity, particularly walking, and are not facility dependent, are associated with longer-term changes in behaviour.

(11.20) Interventions restricted to adults aged 50 years and older are effective in producing short-term changes in physical activity but there is limited evidence that they can be effective in producing mid- to long-term changes.

(11.21) Clear messages should be conveyed that some physical activity is better than none, and that being more active provides greater health benefits.

(11.22) Messages should also highlight that there are exercises suitable for their age group and for people who have not exercised for some time. NHS England, in partnership with Age UK, has recently published a Practical Guide to Healthy Ageing. This guide outlines how to keep fit and independent. It is aimed at people of any age, but is particularly relevant for people aged around 70 years or older who are beginning to find that everyday tasks now take them longer to do and may be suffering from mild frailty. The guide gives examples of how people can meet the recommended guidelines for physical activity including examples of activities that can improve or maintain health such as ballroom dancing and climbing the stairs. It also highlights the sort of activities that people can undertake to improve muscle strength, such as carrying or moving loads like groceries, gardening jobs and chair-based exercises.
(11.23) Activities should be tailored to address physical and health barriers to being more active as well as any concerns over safety.
(11.24) Older people should be offered taster sessions of activities that are likely to appeal.
(11.25) Opportunities should be fun and highlight the social aspect.
(11.26) Opportunities should be inexpensive and good value for money.
(11.27) A key area of engagement will be opportunities for retired women who live alone, particularly as this is a growing social group who are more likely to experience social isolation.
(11.28) Greater mapping of the walking offer across the city is needed, including better understanding of the quantity and timing of sessions and volunteering capacity.

(12) People from low income backgrounds (page 108 of main report)

Key findings and gaps in provision:
(12.1) Plymouth has significantly higher levels of material deprivation and greater proportions of children living in poverty than the national average.
(12.2) The Plymouth Fairness Commission highlighted the escalating cost of living.
(12.3) The most disadvantaged areas of the city are the South West, North West and South East localities.
(12.4) There is variation by neighbourhood: Peverell & Hartley has the highest proportion (16.2%) of ‘higher managerial, administrative and professional occupations’ compared to 2.9% in Devonport. Stonehouse has the highest proportion (11.8%) of ‘never worked and long-term unemployed’ compared to 1.6% in Woodford.
(12.5) Across Plymouth, 10% of all households are lone parents. This increases to 14% in the North West locality compared to 9% in the Central & North East locality.
(12.6) We know that socially disadvantaged groups are more likely to experience inequalities in health. In particular, there are higher rates of smoking and COPD mortality in the West of the city. Certain health behaviours and health conditions are likely to act as barriers to a more active healthy lifestyle.
(12.7) Participation declines with lower socioeconomic class, although Plymouth adults in Socioeconomic Classification (SEC) 5-8 are more active (34%) than the South West (31%) and national average (29%) for this group.
(12.8) Nationally, unemployed respondents and those with ‘Other’ occupations (mainly retired) were the most likely not to have taken any moderate physical activity (23% and 22% vs only 10% of managerial/clerical staff).
(12.9) Locally, we know that cost is a major barrier to participation.
(12.10) The Active People Survey 2011-13 found that 58.9% of survey respondents in socioeconomic classification groups 5-8 (lower supervisory and technical occupations, semi-routine and routine occupations, never worked and long-term unemployed) reported that they had not participated in sport or active recreation in the week compared to 48.9% in socioeconomic classification groups 1-2 (higher and lower managerial, administrative and professional occupations).
(12.11) Locally, unemployed people (79%) and managerial/clerical workers (76-83%) who responded to the Wellbeing Survey were more likely to report that they wanted to be more physically active.
(12.12) National evidence suggests that there may be fewer opportunities to be physically active in areas of high deprivation – this relates to perceptions of personal safety locally, the location and accessibility of facilities such as leisure centres and parks, and lack of activities such as organised walks and sports events. Areas of greater deprivation have reduced access to environments that support physical activity such as parks, gardens or safe areas for play, and are more likely to have transport environments less amenable to active travel.

Recommendations:
(12.13) Approaches should build on existing initiatives to offer opportunities for physical activity
at little or no cost.

(12.14) Efforts to address levels of physical activity for this target group should focus on residents living within the South West, North West and South East localities, particularly the neighbourhoods of Devonport and Stonehouse. Additional focus should be given to families and older people living in poverty, lone parents and the unemployed (the unemployed will not benefit from workplace based initiatives).

(12.15) Initiatives should build on the desire of local unemployed people to be more physically active.

(12.16) Whilst a number of opportunities are currently provided, particularly in more deprived areas of the city, we know from anecdotal evidence that these offers are not always taken up. We need a better understanding of why this is the case and what can be done differently. Given the range of health and social need factors experienced by residents living in the more deprived areas of the city, simply addressing cost alone is unlikely to improve uptake.

(12.17) Any low cost or no cost initiatives to promote physical activity should consider possible indirect costs associated with the offer and whether these may act as a barrier to participation. For example, free swimming lessons might have poor uptake due to the cost of buying swimming costumes, particularly when buying for multiple family members.

(12.18) Residents should be reached through community leaders, community settings and local organisations.

(13) Lone parents (page 108 of main report)

Key findings and gaps in provision:

(13.1) The demands of being a lone parent mean that it is extremely difficult for this group to take part in physical activity.

(13.2) Across Plymouth, 10% of all households are lone parents. This increases to 14% in the North West locality compared to 9% in the Central & North East locality.

(13.3) The recent Wellbeing Survey of Plymouth schools identified that 19% of Year 8 and Year 10 pupils live mainly or only with their mother which may influence barriers to participation. Evidence from Sport England suggests that women have a strong influencing role within their own families and that girls in particular can be more influenced by ‘sporty mums’ than sporting heroes or sporting events. 42% of pupils also responded that they ‘rarely or never’ play games or sports or do other physical activities with their parents or carers. Lone parents are likely to face additional barriers to participation.

(13.4) Areas of Plymouth have high levels of deprivation and higher proportions of low income households. These areas are typically located in the West of the city. Affordability and accessibility must be key considerations.

(13.5) No evidence is available regarding specific barriers for lone parents in Plymouth although they are likely to experience barriers faced by the general population to a greater degree. For example, cost and time have been identified as major barriers to participation for Plymouth residents.

(13.6) Nationally, one of the key factors affecting participation in physical activity is the age of the children and how many children they have.

(13.7) Childcare is a central issue - as well as it being provided, it needs to be in a convenient location, at the right time, at the right price and with the right people.

(13.8) The financial cost of participating in sport and physical activity is a substantial barrier, especially if they have more than one child.

(13.9) Transport is a factor in determining what types of sport and activities people do, especially if they did not have their own car.

(13.10) Lack of confidence is a major barrier at all levels from actually participating in a class to not even having the confidence to go into a gym or leisure centre.

Recommendations:

(13.11) We need a better understanding of the barriers to participation for lone parents in
Opportunities for lone parents to be physically active should be promoted, particularly in the West of the city. These opportunities should be flexible, accessible, and affordable, with low cost childcare options where required. They should also seek to address lack of confidence where possible.

Free or low cost opportunities for lone parent families in accessible locations should be promoted so that physical activity can become part of their everyday life, such as through walking to school or engaging with Plymouth’s green spaces. Stepping Stones to Nature already delivers regular and free family activities on Local Nature Reserves during the school holidays, for example.

Opportunities provided through the workplace will enable employed lone parents to participate in greater levels of physical activity without the concerns associated with lack of childcare.

BME groups (page 108 of main report)

Key findings and gaps in provision:

According to the 2011 Census, 96.1% of Plymouth’s population considered themselves to be White, which is significantly higher than the England average (79.8%).

Whilst we have increasing diversity in the city, the numbers from any given ethnic background are relatively small. This could lead to people being indirectly socially excluded and removed from mainstream society.

The main ethnic minorities in Plymouth are the Polish (0.7%; just over 1,900) and the Chinese (0.5%; just over 1,200).

The localities with the greatest BME populations (particularly Asian/Asian British) are the South East and the South West. They are also the most deprived localities in the city where physical activity levels are generally lower than in other areas of Plymouth.

There is variation across the Plymouth neighbourhoods. In Stonehouse 88.9% of the population are White and 4.7% of the population are Asian/Asian British. However, conversely 98.8% of the population of Elburton & Dunstone are White.

Nationally we know that physical activity levels are lower for BME groups, with the exception of African-Caribbean and Irish populations. This can lead to people being indirectly socially excluded and removed from mainstream society.

Knowledge of levels of physical activity among the non-white participation in Plymouth is limited. In the South West, we know that the proportion of White adults not undertaking any sport or active recreation is 46.2% and the proportion of non-White adults is 46.9%, compared to 46.7% and 48.4% nationally (Active People Survey 2011-13). Locally, White British respondents to the Wellbeing Survey were marginally more likely to report no moderate activity in the past seven days (18% vs 11% of others). These findings contrast the national picture.

Locally identified barriers to participation are not known; although they are likely to be similar to national evidence. Identified barriers include:

- religious concerns about dress, segregation and prayer times
- previous bad experiences of service provision
- family advice that being active is not culturally appropriate for older people, particularly women, or that they can only do certain things
- lack of confidence
- absence of BME role models from within the community
- lack of activities BME people may prefer to get involved with
- lack of culturally appropriate facilities/settings

The Plymouth Fairness Commission highlighted addressing discrimination and social exclusion as priorities for the city.

Recommendations:
(14.10) We need a better understanding of levels of physical activity among BME groups in Plymouth to inform analysis of need.
(14.11) We need a better understanding of the current offer to BME groups in the city.
(14.12) Local facilitators and barriers to participation need to be explored, particularly amongst different BME communities.
(14.13) Opportunities for BME groups to be more physically active should be promoted, particularly in the South East and South West localities and in the Stonehouse neighbourhood. These should take account of the different barriers to greater participation among different community groups. Local communities and ‘experts’ should be involved at all stages to ensure that the potential for physical activity is maximised.
(14.14) Local policy makers, commissioners and managers, together with primary care practitioners, should pay particular attention to the cultural needs of hard-to-reach and disadvantaged communities, including BME groups, when developing service infrastructures to promote physical activity.

(15) Adults with disability or limiting illness (page 108 of main report)

Key findings and gaps in provision:

(15.1) 11,647 (4.65%) of people who live in Plymouth are permanently ill or disabled and are unable to work.
(15.2) Plymouth has a higher proportion of residents whose day-to-day activities are ‘limited a lot’ than the England average. The North West locality has the greatest proportion of residents reporting that their day-to-day activities are limited (23.2%), in addition to high levels of deprivation. The population of Ernesettle is more likely to have a disability or limiting long-term illness and so the needs of this population are likely to be greater. Of note, the mapping of service users revealed that there were fewer users from this neighbourhood.
(15.3) Plymouth has a higher proportion of patients aged 18+ years on the learning disabilities register compared to South West and England’s average in 2011/12.
(15.4) In 2012-13, the percentage of adults with excess weight (i.e. classified as overweight or obese according to their Body Mass Index (BMI)) in Plymouth was 67.4%. The percentage of adults with excess weight by Plymouth neighbourhood ranged from 54.3% in the City Centre to 73.8% in Barne Barton (a difference of nearly 20 percentage points). This information is based on the BMI of people who were referred to hospital (for any condition) and as such should be considered as a proxy measure of excess weight in the Plymouth population as a whole.
(15.5) In the Plymouth Wellbeing Survey, disabled people were much more likely to report no moderate activity (41% vs 12% of others).
(15.6) As participation by those with a limiting disability is not available for Plymouth from Sport England data, regional and national data are reported. Participation has increased since 2005-06, although participation by those with a limiting disability remains substantially lower (12.6%) in the South West than those with no limiting disability (27.8%), with a similar picture nationally (12.2% and 27.2%) (Active People Survey 2011-13). The proportion of adults with a limiting disability who are not undertaking any sport or active recreation in Plymouth is 76.2% compared to 40.6% for adults with no limiting disability reflecting the South West (69.6%; 41.5%) and national picture (69.9%; 42.5%) (Active People Survey 2011-13).
(15.7) A number of barriers have been identified nationally including: inaccurate beliefs about the benefits of physical activity (e.g. it is common for arthritic people to believe that any activity is bad for arthritic joints); negative attitudes towards physical activity; and social and environmental barriers.
(15.8) ‘Physical or other health barriers’ were one of the top barriers to being more physically active given by residents (34%) completing the Wellbeing Survey 2014. Residents aged
60+ (53%) and residents with a disability (87%) were more likely to report physical or other health barriers.

(15.9) As Plymouth has an ageing population, the demand for hydrotherapy pools is likely to increase.

Recommendations:

(15.10) We need a better understanding of the current offer to adults with disability and/or long-term limiting illness in the city and whether a targeted or universal offer is more appropriate depending on the range of need. This is particularly important given that ‘physical or other health barriers’ were identified as one of the main barriers to being more physically active by Plymouth residents in a recent survey.

(15.11) It is important to understand and recognise the distinction between a person living with a physical disability and one living with a learning disability and acknowledge the fact that the two groups may have differing needs and that their barriers to participation in physical activity may also be different.

(15.12) Local facilitators and barriers to participation need to be explored.

(15.13) Given that ‘adults with disability and/or long-term limiting illness’ encompasses a broad population group, a varied offer is needed.

(15.14) Opportunities need to be tailored to meet needs and be fully accessible, including access to specialist coaches and equipment. For example, opportunities in the Barne Barton area should be suitable for residents with health issues relating to excess weight as this is a key health need for this area.

(15.15) Commissioners and providers of targeted opportunities for this population group should be more joined-up and coordinated across the city.

(15.16) Given increasing demand, current provision of - and access to - hydrotherapy pools in Plymouth should be explored.

(15.17) Opportunities should be created for carers to take part in physical activity.

(15.18) Opportunities should be low cost.

(15.19) Opportunities within the neighbourhood of Ernesettle should be explored as residents are more likely to have a disability and/or limiting long-term illness and are less likely to use current facilities in the city.

(15.20) The key to achieving and maintaining a more active lifestyle for people with disabilities and/or limiting illness is to participate in activities which they personally enjoy, perceive as supportive in maintaining activities of daily living and can be easily incorporated into their routine.

(15.21) All providers should consider safety issues associated with a particular disability and appropriate medical advice should always be sought by individuals with particular health problems before beginning an activity programme.

(16) LGBT people (page 110 of main report)

Key findings and gaps in provision:

(16.1) There is no precise data on numbers of Lesbian, Gay and Bisexual (LGB) people in Plymouth, but nationally it is estimated to be 5.0% to 7.0%. This would suggest that approximately 13,300 of people aged 16 years and over in Plymouth are LGB.

(16.2) In 2010, it was estimated nationally that the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition. The median age for treatment for gender variation is 42 years. There is no precise number of the transgender population in Plymouth.

(16.3) Research examining barriers to physical activity for members of the LGBT community is limited. However, prevalence of homophobia in sport suggests the need for promotional materials which promote a more equitable ideal of masculinity and femininity in sport.

(16.4) Studies on the LGBT community and its relationship to sport and physical activity tend to focus on issues of identity and prejudice. In addition, the heterogeneous nature of individuals from the LGBT community (i.e. LGBT is only one marker of identity
intersecting with many others) makes it difficult to identify any overarching practical barriers.

(16.5) Half of all lesbian, gay, bisexual and transgender people say they would not join a sports club and this is twice the number of their heterosexual counterparts.

(16.6) The Plymouth Fairness Commission highlighted addressing discrimination and social exclusion as priorities for the city.

Recommendations:

(16.7) We need a better understanding of levels of physical activity among LGBT people in Plymouth to inform analysis of need.

(16.8) We need a better understanding of the current offer to LGBT people in Plymouth and whether a targeted or universal offer is more appropriate.

(16.9) Local facilitators and barriers to participation need to be explored.

(16.10) Local policy makers, commissioners and managers, together with primary care practitioners, should pay particular attention to the cultural needs of hard-to-reach and disadvantaged communities when developing service infrastructures to promote physical activity.

1.11 In summary, there is still much to do to truly understand the physical activity ‘offer’ to residents of Plymouth and the range of barriers and facilitators to active lifestyles. It is clear that we need a diverse offer to cater for different needs and opportunities to be more active. This should be accessible, convenient and provided at low cost.

1.12 We all have a responsibility to promote active, healthy lifestyles, and to build more physical activity into our daily lives. The findings and recommendations of this Needs Assessment should be reviewed alongside the new national, evidence-based framework for physical activity which aims to support all sectors to embed physical activity into the fabric of daily life (see page 16 of the main report). This plan highlights that action is needed from providers and commissioners in health, social care, transportation, planning, education, sport and leisure, culture, the voluntary and community sector, as well as public and private employers. Local efforts to promote active lifestyles should align to the national ambition to:

- change the social ‘norm’ to make physical activity the expectation
- develop expertise and leadership within professionals and volunteers
- create environments to support active lives
- identify and up-scale successful programmes nationwide

1.13 Whilst it is important to highlight physical inactivity as a priority for the city, it should not be looked at in isolation. Thrive Plymouth focuses on tackling health inequalities across the city through addressing lifestyles that encompass multiple rather than individual unhealthy behaviours, including physical inactivity, poor diet, tobacco use and excess alcohol consumption. Locally, the findings will be used specifically to inform the work of Thrive and Plymouth’s Healthy Lives for Healthy Weight Action Plan. A Physical Activity Group is being set up by the Office of the Director of Public Health (ODPH), Plymouth City Council, with relevant partners to inform this work. The ODPH is also collaborating with Public Health England to establish a Peninsula-wide Physical Activity Network Group dedicated to increasing levels of physical activity locally.