

# Sport and Physical Activity Needs Assessment

## Prepared to Support The One Barnet Sport and Activity Review

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# Executive Summary

The overall purpose of the Sport and Physical Activity needs assessment is to examine sport and physical activity participation amongst the Barnet population and the health implications of these behaviours. It aims to provide the necessary evidence to ensure planning for leisure is evidence-based and tailored to the specific needs of the borough and to facilitate the future leisure commissioning.

## Overview

The needs assessment examines the population of Barnet, their health and how active they are before looking in detail at how different groups in the borough use leisure facilities, what kinds of activity they might like to do and what kinds of motivations and barriers exist. Stakeholders were asked if our findings had resonance with them and have incorporated a rapid facilities mapping exercise to demonstrate how existing facilities meet the needs we have reported on.

We have also looked at evidence of what interventions work to increase physical activity with a view of providing a perspective on how sport and physical activity in Barnet might be increased in the most effective and resourceful way.

We have identified the limitations of this needs assessment and made recommendations about what further knowledge would assist in setting the strategic direction for physical activity, sport and leisure in Barnet in future.

The needs assessment does not intend to comment on a number of issues, which have arisen over the Olympic period – provision of competitive input in schools, playing fields, elite sport etc. These might be addressed by the future development of a strategic statement for physical activity for Barnet, which we would see as a logical next step.

# Key findings

## *1.Strategic context*

- The importance of physical activity is recognised within existing strategic commitment of the Borough in particular within the Health and Well-being Strategy. There is the lack of comprehensive strategic approach to physical activity which incorporates sports development, active travel, environmental measures, the use of leisure facilities and community buildings.

## *2. The population and health profile of Barnet*

- Barnet's population is set to grow partly due to continued migration and also as a result of regeneration and new housing developments. In line with this growth the age and ethnic profile of the borough is also expected to change.
- Physical inactivity is a major risk factor for coronary heart disease (CHD) and type II diabetes.
- Cardio-vascular disease mortality increases as area deprivation increases.
- In Barnet, 18.3% of adults are classified as obese. 9.5% of children in Reception and 17.7% of children in Year 6.
- Given the rise of obesity levels in children and the high lifetime risk of developing diabetes associated with early obesity, the obesity epidemic is likely to translate into a diabetes epidemic in future years.
- Adults and children who are overweight or obese are less likely to meet the physical activity recommendations of at least moderate intensity physical activity on five or more days a week compared with those who are not overweight or obese.
- Spatial planning can promote participation through the provision of accessible parks, allotments, open spaces, leisure facilities and an attractive and safe public realm which encourages walking, cycling and socialising.
- Physical inactivity costs the NHS approximately £4.1 million per year. It also creates costs for the wider economy, through sickness absence and through the premature death of productive individuals, and increases costs for individuals and their carers.

## *3. The physical activity profile of Barnet*

- People in Barnet are less active than those in England and London with only 19% of residents taking part in 3x30min sessions of moderate activity per week. This is also the case when Barnet is compared to local boroughs in north central London. Only Enfield has lower levels of physical activity.
- In addition to low levels of activity there is a downward trend in contrast to national trends which are rising, though London trends are similarly downward.

- There are less women than men accessing leisure in Barnet, less non white groups and less people who live in the more deprived areas, particular along the west side of the borough, but also in the Underhill area. Those groups who are less active in Barnet are also more likely to be suffering from lifestyle diseases. Intermediate levels of activity are to be found along the eastern fringes of the borough – Finchley/Woodhouse and Brunswick Park and the highest levels in the central areas, with the exception of Underhill.
- Of those groups who are the most sedentary – which is 48.8% of the population - the pattern is repeated with those with life limiting illness or disability, older than 55 years, in lower socio economic groups, women and non-white groups being the most likely to sedentary.
- The greatest public health benefit is to get these groups at least minimally active.
- Data for children and young people levels of activity is poor due to the lack of a requirement to record this information. The data that does exist is limited but suggests that Barnet children and young people maybe less active than the national average.
- The data does suggest that young people in Barnet, as other areas, become less active through their school career, thus reducing their propensity to maintain an active lifestyle in to adult hood.
- In terms of volunteering and club membership in Barnet, club membership is high but this reflects the affluent nature of the borough since this would include membership of health and fitness clubs. The level of volunteering is lower than the national average at 3.5% compared to 7.3% of people who spend an hour or more a week volunteering in sport. Many grassroots clubs that support young people in being involved in sport and physical activity are dependent on volunteers.
- In addition the infrastructure of community based organisations is potentially threatened by low levels of volunteers, this suggests that Barnet has an over reliance on private health and fitness clubs.
- Satisfaction with sport provision in the borough is significantly lower than at the national level. Only 57.4% of adults living in Barnet are satisfied with sports provision compared to 69% at the national level. This suggests that facilities and activities for sport in the borough are not meeting the requirements of Barnet residents.
- Overall Barnet participation is high in affluent populations and lower in deprived groups.

#### 4. Market segmentation

- In order to increase participation in physical activity it is important to understand the groups of people we have in Barnet and how we can encourage them to be more active. Sport England has developed a web-based tool which splits the adult population of any local authority into 19 segments based on their age, gender and socio-demographic information. They have provided information on sporting activity and preferences for each segment which offers a useful insight into the types of

people providers need to target with interventions. In addition, details on motivating factors and barriers for each group also indicates how these groups can be most effectively targeted. They have given each segment a name which is the commonest name among that segment.

- When we look at the overall population of Barnet, the five most prevalent market segments are relatively active compared to the general population. These groups need less input to achieve regular participation in physical activity. Additionally, these groups are from a higher economic group and have both the financial and educational resources to seek opportunities for physical activity.
- Less-active segments of the population are present in smaller numbers. They have more barriers to physical activity including health and disability, family/childcare issues and economic barriers.
- While it is beneficial for all segments to increase their levels of physical activity, the biggest public health benefit is achieved by getting those who undertake no regular physical activity become at least minimally active. Thus the groups which should be a priority for intervention to increase physical activity are:
  - Young mothers - Paula, Leanne and Jackie
  - Individuals of middle age - Roger and Joy and Brenda, also Kev and Elaine
  - Older adults - Elsie and Arnold and Ralph and Phyllis

## 5. Stakeholder responses

In collecting stakeholder views through a range of conversations several themes have emerged from all parties, the responses were well informed and consistent. These ranged from personal concerns about using facilities to broad views from a policy and resident perspective.

### Personal Concerns:

- cost
- wanting someone to go with
- body image
- not knowing about what to wear, where to go, how to find your way around in a new environment
- quality of facilities
- lack of transport to reach some facilities
- childcare

The pricing of swimming with a child often means the parent has to pay full price even though they may be splashing in a shallow pool with a child rather than making full use of the pool. This puts parents off going as it became very expensive.

There are common concerns overall about the cost of using local authority facilities amongst older people and those with disabilities.

There was a strong interest in alternative activities – not just those based in leisure facilities. Dancing, Keep fit classes, using parks, cycling, and walking were all raised as activities people felt that they might like to do if they could overcome some of the personal barriers and had the opportunity.

In addition to this the lack of information about what was available came up in each group. The use of the council's website seemed to be an issue and there was a reluctance to ask the council about leisure facilities if people were not aware of what was available. Knowledge of professionals in a position to advise on becoming active was raised in addition to no one viable source of information on which to base this.

## **Broader Concerns:**

The stakeholders had a variety of ideas about what would encourage people to be more active including for example, improving play areas, more use of parks as a resource for free gyms, safer cycling, better transport to venues and environmental improvement through planning and regeneration. There was some feeling that the leisure review should be part of wider consideration to physical activity across the Borough.

The use of community facilities particularly schools was raised as a barrier since it was often not possible to use these most local and accessible of locations.

It was felt that the provision of physical activity for children and young people is overly reliant on the Barnet Partnership for School Sports and Sports Development Team.

Lack of Council funding have reduced the opportunities for physical activity programmes to fully meet the needs of less active groups in the population.

The lack of co-ordination of Barnet policies in the context of physical activity and leisure was seen as a significant issue for promoting physical activity and was viewed as ultimately the key to effectively promoting physical activity and use of leisure facilities. There needed to be a consistent view on the strategic direction for physical activity across all areas of the councils business. It was also felt that this would enable other key policy decisions to be informed about the purpose of some roles and would assist in accessing future funding and forming more effective relationships with the private sector and community providers.

## **6. *Current physical activity services***

- There are several programmes supported by the council which offer good access to schools, young people and disadvantaged groups. A number of events and opportunities are provided throughout the year and all those involved work well in providing these. Activities which lead to qualifications and work experience are open for disadvantaged young people.
- The School Travel Co-ordinator supports schools in reviewing their school travel plans and organises promotional activities to increase walking and cycling in schools.
- Community support for physical activity and sport is provided through networks of clubs and via the support of Pro Active North London (the local community sports partnership). Pro Active is influential in providing support and assistance locally to



both council officers, community clubs and organisations and the school sports partnership. There is more potential to work with Pro Active North London if Barnet had a more coherent approach to physical activity and sports and could adopt a broader remit and perspective.

- Barnet has three major regeneration areas which will produce 32,000 new homes in the next 20 years. Walking and cycling routes are well integrated within regeneration areas. This provides the ideal opportunity for integrating physical activity and sport into lifestyles.
- The Council requires new developments to produce and maintain 'Development Travel Plans' to reduce vehicle movements.
- Barnet is one of the greenest boroughs in London with 73 public parks. The majority of sites which have poor accessibility are located in residential areas away from the main road where bus routes run.
- As with parks, children's play facilities are not evenly distributed through Barnet. Less than half of the parks in Barnet have play provision for children. Accessibility to play sites via public rights of way, the cycle network, bus and rail needs to be improved.
- Barnet is relatively well provided for in terms of distribution of playing pitches. Further work is required on assessing distribution of these facilities outside of open spaces.
- There is a high level of demand for allotments.
- Promoting active travel, the use of parks, play areas and open spaces are essential if there is any desire to move away from a wholly provider based landscape for leisure and sport. In addition these promote the integration of activity into lifestyles which is essential for populations where income, transport and access are also a challenge. Many of the policies which guide the development of these are out of date.

## *7. Leisure facility needs analysis*

Leisure services are provided across the borough by GLL. There are several venues and analysis has shown that though these are open to all residents, local populations attend local venues with an average of 43.3% of people attending sports facilities living within 2km distance from these. The main exception on this would be Church Farm Swimming Pool which serves a large number of Enfield residents.

The gap analysis has identified the physical access gaps in provision, relating to both facility size and capabilities. It has also explored the relationship between the resident population across the Borough of Barnet and the current membership profiles of GLL members at the six main sport centres. By examining the demographic profile of the Borough, as well as population projections, it has been possible to compare the gaps in provision and levels of current and future need. This has been considered in line with the priority groups, identified within the wider Need Assessment.

### ***Priority groups***

The largest priority group populations are located on the west and south west of the Borough. Key wards include Burnt Oak, Colindale, Childs hill and East Finchley (to the east). The population between 2012 and 2031 is projected to increase most significantly in the west and central regions of the Borough.

### ***Accessibility***

In terms of physical access to sport facilities the most deprived area across the majority of facility types is the west part of Edgware. Other areas that have relatively low accessibility levels to a selection of facility types include Burnt Oak and Colindale (west), Childs Hill (south), Hale and Mill Hill (central), High Barnet (north, particularly gyms access) and East Barnet (north east, particularly STPs).

When considering facility size as well as travel time, as an indicator of overall availability of facilities, priority wards include Edgware, Golders Green, Childs Hill, Garden Suburb and High Barnet (STPs).

### ***GLL membership gap analysis***

The analysis has reviewed the membership conversion rates at GLL centres in terms of catchments around the centres and also geographic trends across the whole Borough to identify gaps or areas in under representation.

In terms of the performance of actual centres, with respect to the profile of the local catchments they serve, Compton Sport Centre has low levels of female and 0-15 year old members. Hendon Sport Centre has the lowest levels of 55+ year old members. Copthall Pool has the widest catchment area and Compton and Burnt Oak sport centre have the lowest relative levels of ethnic minority group members.

The analysis compared the points of origin of members with their individual demographic profiles to identify which areas of Barnet have the lowest membership conversion rates for different types of priority group indicators. Key wards which should be attracting more members from specific priority groups include Childs Hill, Colindale, Edgware, Garden Suburb and Underhill.

### ***Supply and demand***

The supply and demand analysis has benchmarked levels of supply, considered trends in participation and demand (including latent demand) and utilized Sport England's facility Planning Model.

In terms of supply, this analysis has supported the findings from the Gap Analysis. There are generally low levels of provision across all facilities in the west with wards such as Colindale with minimal levels of facility share for all activities.

In terms of participation, rates in Barnet are relatively low compared with neighbouring authorities and the North London County Sports partnership area and across London. These participation rates have continued to fall at a significant rate, suggesting that urgent action is required.

There has been a slight increase in participation rates for swimming, football and tennis but generally all other activities have seen a decline. There are pockets of latent demand, mainly in the south and south east (and small areas of the south west), which supports the Gap Analysis and suggests that these should be areas where capacity and accessibility need to be reviewed as a matter of priority.

Sport England's Facility Planning Model identified that levels of swimming provision are generally acceptable however new provision will be required as the population grows over the next ten years. The most significant levels of unmet demand are across sport halls. This can be addressed by firstly opening up more school provision for community use and secondly by addressing the programming at existing sites. It may be possible to relocate indoor football (traditionally on sport halls) onto Synthetic Turf Pitches (STPs) if available.

There is clearly a need for new sport facility provision across the Borough of Barnet and this need will only increase given the significant population growth projections. At the same time there is the opportunity to refine certain facility mixes and relocated facilities so they best meet the needs (and address the gaps) of the local resident population. The planning of new facility provision or the rationalisation of existing facilities should balance the areas of priority identified in the Gap Analysis and the levels of undersupply for particular sports identified within the Supply and Demand section.

## *8. Literature review on public health interventions to increase participation in physical activity*

- Multisectoral policies are needed to promote physical activity.
- Consistent, coherent, simple and clear messages should be communicated through many channels and in forms appropriate to local culture, age and gender. Simple, direct messages need to be communicated on the quantity and quality of physical activity sufficient to provide sustainable health benefits.
- School policies and programmes should support the adoption of healthy diets and physical activity.
- Strategies should be geared to changing social norms and improving community understanding and acceptance of the need to integrate physical activity into everyday life.
- Routine brief interventionsd combined with simple information and skill-building to change behaviour, taking a life-course approach, can reach a large part of the population.

## *Recommendations*

There are several programmes supported by the council which offer good access to schools, young people and disadvantaged groups. A number of events and opportunities are provided throughout the year and all those involved work well in providing these. However funding restrictions have reduced the opportunities for these programmes to fully meet the needs of population groups and the profile of this work could be much higher.

Community support for physical activity and sport is provided through networks of clubs and via the support of Pro Active North London (the local community sports partnership). Pro Active is influential in providing support and assistance locally to both council officers, community clubs and organisations and the school sports partnership. There is more potential to work with Pro Active North London if Barnet had a more coherent approach to physical activity and sports and could adopt a broader remit and perspective.

The development of Barnet and the areas of regeneration provide the ideal opportunity to ensure that physical activity and sport are integrated into the infrastructure. Promoting active travel, the use of parks, play areas and open spaces are essential if there is to be a move from leisure facility based physical activity and sport. Such a move would promote

the integration of activity into lifestyles which is essential for populations where income, transport and access are also a challenge.



# Introduction

The needs assessment examines the population of Barnet, their health and how active they are before looking in detail at the type of groups in the borough and how they use leisure facilities, what kinds of activity they might like to do and what kinds of motivations and barriers exist. Stakeholders were asked if our findings had resonance with them and have incorporated a rapid facilities mapping exercise to demonstrate how existing facilities meet the needs we have reported on.

We have also looked at evidence of what interventions work to increase physical activity with a view of providing a perspective on how sport and physical activity in Barnet might provide for the population in the most effective and resourceful way.

We have identified the limitations of this needs assessment and made recommendations about what further knowledge would assist in setting the strategic direction for physical activity, sport and leisure in Barnet in future.

The needs assessment does not intend to comment on a number of issues, which have arisen over the Olympic period – provision of competitive input in schools, playing fields, elite sport etc. These might be addressed by the future development of a strategic statement for physical activity for Barnet, which we would see as a logical next step.

## Chapter 1: The Strategic context

Physical inactivity is one of the major risk factors causing death and ill-health both globally and locally. Increasing physical activity has the potential to improve the physical and mental health of the nation, reduce all-cause mortality and improve life expectancy. It can also save money by significantly easing the burden of chronic disease on the health and social care services. Increasing cycling and walking will reduce transport costs, save money and help the environment. Fewer car journeys can reduce traffic, congestion and pollution, improving the health of communities<sup>1</sup>. Other potential benefits linked to physical activity in children and young people include the acquisition of social skills through active play (leadership, teamwork and co-operation), better concentration in school and displacement of anti-social and criminal behaviour<sup>2</sup>.

Physical activity, health and well-being are embedded within policies, strategies and guidance publications across a wide range of sectors and service areas. This section describes our understanding from the term physical activity and presents the key points from relevant national, regional and local documents to establish the strategic context for the Barnet leisure review needs assessment.

For some examples of how other organisations have addressed these challenges see Appendix 1 Chapter 1.

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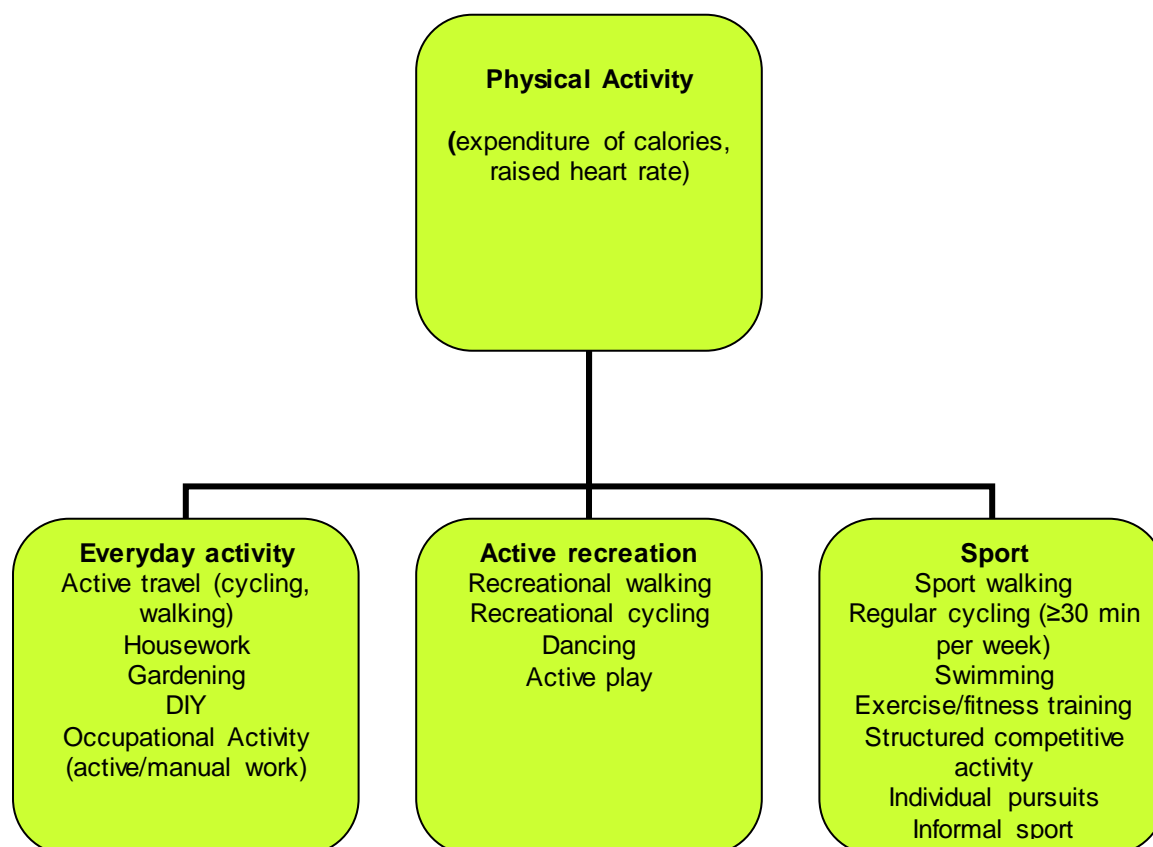
<sup>1</sup> Department of Health (2009) Be active, be healthy: A plan for getting the nation moving London: Department of Health

<sup>2</sup> Warwick I, Mooney A and Oliver C (2009) National Healthy Schools Programme: Developing the evidence base. London: Thomas Coram Research Unit and Institute of Education, University of London.

## 1.1 What is Physical Activity?

Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport (Figure 1).

**Figure 1. The forms of physical activity.**



Being active needs to be easy and enjoyable. It needs to become part of daily life, not something that has to be added on. Ways of getting more active includes:

- Active travel – walking and cycling at least some of the way to shops, school or work
- Active recreation – dance, gardening, DIY, rambling, health walks
- Fitness activity – joining fitness classes, power walking, jogging, cycling for fitness
- Competitive and adventurous activity – team and individual sports, outdoor pursuits
- Occupational activity – post deliverers, newspaper round, construction or landscaping work
- Active play – free range activity in parks, streets and playgrounds
- Reducing sitting – less TV and computer games

## 1.2 National Context

**1.2.1 Implications of the 2011 Health and Social Care Bill<sup>3</sup>** The January 2011 Health and Social Care Bill sets out that Primary Care Trusts (PCT) will be abolished in 2013 and their health care commissioning function will be replaced by groups of GPs who will be responsible for the use of the majority of the NHS Budget. PCT public health responsibilities for local health improvement will transfer to councils.

Councils will lead on promoting integration and partnership working between the NHS, social care, public health and other local services and strategies Health and well-being boards will be created to integrate commissioning of local NHS services, social care and health improvement.

**1.2.2 Healthy Lives, Healthy People: our strategy for public health in England<sup>4</sup>.** The Coalition Government's Health White Paper sets out a new vision for public health emphasising the importance of healthy lifestyles. Being physically active is a vital part of a healthy lifestyle.

The new National Public Health Outcomes Framework<sup>5</sup> is intended to refocus the whole system around the achievement of positive health outcomes for the population and reducing health inequalities.

The indicators are grouped into four main domains: 'Improving the wider determinants of health'; 'Health Improvement'; 'Health Protection' and lastly, 'Healthcare public health and preventing premature mortality'. Physical Activity is mainly addressed within the Health Improvement domain, alongside other lifestyles factors. Indicators that are relevant to physical activity are:

### Domain 2 Health Improvement

- Excess weight in adults
- Proportion of physically active and inactive adults
- Recorded diabetes

### Domain 4 Healthcare public health and preventing premature mortality

- Mortality causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from respiratory diseases
- Health-related quality of life for older people
- Hip fractures in over 65s

**1.2.3 Start Active Stay Active** is the new UK-wide physical activity guidelines issued by the four Chief Medical Officers (CMOs) of England, Scotland, Wales and Northern Ireland. The guidelines updates the existing guidelines for children, young people and adults, and includes new guidelines for early years and older people for the first time in the UK<sup>6</sup>.

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<sup>3</sup> Health and Social Care Bill (2011) <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

<sup>4</sup> Department of Health (2010) Healthy Lives, Healthy People: our strategy for public health in England, Department of Health

<sup>5</sup> Department of Health (2011) NHS Outcomes Framework 2012-13, Department of Health.

<sup>6</sup> Department of Health (2011) Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers: Department of Health.



They advised us that physical activity is important for all age groups and that excessive sedentary behaviour is an independent risk to health for all ages. Adults should aim to achieve at least 150 minutes of moderate intensity activity over the week (60 minutes every day for children and young people, 180 minutes every day for children under 5 years old). All age groups should minimise the amount of time spent being sedentary (sitting) for extended periods.

The flexibility of the guidelines creates new ways to achieve the health benefits of an active lifestyle. These include:

- A life course approach
- A stronger recognition of the role of vigorous intensity activity
- The flexibility to combine moderate and vigorous intensity activity
- Weekly target; daily activity
- New recommendations on sedentary behaviour

**1.2.4 The NHS Health Check** programme is also an important national programme that relates to adult physical activity<sup>7</sup>. The programme aims to help prevent heart disease, stroke, diabetes and kidney disease (vascular disease). It is a national initiative that offers preventative checks to all those aged 40 –74 who have not already been diagnosed with one of these conditions, to assess their risk of vascular disease followed by appropriate support, advice and interventions to help them reduce or manage that risk. The NHS Health Check programme is an ideal opportunity in identifying and tackling modifiable factors that impact on vascular disease such as physical inactivity and managing those sedentary adults who are at risk of developing the above conditions.

**1.2.5 Transport Planning and Policy Guidance**<sup>8</sup> aims to integrate planning and transport at the national, regional, strategic and local level to:

1. promote more sustainable transport choices for both people and for moving freight
2. promote accessibility to jobs, shopping, leisure facilities and services by public transport, walking and cycling and
3. reduce the need to travel, especially by car

The guidance set out strategies and measures for local authorities to promote walking and cycling as part of their local walking and cycling strategies.

**1.2.6 Sport England Strategy: A Sporting Habit for Life 2012-17** aims to create a meaningful and lasting community sport legacy by growing sports participation at the grassroots level. By offering long-term pathways that help young people continue playing sport into adulthood the strategy wants to create a lifelong habit, in particular, amongst 14 to 25 year-olds playing sport. National governing bodies (NGBs) will be supported by County sports partnerships and continue to play a pivotal role in increasing participation, among young people.

The strategy will invest the funding fewer than four main work areas including Whole Sport Plans, School Games, Facilities and Local Investment.

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<sup>7</sup> Department of Health (2009) Putting Prevention First. NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance. Department of Health.

<sup>8</sup> Department for Communities and Local Government (2011) Planning Policy Guidance 13: Transport. [www.communities.gov.uk](http://www.communities.gov.uk)

There are five London Pro-Active Partnerships in the East, Central, North, South and West of London and they are part of the national County Sports Partnership network. Each Partnership consists of a network of organisations committed to working together to increase participation in physical activity and sport. ProActive London aims to improve the health and well being of Londoners, provide strategic co-ordination and contribute to the London 2012 legacy through sport and physical activity. The Partnerships are responsible to roll the national strategy locally.

**1.2.7 No-one on the sidelines: Physical Activity Strategy 2007 – 2016:** ProActive North London has three principle aims for the period up to 2016<sup>9</sup>. They are as follows:

- To increase participation by 31% of adults across north London to participate in 3 X 30 minute sessions of physical activity each week, an increase of 1% year-on-year from 2007 onwards.
- To widen access to sport and physical activity among low participation groups such as women, ethnic minorities, people over 50, those on low incomes and people with disabilities.
- To support the development of progression pathways by increasing the number of accredited clubs, coaches and facilities.

By 2016 the Partnership also hopes to increase the number of young people and adults volunteering in sport and maximize the benefits to north London of the 2012 Games.

**1.2.8 A Sporting Future for London:** Mayor's sports strategy<sup>10</sup> aims to deliver a grass-roots sporting legacy for Londoners from the 2012 Olympic and Paralympic Games by securing a sustained increase in participation in sport and physical activity amongst Londoners and using sport to assist in tackling social problems including ill health, crime, academic underachievement and lack of community cohesion. The Mayor is committed to using the Games to transform the sporting landscape by making sport and physical activity accessible to all. The Mayor is also aiming to strengthen the link between sport and physical activity.

**1.2.9 NICE Physical Activity Briefing:** In addition to NICE guidance in July 2012 new briefings were announced for local authorities to assist in the development and response to increasing physical activity. The recommendations are covered by this needs assessment, and the Public Health guidance covered in Chapter 7.

## *1.3 Local Context*

The Leisure Review Needs Assessment reflects on a range of local plans and strategies which support Barnet's wider priorities. Some of these include the draft Health and Well-being Strategy, Joint Strategic Needs Assessment, the Core Strategy and the Local Development Plan. These policies, programmes and strategies have all been considered as important markers in the development of this needs assessment and form part of the evidence base.

**1.3.1 Keeping Well, Keeping Independent: A Health and Wellbeing Strategy for Barnet (2012-2015)**<sup>11</sup> aims to reduce health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent' at the background of a growing and changing Borough with less public money available to spend.

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<sup>9</sup> ProActive North London (2007) No-one on the sidelines: Physical Activity Strategy 2007 – 2016.

<sup>10</sup> Greater London Authority (2009) A Sporting Future for London. GLA.

<sup>11</sup> Keeping Well, Keeping Independent: A Health and Wellbeing Strategy for Barnet (Draft) (2012-2015)

The strategy aims to deliver joined-up care through integrated' prevention plan as activities need to be integrated with other organisations and policies and as part of everyday service provision.

Enabling people to be more physically active has been identified as key prevention activities that need to be started in Barnet. The strategy recognises that people need to be helped to be aware of the benefits of being more physically active, and how to do this simply as part of everyday activities. But in addition, planners, nursery and pre-school groups, schools, higher education establishments, employers, voluntary organisations, community organisations and others need to create circumstances such that being more physically active is easier and something that needs to be actively opted-out from rather than something that has to be opted-in to.

**1.3.2 Joint Strategic Needs Assessment (2011-2015)**<sup>12</sup> sets out the current health and social care needs of Barnet's residents and anticipate how these may change over the coming years against a background of reduced public spending and changes to the NHS landscape. The focus is on the importance of lifestyle choices in determining future health and social care outcomes. The fundamental purpose of the document is to support the commissioning, shaping and delivery of local services. The link between chronic disease and physical activity was recognised, however, the needs assessment failed to make recommendations to increase physical activity.

**1.3.3 Core Strategy (2011)** contains the 'vision' for the Local Development Framework and the most fundamental, cross-cutting objectives and policies that the local authority and its partners will seek to deliver. The Core Strategy contributes to achieving the vision and objectives of Barnet's Sustainable Community Strategy and helps our partners and other organisations to deliver relevant parts of their programmes<sup>13</sup>. It covers the physical aspects of location and land use traditionally covered by planning.

The Strategy recognises that spatial planning can address unhealthy lifestyles, such as being overweight, obesity, particularly in children, through the provision of accessible parks, allotments, open spaces, leisure facilities and an attractive and safe public realm which encourages walking, cycling and socialising. It aims to improve health and well being in by ensuring increased access to Barnet's green spaces and opportunities for higher levels of physical activity through the Green Infrastructure SPD.

#### **1.3.4 Barnet's Sustainable Community Strategy (2010 – 2020) – One Barnet**

The Sustainable Community Strategy is the overarching plan that sets out the vision, core values and priorities for Barnet, which have been agreed by local partners including NHS commissioners. Key priority areas are healthy and independent living for all and greater choice<sup>14</sup>.

The Local Strategic Partnership (replaced by the One Barnet Partnership Board in March 2011) has revised the borough's Sustainable Community Strategy (SCS) for the period 2010 to 2020. One Barnet sets out the strategic vision for Barnet as a place and provides the vehicle for considering and deciding how to address difficult cross-cutting issues such as maintaining the quality of life that makes the borough an attractive place to live.

The Barnet Partnership recognises that in order to achieve the vision and deliver the strategy, public services must work together as '**One Barnet**' (formerly known as Future Shape) and that organisations must work together to realise efficiencies, provide seamless

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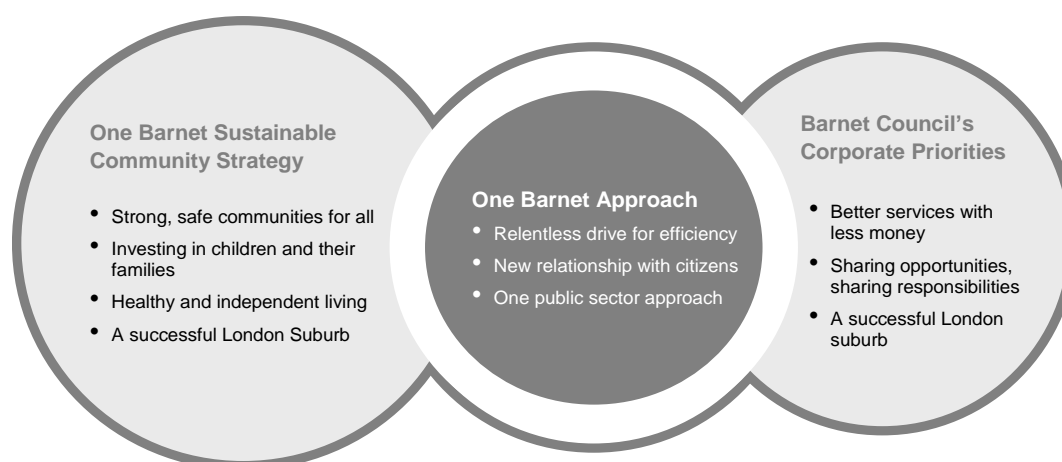
<sup>12</sup> Joint Strategic Needs Assessment: Barnet 2011-15

<sup>13</sup> London Borough of Barnet (2011) Core Strategy Submission Stage: Development Plan Document

<sup>14</sup> Barnet's Sustainable Community Strategy (2010 – 2020)

customer services and develop a shared insight into the needs and priorities to inform commissioning of services and prioritization of scarce resources.

**Figure 2. One Barnet Approach**



The integration of health and social care services to promote better outcomes, increase independence and reduce bureaucracy is a key objective for the Council in delivering its priority for better services with less money.

One of the key aims of the Sustainable Community Strategy is to create a health supporting environment by working together to identify and address the factors underpinning health inequalities in Barnet. This includes ensuring that new developments provide for a quality of life that facilitates healthier lifestyles. Leisure Review is integral part of One Barnet plans and is amongst the five reviews that are currently underway.

**1.3.5 The Local Development Framework Development Management Policies (DMP) (2011)** sets out the borough-wide planning policies that implement the Core Strategy and will be used for day to day decision making by the Planning Service and the policy basis for delivering the long-term spatial vision<sup>15</sup>. It also provides additional detail and guidance on how the Council will make decisions on applications for planning permission.

The outcomes of Leisure Review should be incorporated in the planning permission process.

**1.3.6 Barnet Sport, Physical Education Strategy (2008 – 2013)** sets out Barnet's vision and aspirations for sport and physical activity. It seeks to encourage regular participation in sport and physical activity; ensuring there is choice of opportunity; creating a strong and vibrant sporting and community infrastructure in Barnet and ensuring that Barnet residents benefit from and are involved in London 2012<sup>16</sup>. The strategy recognizes that sport and physical activity can make an important contribution to delivering local, London and national strategic priorities, including the ambitions and targets set out in Barnet's Sustainable Community Strategy. However, this strategy due to expire next year and there are no plans to renew the strategy at present.

**1.3.7 Barnet Play Strategy (2007-2011)** sets out a framework for working in partnership to improve the choice of play provision for 0-18 year olds and highlights the contribution of

<sup>15</sup> The Local Development Framework Development Management Policies (

<sup>16</sup> Barnet Sport, Physical Education Strategy 2008 to 2013 (2008)

play to the five Every Child Matters outcomes<sup>17</sup>. The priorities in the strategy have been informed by consultation with children and young people in the borough and by an audit of existing provision. Informed by Barnet's vision for the future, the play audit and consultation with children and young people, the strategy focuses on five priority areas.

These priorities are to:

- Highlight the importance of play in Barnet
- Ensure that play opportunities are inclusive
- Improve children's health and well-being through play
- Ensure play provision is safe but challenging
- Involve children, young people and their families in improving play provision

It is understood that there is no long term plans for this strategy.

## *1.4 Summary of key findings*

- Regular physical activity of moderate intensity can bring about major health benefits as well as cost savings for the NHS. Sedentary behaviour is a risk to health for all age groups.
- The Chief Medical Officer has advised us that adults should aim to achieve at least 150 minutes of moderate intensity activity over the week (60 minutes every day for children and young people, 180 minutes every day for children under 5 years old). All age groups should minimise the amount of time spent being sedentary (sitting) for extended periods.
- The importance of physical activity is recognised within existing strategic commitment of the Borough in particular within the Health and Well-being Strategy. There is the lack of comprehensive strategic approach to physical activity which incorporates sports development, active travel, environmental measures, the use of leisure facilities and community buildings.
- The legacy of 2012 Olympic and Paralympic Games poses a prime opportunity to establish sustained increase in participation in sport and physical activity.
- Barnet Sport, Physical Education Strategy (2008 – 2013) There are no plans to renew this strategy at present which has a potential to set future directions in Barnet for sustainable participation by building up on the momentum created by 2012 Olympic and Paralympic Games.
- Barnet Play Strategy (2007-2011) There are no plans to renew this strategy at present which aims to improve children's health and well-being by increasing play opportunities and engaging parents to minimize sedentary behaviour.

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<sup>17</sup> Barnet Play Strategy 2007-2011 (2007)

**The following chapters identify the characteristics of Barnet, the relationship with physical activity and sport and what we know about the market and current provision.**

# Chapter 2: The Population and Health Profile for Barnet

## Introduction

This chapter examines the population characteristics and health profile of Barnet and how the population is changing to forecast future leisure needs.

## 2.1. Population numbers

Barnet has an overall population of almost 350,000 making it the most populous borough in London.

**Table 1. Chart showing population numbers for London Boroughs in order of most populous borough first**

Borough	Population
Barnet	349,840
Croydon	345,562
Ealing	318,516
Bromley	312,380
Enfield	294,927
Wandsworth	289,574
Southwark	287,041
Lambeth	284,484
Redbridge	270,501
Lewisham	266,480
Hillingdon	266,114
Brent	256,556
Westminster	253,112
Newham	240,124
Tower Hamlets	237,896
Hounslow	236,760
Havering	236,137
Camden	235,362
Harrow	230,057
Greenwich	228,509
Bexley	227,957
Waltham Forest	227,145
Haringey	224,996
Hackney	219,228
Merton	208,794
Sutton	194,195
Islington	194,080

Richmond Upon Thames	190,920
Barking & Dagenham	179,741
Hammersmith & Fulham	169,705
Kensington & Chelsea	169,494
Kingston Upon Thames	168,955
City Of London	11,677

Source: ONS population projections for 2011

Barnet is significantly more ethnically diverse than the overall population of England but slightly less diverse than London as a whole. It is relatively young population compared to the overall population of London and England.

**Table 2. Chart showing population numbers and percentages for different population groups in Barnet**

Population group	Population number	Percentage population
Total population	349840	100%
0-15 yrs	71209	20%
16-34 yrs	93515	27%
35-54 yrs	102118	29%
55 yrs +	82998	24%
Male	171061	49%
Female	178779	51%
White	236142	67.5%
BME groups	113698	32.5%
Disabled	52476	15%
Non disabled	297364	85%

Source: ONS (2008 based population projections for 2011), Barnet College Strategic Plan 2010, JSNA

**Table 3. Chart showing population numbers and percentages by age for Barnet, London and England (16+)**

Geographical area	16 to 19 yrs	20 to 24 yrs	25 to 34 yrs	35 to 49 yrs	50 to 64 yrs	65+ yrs
Barnet (% population)	6.2%	7.1%	24.1%	27.6%	18.1%	16.8%
London (% population)	5.3%	9.0%	24.5%	29.4%	17.9%	13.8%
England (% population)	6.2%	8.5%	16.5%	26.8%	22.4%	19.7%

**Table 4. Chart showing population numbers and percentages by ethnicity for Barnet, London and England (16+)**

Geographical area	White	Non-White
Barnet (% population)	71.30%	28.70%
London (% population)	69.70%	30.30%
England (% population)	87.50%	12.50%

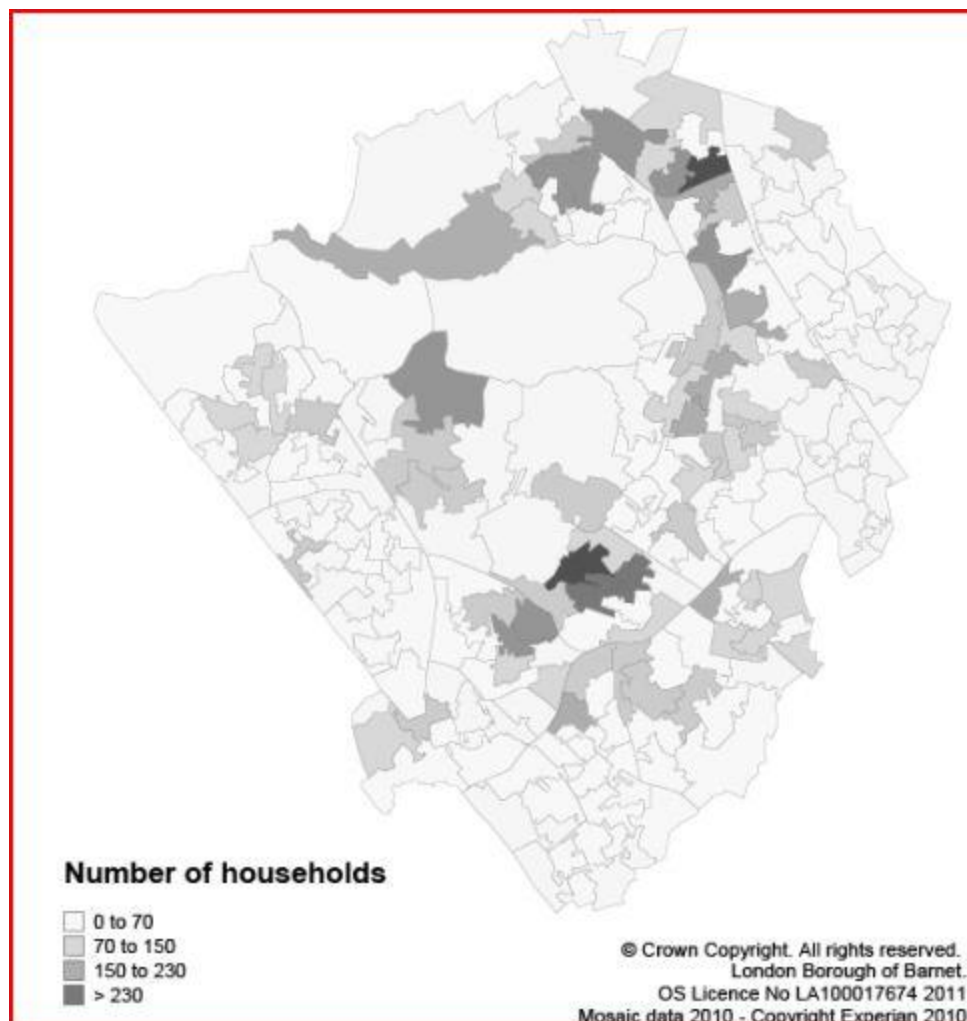
Source: ONS Mid-2009 experimental statistics



### 2.1.1 Age

There are 45,333 people aged over 65 years living in Barnet. The prevalence of this age group varies throughout the borough but the highest density of people over 65 years can be found in Totteridge and in the central areas of the borough around Finchley Church End and Mill Hill.

**Figure 1. Map showing distribution of population of over 65 year olds**



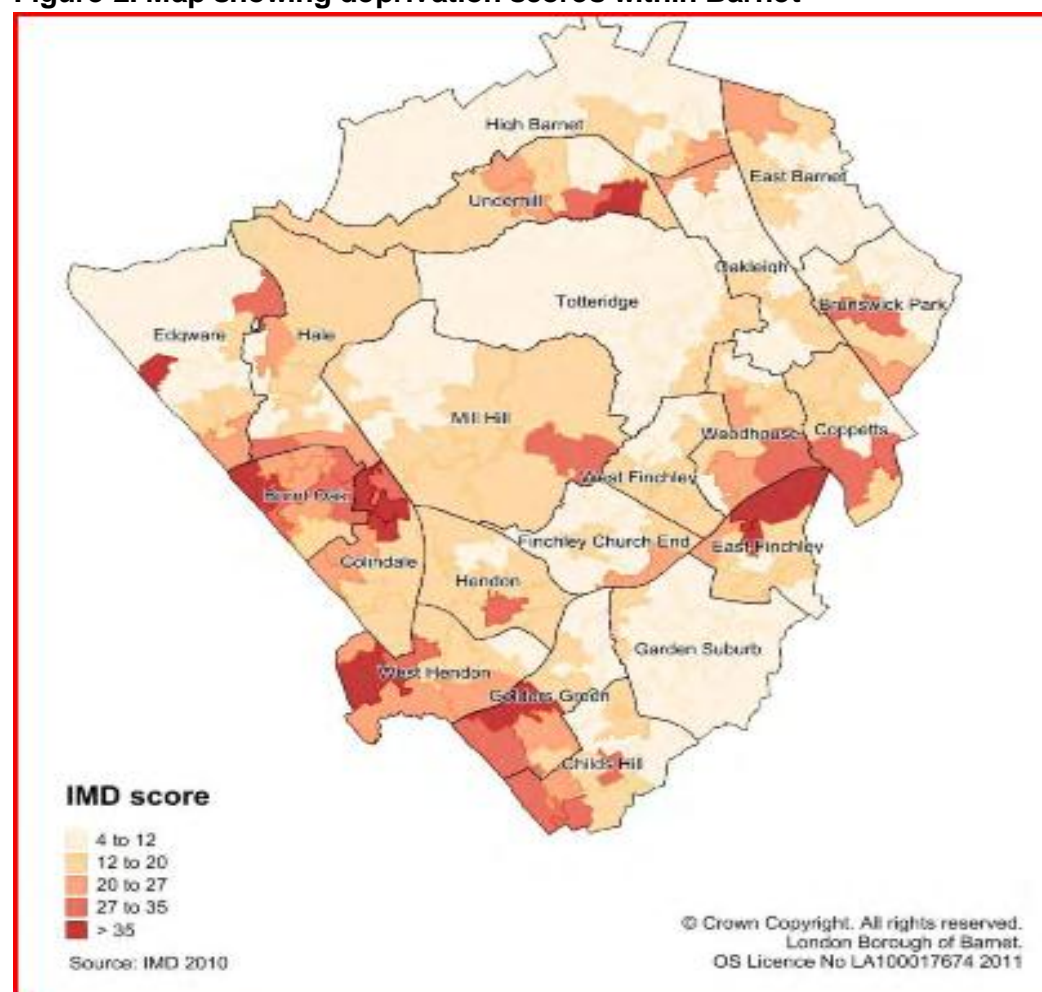
Source: JSNA (based on Mosaic by LSOA)

### 2.1.2 Deprivation

Barnet is a relatively affluent borough compared to other areas of England and London. It ranked 165<sup>th</sup> out of 326 local authorities in England and the affluence of the borough overall is increasing. However Barnet's deprivation levels within the borough are particularly diverse. The map illustrates how the most western and eastern edges of the borough have the highest deprivation scores<sup>18</sup>.

<sup>18</sup> Joint Strategic Needs Assessment: Barnet 2011-15

**Figure 2. Map showing deprivation scores within Barnet**



## 2.1.3 Ethnicity

Barnet is an incredibly diverse borough. Barnet's population is most diverse in younger age groups (particularly the under 19 age group) and becomes progressively less diverse in older age groups<sup>19</sup>.

## 2.1.4 Disability

In the UK it is thought that approximately 15% of the population could be defined as disabled under the disability discrimination act according to the General Household survey 2001. This incidence rate has been applied to ONS population projections for Barnet

<sup>19</sup> Joint Strategic Needs Assessment: Barnet 2011-15

**Table 7. Projected estimates of disability by age group in Barnet**

	2010 estimate	2015 estimate	2020 estimate
Barnet residents aged 18-64 with a moderate physical disability	16,126	16,971	17,987
Barnet residents aged 65+ with a moderate physical disability	13,383	14,820	16,284
Barnet residents aged 18-64 with a serious physical disability	4,600	4,839	5,196
Barnet residents aged 65+ with a serious physical disability	7,999	8,855	9,828

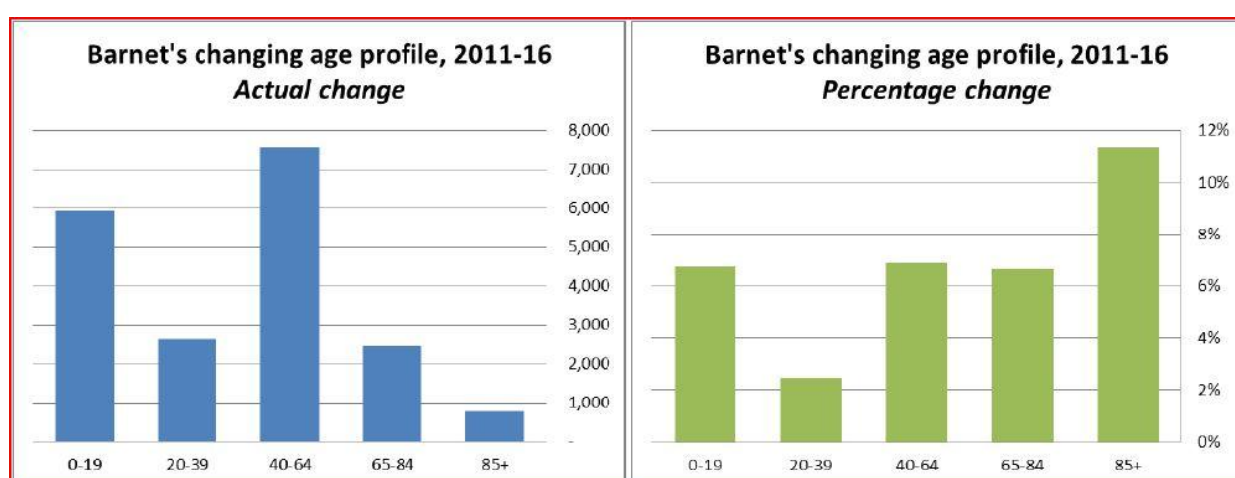
Source: Incidence rates from General Household Survey 2001 applied to ONS population projections

## 2.2 Population changes

Since 2011 Barnet has been London's most populous borough with a population of 349,800 residents. The population is set to grow with continued migration of people from abroad and elsewhere in the UK into the borough. Some areas of the borough will experience more population growth than others. The population in the west is set to increase the most and it is estimated there will be an additional 15,000 residents between 2011 and 2016 which is an increase of 12%. This growth is probably caused by regeneration of the area and new housing developments. The areas expecting the most significant growth in population density are Colindale (36% ) and West Hendon (11%) In contrast, the population in the North of the borough is forecast to decrease by 1%<sup>20</sup>.

Population changes in the borough are not limited to overall population growth alone. The age and ethnic profile of the population is set to change also. The most significant growth in population numbers by age group is in the 45-49 year old group. There is also significant growth in population numbers for 0-15 year olds, particularly for 5-9 year olds. The most significant proportional growth is in the 65-69 year old group but there is also proportionally high growth in those over 75 years of age, especially in those over 90 years old.

**Figure 3. Graphs showing forecasted population changes by age for Barnet borough**



Source: JSNA

<sup>20</sup> Joint Strategic Needs Assessment: Barnet 2011-15

Barnet's population is also set to become increasingly diverse. The local non-white population is set to increase from 33.1% to 35% of the total population over the next 5 years<sup>21</sup>. This increasing diversity is the result of a high birth rate among BME groups. Just under half of all births are in BME groups despite the overall population of BME groups being relatively small compared to the local White population.

Barnet fastest growing population group is 'other' which includes ethnicities such as Iranians, Afghans and Arab peoples. This group will increase by 19% between 2011 and 2015 compared to an average growth rate of 5.5%. The 'Black Other' community will undergo the second fastest proportional population growth. This group will increase by 15.1% between 2011 and 2016. The Indian community will remain the largest BME group but population growth in this community is slower than for other ethnicities at just 4.9%.

**Table 8. GLA 2007 Round Ethnic Group Projections - PLP Low**

Borough	AEG	2011	2016	Diff	% Diff
Barnet	All Ethnicities	339,730	367,720	27,990	8%
Barnet	White	225,829	236,610	10,780	5%
Barnet	Black Caribbean	4,032	4,258	225	6%
Barnet	Black African	19,533	22,446	2,912	15%
Barnet	Black Other	6,548	7,629	1,081	17%
Barnet	Indian	32,045	35,107	3,062	10%
Barnet	Pakistani	5,820	6,741	921	16%
Barnet	Bangladeshi	1,833	2,072	239	13%
Barnet	Chinese	9,306	10,868	1,562	17%
Barnet	Other Asian	11,502	12,907	1,405	12%
Barnet	Other	23,282	29,083	5,801	25%

## 2.3. The health profile of Barnet

The benefits of regular physical activity have been clearly set out across the life course. In particular, for adults, doing 30 minutes of at least moderate intensity physical activity on at least 5 days a week helps to prevent and manage over 20 chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions<sup>22</sup>. The strength of the relationship between physical activity and health outcomes persists throughout people's lives, highlighting the potential health gains that could be achieved if more people become more active throughout the life course.

There is a clear inverse relationship between physical activity and all-cause mortality. There is approximately a 30% risk reduction when comparing the most active with the least active<sup>23</sup>. While increasing the activity levels of all adults who are not meeting the recommendations is important, targeting those adults who are significantly inactive (i.e.

<sup>21</sup> Joint Strategic Needs Assessment: Barnet 2011-15

<sup>22</sup> Department of Health (2004) At least five a week: evidence on the impact of physical activity and its relationship to health. London: Department of Health.

<sup>23</sup> Department of Health (2011) Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers. London, Department of Health.

engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease.

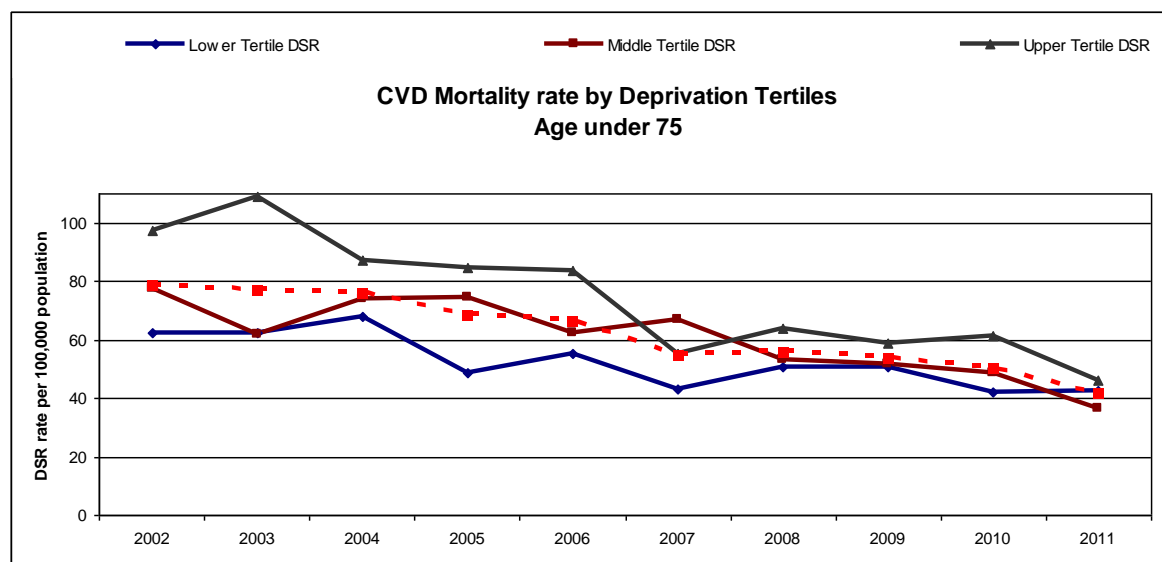
Independent of the level of overall physical activity some research also suggests that sedentary behaviour is associated with all-cause mortality<sup>24</sup>.

### 2.3.1 Cardiovascular disease

Cardiovascular disease (CVD) is a disease of the heart and blood vessels. It includes the conditions ischemic heart disease (which may include angina or a heart attack), stroke/ transient ischemic attack (mini-stroke) and peripheral vascular disease.

Figure 9 shows a downward trend in deaths in Barnet from coronary heart disease in recent years. This has been constructed by ranking super output areas in order of deprivation and then dividing these into three groups of lowest, middle and highest deprivation. People living in the most deprived parts of the borough are most likely to die prematurely.

**Figure 4. Age-standardized death rates from coronary heart disease in people aged under 75 years grouped by super-output areas ranked in order of deprivation**



There is a clear dose-response relationship between physical activity and coronary heart disease; the higher the level of physical activity, the lower the risk of disease. Physical inactivity and low fitness are major independent risk factors for coronary heart disease in both men and women, at a level similar to that of smoking cigarettes. Inactive and unfit people have almost double the risk of dying from coronary heart disease compared with more active and fit people.

Physical activity also has beneficial effects on preventing stroke and treating peripheral vascular disease, and on modifying the classical cardiovascular risk factors such as high blood pressure and adverse lipid profiles. Physical activity does not need to be vigorous to confer protection from cardiovascular disease: 30 minutes of moderate intensity physical activity a day on at least 5 days a week is sufficient to achieve benefit. Exercise-based

<sup>24</sup> Sedentary Behaviour and Obesity Expert Working Group. Sedentary Behaviour and Obesity: Review of the Current Scientific Evidence. London: Department of Health, 2010.

cardiac rehabilitation programmes for patients with coronary heart disease are generally effective in reducing the risk of premature death<sup>25</sup>.

## 2.3.2 Diabetes

Diabetes is a chronic and progressive disease in which the amount of glucose in the blood is too high. It affects both children and adults and there are two main types. Type 1 diabetes develops if the body is unable to produce any insulin, affects about one per cent of the population and requires lifelong treatment while Type 2 develops mainly in people older than 40, is caused by a shortage of insulin or a fault in the way the body's cells responds to insulin. Type II accounts for around 90% of all diabetes.<sup>26</sup>

Social deprivation and ethnicity are major risk factors for developing Type 2 diabetes. People residing in the most deprived areas in the UK are two-and-a-half times more likely than the people residing in areas of average deprivation to have diabetes at any given age<sup>27</sup>.

A report by Diabetes UK to the All Parliamentary Group for Diabetes in 2006 stated that the highest observed prevalence is in Asians (20%) and Black Africans and African Caribbeans (17%) compared to an overall prevalence in the general population of three per cent<sup>28</sup>. The average age at diagnosis is also lower in these groups and the risk of death from diabetes is between three and six times higher; as these groups are also susceptible to the cardiovascular and renal complications of diabetes.

In 2010-11 Barnet GPs have identified that there are 16,422 individuals aged 17 and over (4.4% of the registered population) living with diabetes. However, prevalence was highest in the West cluster (5%) and lowest in the South (3.7%). It should be noted that this may not be a true picture of the disease pattern as a number of cases may remain undiagnosed.

Physical inactivity is a major risk factor for the development of Type II diabetes, with active people having a 33-50% lower risk compared with inactive people. High-risk individuals in particular can substantially reduce their risk of developing Type II diabetes by becoming more active. Regular, moderate intensity physical activity is sufficient to reduce the risk of developing Type II diabetes, although the optimum type, intensity, frequency, duration or volume of activity needed are unclear. Regular physical activity can produce metabolic benefits that contribute to management of Type II diabetes. Also, risk of premature death is much lower in active and fit persons with Type II diabetes than in patients who are inactive and unfit. In addition, there is evidence for an association between low physical activity and impaired glucose tolerance<sup>29,30</sup>

Independent of exercise levels, sedentary behaviours, especially TV watching, are associated with significantly elevated risk of impaired glucose tolerance and Type II diabetes, whereas even light to moderate activity is associated with substantially lower

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<sup>25</sup> Department of Health (2004) At least five a week: evidence on the impact of physical activity and its relationship to health. London: Department of Health.

<sup>26</sup> NHS Choices <http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Introduction.aspx> (last accessed 090712).

<sup>27</sup> The Information Centre <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/diabetes> last accessed 090712).

<sup>28</sup> Diabetes UK (2004) Diabetes in the UK 2004, A report from Diabetes UK. London: Diabetes UK

<sup>29</sup> Annuzzi G, Vaccaro O, Caprio S, Di Bonito P, Caso P, Riccardi G, Rivellese A. Association between low habitual physical activity and impaired glucose tolerance. Clin Physiol. 1985 Feb; 5(1):63-70.

<sup>30</sup> Ivy JL. The role of exercise training in the prevention and treatment of insulin resistance and non-insulin-dependent diabetes mellitus. Sports Med. 1997 Nov; 24(5):321-36.

risk. This emphasizes the importance of reducing prolonged TV watching and other sedentary behaviours for preventing impaired glucose tolerance and diabetes<sup>31</sup>.

### 2.3.3 Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a long term condition in which airways are narrowed and can result in severe shortness of breath. The term COPD covers a group of illnesses: chronic bronchitis, emphysema and bronchiolitis or small airways disease. It is caused primarily by smoking and is more common in males and increases with age.

In 2010-11 the prevalence of COPD in Barnet was 1% same as that of London average. Barnet death rates from COPD are significantly lower than the London and England averages also lower death rates compared to majority of boroughs in London.

There are a number of studies which have looked at the impact of pulmonary rehabilitation for people who have been in hospital with an exacerbation of COPD on hospital admissions and other patient-important outcomes such as quality of life<sup>32</sup>. Overall, pulmonary rehabilitation involving some sort of exercise programme significantly reduced hospital admissions (pooled odds ratio 0.22 [95% CI 0.08 to 0.58] and mortality (OR 0.28; 95% CI 0.10 to 0.84).

### 2.3.4 Cancer

Physical activity is associated with a reduction in overall risk of cancer. There is a marked protective effect on colon cancer: the most active individuals have, on average, a 40-50% lower risk than the least active. Physical activity is also associated with a reduced risk of

breast cancer among postmenopausal women, and possibly also to a reduction in risk of lung cancer. Physical activity can also have an indirect effect through its role in the prevention of obesity which, in the USA, has been estimated to result in 10% of all-cause cancer. For optimal protection, activity should be maintained throughout the lifetime.

In Barnet while there is trend of increasing incidence of breast cancer, colorectal cancer incidence is stable. There is a downward trend for mortality when all cancers are considered together across our cancer network. This pattern is in common with the England and London rates. Barnet is significantly lower. Barnet has a breast cancer mortality rate of 21.26 (CI 17.56 -24.96) lower than the London and England averages. This rate is also the lowest in the North London Cancer Network. Colorectal cancer remains the second most common cancer death after lung cancer nationally and is the fourth most common cancer death in Barnet (15.9 per 100,000 ONS 2009). Mortality from colorectal cancer is declining across all NCL organisations reflecting the national, London and network mortality rates, with no outlying PCTs.

### 2.3.5 Falls

The risk of falling increases as people get older and falls represent the most frequent type of serious injury in the over 65s age group and the commonest reason for hospital

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<sup>31</sup> Sedentary Behaviour and Obesity Expert Working Group. Sedentary Behaviour and Obesity: Review of the Current Scientific Evidence. London: Department of Health, 2010.

<sup>32</sup> Cochrane (2009). Pulmonary rehabilitation for people who have been in hospital with an exacerbation of COPD. The Cochrane Library. Jan 2009.



attendance. The most serious consequence of falling is hip fracture. The consequences of falls have a significant impact on both NHS and social care services.

In Barnet, the total number of people predicted to have a fall in 2020 from the POPPI data is predicted to increase by 20% from 13,146 in 2010<sup>33</sup>. Further projections to 2030, suggest an increase of 54% to 20,239 people. The predicted number of hospital admissions as a result of falls is a useful indicator of older people's wellbeing and is predicted to increase by 52% in Barnet.

It is difficult to determine accurate prevalence of falls because many falls go unreported and there is poor recording of falls as the cause of an injury. Using estimates produced by Department of Health on the number of falls and their consequences for a typical PCT, in Barnet for over 65 years old population (47,253) there are 18,083 falls occur each year.

There is strong evidence that physical activity is important in preserving adequate to good skeletal health and in preventing fractures. Exercise, even at advanced ages and in people of varying physical activities, can improve balance, strength and other risk factors approximately 30% for falls and injury. Multi-component exercise programmes which include strength and balance training and Tai chi are most effective<sup>34</sup>.

## **2.3.6 Mental Health**

Nationally and locally, the prevalence of poor mental health is numerically significant but often overlooked; during 2010-11, there were almost 24,000 residents suffering from depression recorded on local GP lists. The Department of Health's POPPI system estimates that there will be 4,179 people in Barnet over the age of 65 with depression, 32% of whom will have severe depression. Deterioration in physical health and capacity, together with feelings of isolation and loneliness, means that the risks of depression can increase quite significantly with age.

Poor mental health is also associated with personal and social problems, such as someone's ability to go to work and stay in employment. In Barnet, almost half of all Incapacity Benefit claimants are receiving benefit due to mental health issues (4,040 people). With ongoing economic uncertainty and changes to the benefit system, it is important that mental health is adequately understood and managed.

People who lead an active lifestyle over several years have a reduced risk of suffering symptoms of clinical depression. There is an approximately 20% to 30% lower risk of depression and dementia for adults participating in daily physical activity<sup>35</sup>. Physical activity helps people to function better through alleviation of stress, and improved sleep, and in older people, through some aspects of cognitive function. Regular moderate intensity activity can improve psychological well-being. There is also some evidence that physical activity helps people feel better through improvement in mood, reduced anxiety and enhanced self-perceptions.

## **2.3.7 Adult Obesity**

Being obese increases the risk of a number of diseases including coronary heart disease, stroke, diabetes, high blood pressure, respiratory conditions, certain cancers and musculoskeletal problems. Obesity in Barnet is rising according to our monitoring data from general practice lists. Without action to halt to rise in obesity, morbidity and mortality

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<sup>33</sup> Projecting Older People Population Information System (POPPI) <http://www.poppi.org.uk/>

<sup>35</sup> Department of Health and Human Services (2008) Physical Activity Guidelines Advisory Committee Report, Washington DC: US Department of Health and Human Services



will increase and will likely result in a reversal of the current downwards trend in death rates.

Almost 25,000 (18.3%) Barnet residents aged 18 plus are obese<sup>36</sup>. Although this represents a lower prevalence than nationally and in the region it is still a significant number, especially considering that those who are obese are at greater risk of premature death and are more likely to suffer from conditions such as diabetes, heart disease, hypertension, stroke, cancers, musculoskeletal diseases, infertility and respiratory disorders.

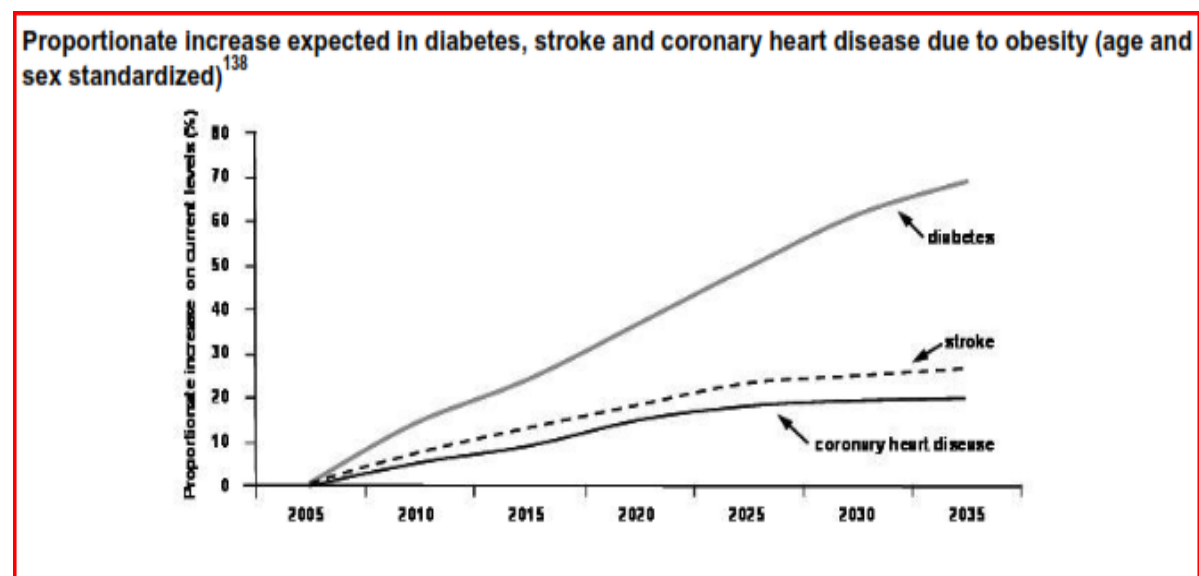
**Table 5. Adult Obesity Rates in Barnet in comparison to London and England**

	Barnet	London	England
Adult obesity rate	18.3%	20.7%	24.2%

Source: The Network of Public Health Observatories (2012) Health Profiles.

The chart below illustrates the effect that unchecked obesity has on the incidence of three key conditions: diabetes, stroke and coronary heart disease. Obesity has been called ‘the new epidemic’ and likened in its risks to health to smoking. Whilst currently fewer people die in Barnet due to the direct and indirect effects of obesity, it is clear that without adequate action, morbidity and mortality will rise considerably over the coming years and will probably reverse the current downward trend in death rates.

**Figure 9. Proportionate increase expected in diabetes, stroke and coronary heart disease due to obesity**



### 2.3.8 Sedentary behaviour and obesity

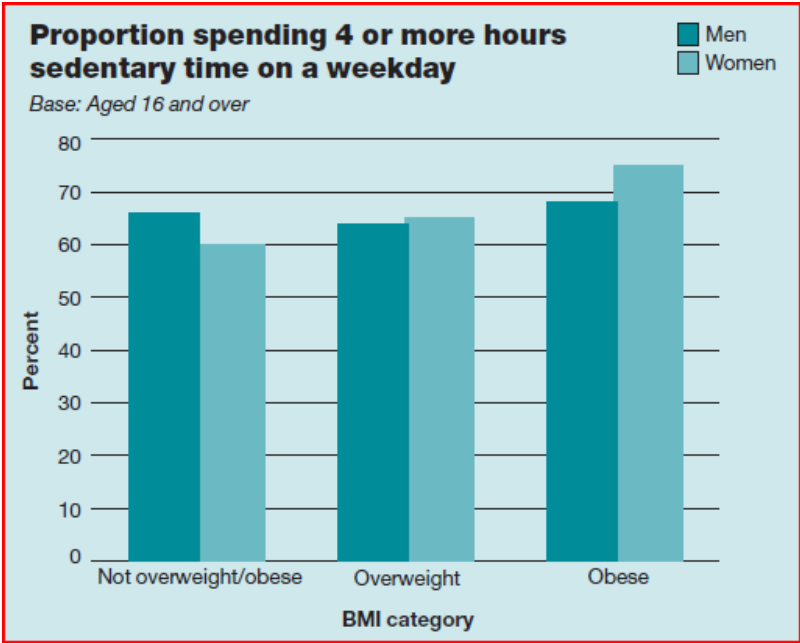
Taken from Health Survey for England 2008 Figure 12 shows self reported activity levels by BMI category. Both men and women who were overweight or obese were less likely to meet the DoH 2004 physical activity recommendations of at least moderate intensity

<sup>36</sup> The Network of Public Health Observatories (2012) Health Profiles.

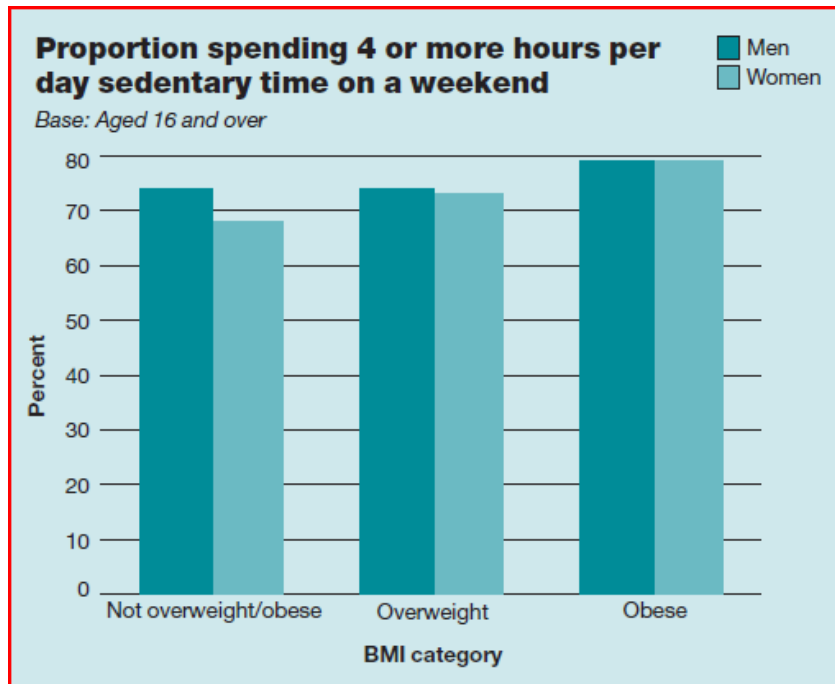
physical activity on five or more days a week compared with men and women who were not overweight or obese. 46% of men who were not overweight or obese met the recommendations, compared with 41% of overweight men and 32% of obese men.

A similar pattern emerged for women, with 36% of women who were not overweight or obese in category meeting recommendations, compared with 31% of overweight and 19% of obese women. Given these findings, it is not surprising that obese men and women had the highest rates of low activity (36% and 46% respectively). Thus, there was a clear association between meeting the physical activity recommendations and Body Mass Index (BMI) category.

**Figure 10. Proportion spending 4 or more hours sedentary time on a weekday**



**Figure 11. Proportion spending 4 or more hours per day sedentary time on a weekend**



### 2.3.9 Childhood obesity

Every year since 2005, as part of the National Child Measurement Programme (NCMP), children in Reception and Year 6 are weighed and measured during the school year to inform local planning and delivery of services for children; the population-level surveillance data gathered allows analysis of trends in growth patterns and obesity (National Obesity Observatory, 2010). Nationally, there has been a rapid increase in the prevalence of overweight and obesity. In children this is considered a primary predictor of obesity in adulthood. The health outcomes of sustained obesity are numerous and include increased incidence of Type 2 Diabetes, CHD, stroke, depression, some cancers and back pain. Obesity throughout adulthood decreases life expectancy by up to nine years. Tackling obesity is an important step towards slowing the rising prevalence of diabetes locally.

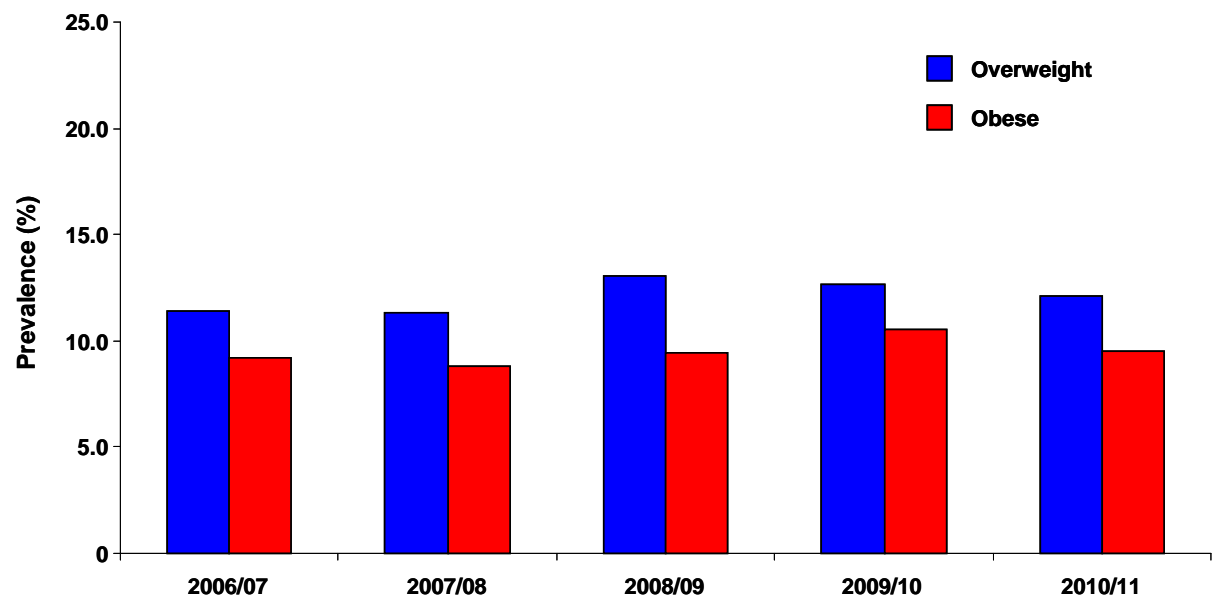
Barnet has lower levels of childhood obesity than at the national level. However, there are still a significant proportion of children in the borough living with obesity as 17.5% of children are obese. The proportion of year 6 children (aged 10-11 years) who are obese is rising in Barnet. This is monitored annually by public health and our data base shows 17.7% of year 6 children were obese in 2009-10 compared to 19.5% in 2010-11. The proportion of children in reception (aged 4-5 years) who are obese has decreased from 10.5% in 2009-10 to 9.5% in 2010-11. However, the proportion of reception children who are obese has increased since monitoring began in 2007.

**Table 6. Child Obesity Rates in Barnet in comparison to London and England**

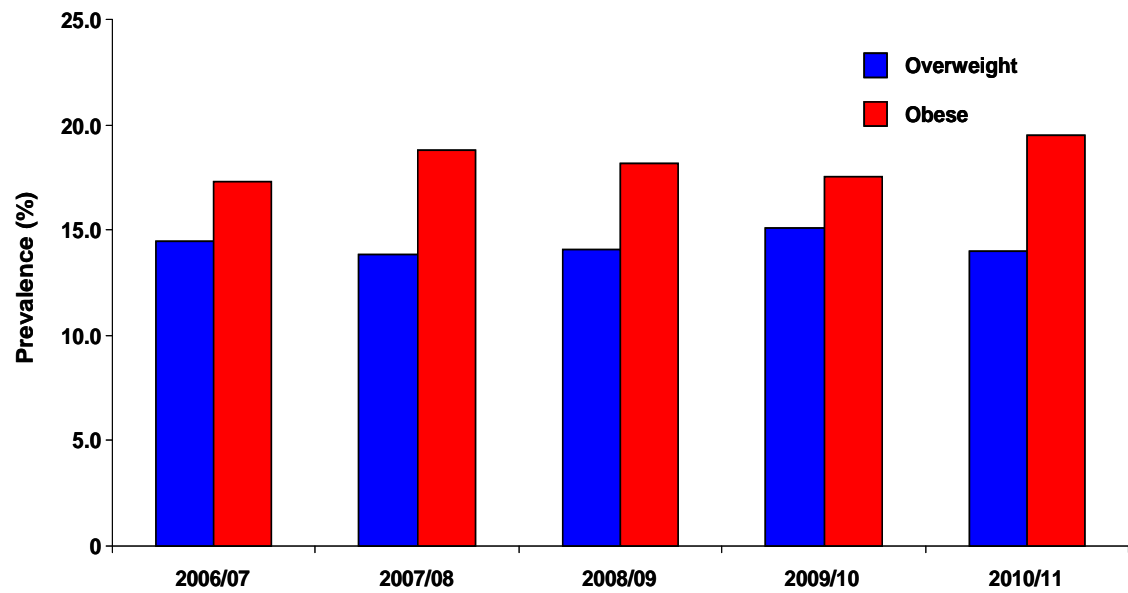
	Barnet	London	England
Childhood obesity rate	17.5%	21.8%	18.7%

Source: The Network of Public Health Observatories (2012) Health Profiles.

**Figure 12. The prevalence of overweight and obesity in reception class children in Barnet schools**

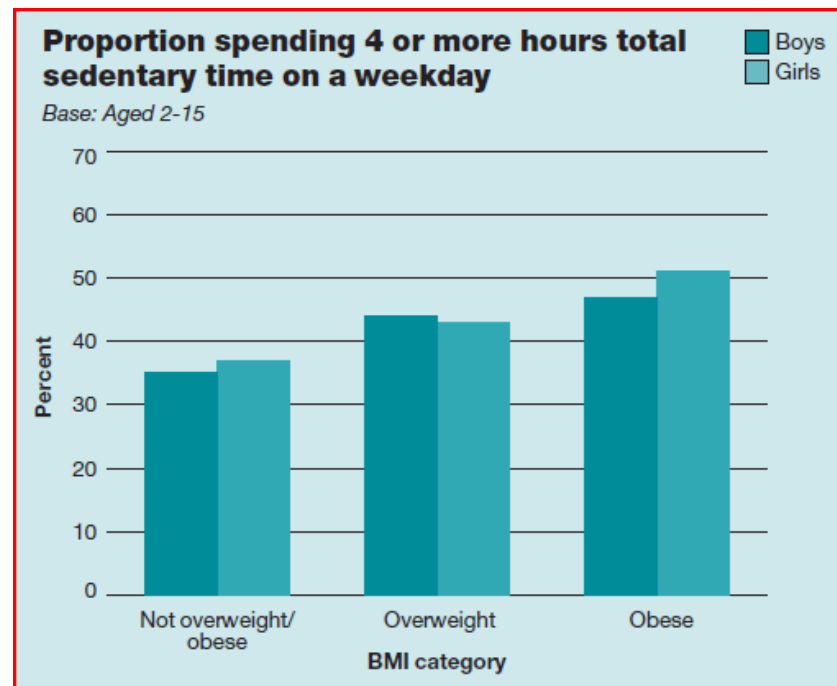


**Figure 13. The prevalence of overweight and obesity in Year 6 children in Barnet schools**



The figure below shows the proportion of children who were sedentary for more than four hours on a typical weekday or weekend day according to BMI categories<sup>37</sup>. Among both boys and girls there was a relationship between sedentary time and BMI category. For boys, on weekdays, the proportion who spent 4 or more hours doing sedentary activities was 35% of those who were not overweight or obese, 44% of those classed as overweight and 47% of those classed as obese. For girls, a comparable pattern was found; 37%, 43% and 51% respectively.

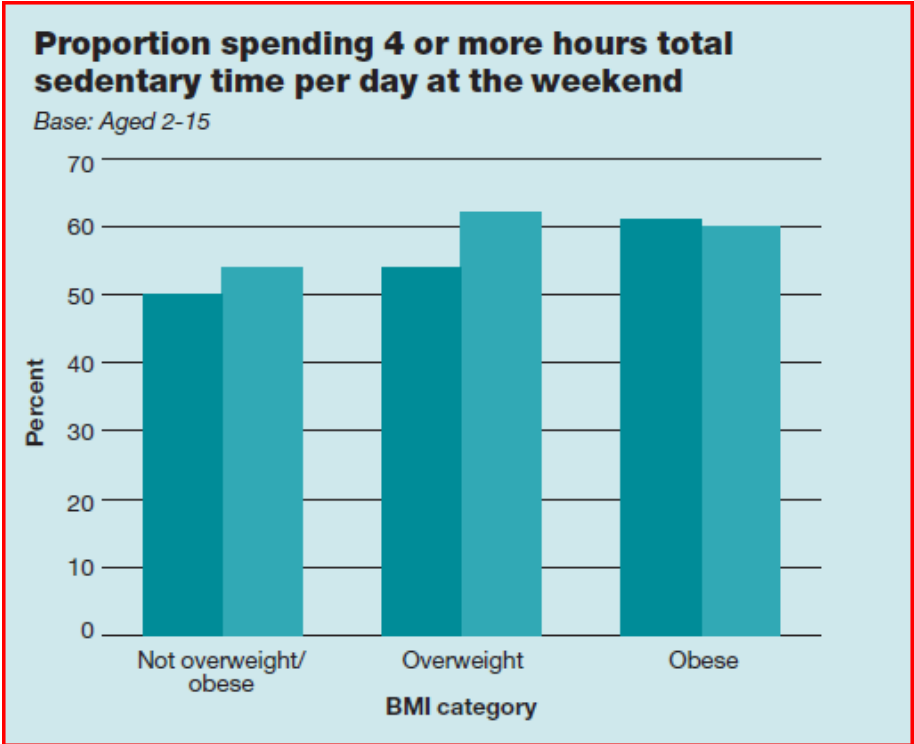
**Figure 14. Proportion spending 4 or more hours total sedentary time on a weekday**



For boys, the relationship between weekend sedentary behaviour and BMI was very similar to that of weekday sedentary behaviour. For girls, similar proportions of those who were overweight and obese were sedentary for four or more hours on weekend days (62% and 60% respectively). Thus, there was a clear association between sedentary behaviour and Body Mass Index (BMI) category.

<sup>37</sup> The Health and Social Care Information Centre (2010) Health Survey for England 2008: Volume 1 Physical Activity and Fitness.

**Figure 15. Proportion spending 4 or more hours total sedentary time per day at the weekend**



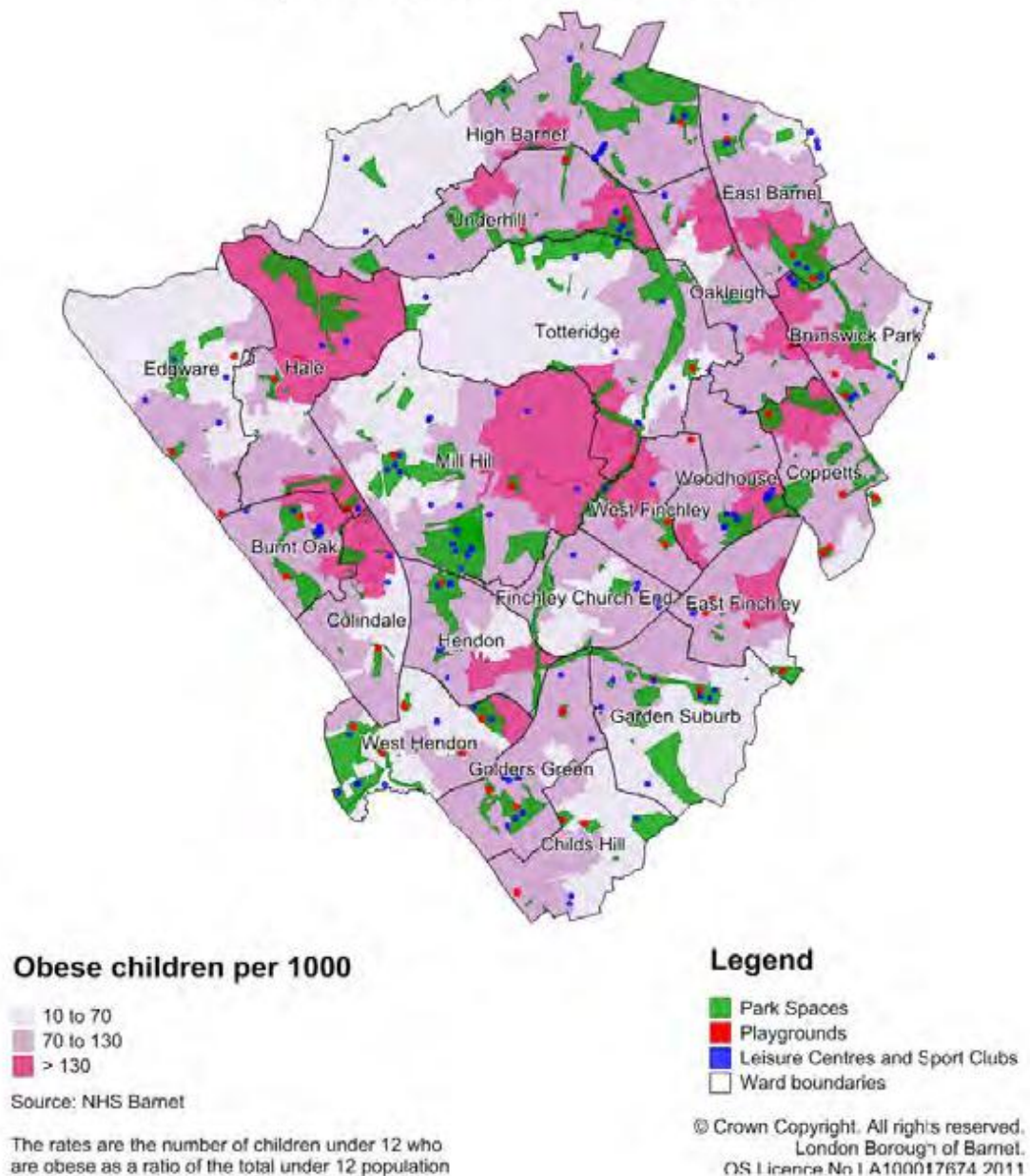
Physical activity by itself can result in modest weight loss of around 0.5kg-1kg per month but the most effective way to lose weight involves a combination of physical activity and diet.

### 2.3.10 Environment and obesity

One of the ways that local authorities can support healthy lifestyles is by making planning decisions that safeguard local parks and open spaces. Barnet Council has outlined commitments to protect and enhance Barnet's open spaces in its planning policies, ensuring that access to open spaces is improved and that they become more attractive as places to a wider range of users. This is especially important for encouraging active lifestyles among children.

Figure 16.

## Child obesity rate by LSOA and park spaces in Barnet



## 2.4 Cost of Physical Inactivity

Apart from the obvious costs to individuals and their families in terms of ill health and reduced life expectancy, there are other costs associated with physical inactivity. These include:

- treatment of disease (such as heart disease, diabetes, cancer, obesity, depression and dementia)
- injuries from falls

- social care arising from loss of functional capacity and mobility in the community
- sickness absence from work and school
- loss of work skills through premature death or incapacity
- lower quality of life and mental wellbeing for individuals and carers.

The estimated direct cost of physical inactivity to the NHS across the UK is £1.06 billion. This is based upon 5 conditions specifically linked to inactivity, namely coronary heart disease, stroke, diabetes, colorectal cancer and breast cancer. This figure represents a conservative estimate, since it excludes the costs of other diseases and health problems, such as osteoporosis and falls, which affect many older people.

Estimates for Barnet, based on the cost to the NHS of treating diseases associated with inactivity, are approximately £4.1 million per year<sup>38</sup>.

**Table 7. Health costs of physical inactivity**

Geography	The Health Costs of Physical Activity	
	Cost	Cost per 100,000 pop
Barnet	£4,147,240	£1,248,695
London	£105,092,430	£1,394,386
England	£764,661,980	£1,531,401

Source: Department of Health - Be Active Be Healthy, Year: 2006/7  
Measure: Health costs of physical inactivity

Inactivity also creates costs for the wider economy, through sickness absence and through the premature death of productive individuals. It also increases costs for individuals and for their carers. In England, the costs of lost productivity have been estimated at £5.5 billion per year from sickness absence and £1 billion per year from the premature death of people of working age making a total of £8.3 billion each year<sup>39</sup>.

## 2.5 Summary of key findings

- Barnet is the most populous borough in London and is relatively young. Although Barnet is affluent borough compared to other areas of England and London, there is a wide variance within the borough. The most western and eastern edges of the borough have the highest deprivation scores.
- Barnet's population is set to grow partly due to continued migration and also regeneration and new housing developments. In line with this growth the age and ethnic profile of the borough will also expected to change.
- CVD mortality increases as area deprivation increases in Barnet. Physical inactivity and low fitness are major independent risk factors for coronary heart disease in both men and women, at a level similar to that of smoking cigarettes. I
- Physical inactivity is a major risk factor for the development of Type II diabetes, with active people having a 33-50% lower risk compared with inactive people.

<sup>38</sup> Department of Health (2009) Be active, be healthy: A plan for getting the nation moving London: Department of Health

<sup>39</sup> Department of Health (2011) Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers: Department of Health.



Independent of exercise levels and sedentary behaviours are associated with significantly elevated risk of Type II diabetes.

- Barnet death rates from COPD are significantly lower than the London and England averages also lower death rates compared to majority of boroughs in London. Overall, studies have shown that pulmonary rehabilitation involving some sort of exercise programme significantly reduces hospital admissions and mortality for people with COPD.
- Physical activity is associated with a reduction in overall risk of cancer. There is a marked protective effect on colon cancer: the most active individuals have, on average, a 40-50% lower risk than the least active. Independent of exercise levels and sedentary behaviours are associated with significantly elevated risk of some types of cancers.
- The risk of falling increases as people get older and falls represent the most frequent type of serious injury in the over 65s age group and the commonest reason for hospital attendance. Physical activity can delay the progression of osteoporosis and activities that promote strength, balance and power may be important for older people because of their potential to prevent falls.
- There is an approximately 20% to 30% lower risk of depression and dementia for adults participating in daily physical activity. Physical activity helps people to function better through alleviation of stress, and improved sleep, and in older people, through some aspects of cognitive function.
- In Barnet, 18.3% of adults are classified as obese. Adults who are overweight or obese are less likely to meet the DoH 2004 physical activity recommendations of at least moderate intensity physical activity on five or more days a week compared with those who are not overweight or obese.
- In Barnet, 9.5% of children in Reception are obese compared to 17.7% of children in Year 6.
- There is a clear association between sedentary behaviour and Body Mass Index (BMI). Physical activity by itself can result in modest weight loss but the most effective way to lose weight involves a combination of physical activity and diet.
- Spatial planning can address unhealthy lifestyles, such as being overweight, obesity, particularly in children, through the provision of accessible parks, allotments, open spaces, leisure facilities and an attractive and safe public realm which encourages walking, cycling and socialising.
- Lack of physical activity cost to the NHS and the wider economy, through sickness absence and through the premature death of productive individuals.

# Chapter 3: The Physical activity profile for Barnet

## *Introduction*

In this chapter physical activity levels of the borough will be examined. It starts by explaining how physical activity is measured in England, the existing data sources and how the data should be interpreted. This is followed by looking at overall participation and how participation is varied in different population groups and in different geographical areas of the borough. Understanding these variations is important in ensuring that services are provided in the areas to people who are most in need.

### *3.1 Measuring physical activity*

Sport England undertakes an annual telephone survey of recreational physical activity called the Active People Survey (APS). The survey started in 2006 and provides the largest sample size of any sport and recreation survey in Europe. 500 individuals are interviewed from each local authority on an annual basis. This relatively large sample size allows detailed analysis at the borough level. As far as we are aware, this is the only survey providing data on levels of physical activity within local authority areas.<sup>40</sup>

The main purpose of APS is to assess participation in physical activity and identify variation in participation between different groups and areas. In addition to this, APS also identifies the proportion of people who are members of sports clubs, who volunteer in sports and who receive tuition or coaching. Additionally, levels of satisfaction with sports provision are also measured.<sup>1</sup>

Although the detailed information provided by APS is an invaluable resource it must be interpreted with caution. The levels of physical activity are self-reported and are not validated with objective measures of physical activity. Health Survey for England 2008 was a household survey which focused on physical activity. It objectively measured physical activity using accelerometers in addition to self-reported levels. The survey found significant discrepancies between self-reported levels and objective measures.<sup>41</sup> However, as this survey was conducted at the national level there is insufficient data to analyse levels of participation within Barnet.

There a number of key indicators of participation in physical activity which are measured by the Active People Survey. These indicators classify levels of participation by frequency per week. Thus the 3 x 30 indicator is defined as “the percentage of the adult population participating in sport at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks.” This is equivalent to 30 minutes on 3 or more days per week. This indicator does not include some physical activities which are not considered ‘sport’, even if they are moderate intensity, such as recreational walking and cycling. It only includes these activities if they are strenuous (e.g. power walking) or if they are undertaken at least once per week.

Local authorities are concerned with the level of physical activity as defined by national guidelines not just sport. In view of this Sport England introduced the National Indicator 8 (NI8). This indicator is defined as “the percentage of the adult population participating in

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<sup>40</sup> Active People Survey. Available at: [http://www.sportengland.org/research/active\\_people\\_survey.aspx](http://www.sportengland.org/research/active_people_survey.aspx)  
Accessed July 2012

<sup>41</sup> Health Survey for England 2008: Physical activity and fitness. NHS Information Centre. Available at: <http://www.ic.nhs.uk/pubs/hse08physicalactivity> Accessed July 2012

sport and active recreation at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks.” This is equivalent to 30 minutes on 3 or more days per week. NI8 includes recreational walking and cycling whereas 3 x 30 does not. This means infrequent cycling of less than once per week and any walking for the purpose of health and recreation is included. The NI8 indicator does not include walking or cycling for transport or some activities like dancing. The other caveat of the NI8 indicator is that results for local authorities are only reported every 2 years (even though the data is collected annually) whereas they are reported annually for the 3 x 30 indicator. This is because Sport England decided a larger sample size was needed for the NI8 indicator.<sup>42</sup>

Both NI8 and 3 x 30 indicators include five light intensity activities for those aged 65 and above in recognition that these lighter activities place a higher degree of physical demand on this age group. These lighter activities are yoga, pilates, bowls, archery and croquet.<sup>1</sup> It is also important to note that for both indicators only 30 minutes of continuous activity is counted towards the results. Therefore if someone does 25 minutes of jogging everyday this would not be counted. It is therefore possible that the Active People Surveys underestimate physical activity.

**Figure 1: Chart explaining different indicators from Active People Survey**

Indicator	Explanation
0x 30	The percentage of the adult population who did not participate in any 30 minute sessions of sport of moderate intensity in the last 4 weeks i.e. no 30 minute sessions/week <b>Does not include recreational walking or recreational cycling</b>
1 x 30	The percentage of the adult population participating in sport, at moderate intensity, for at least 30 minutes on at least 4 days out of the last 4 weeks. This is equivalent to 30 minutes on 1 or more day a week. * <b>Does not include recreational walking or recreational cycling</b>
3 x 30	The percentage of the adult population participating in sport, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks. This is equivalent to 30 minutes on 3 or more days a week. * <b>Does not include recreational walking or recreational cycling</b> The ‘3x30’ sport indicator does include cycling if done at least once a week, moderate intensity for 30 minutes.
NI8	The percentage of the adult population participating in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks. This is equivalent to 30 minutes on 3 or more days a week. * <b>NI8 includes recreational walking and cycling</b> This indicator includes infrequent cycling (less than once a week) and any walking for the purpose of health and recreation (not just as a mode of transport)
5 x 30	The percentage of the adult population participating in sport, at moderate intensity, for at least 30 minutes on at least 20 days out of the last 4 weeks. This is equivalent to 30 minutes on 5 or more days a week. * <b>Does not include recreational walking or recreational cycling</b>

<sup>42</sup> Information obtained by consultation of Proactive North London

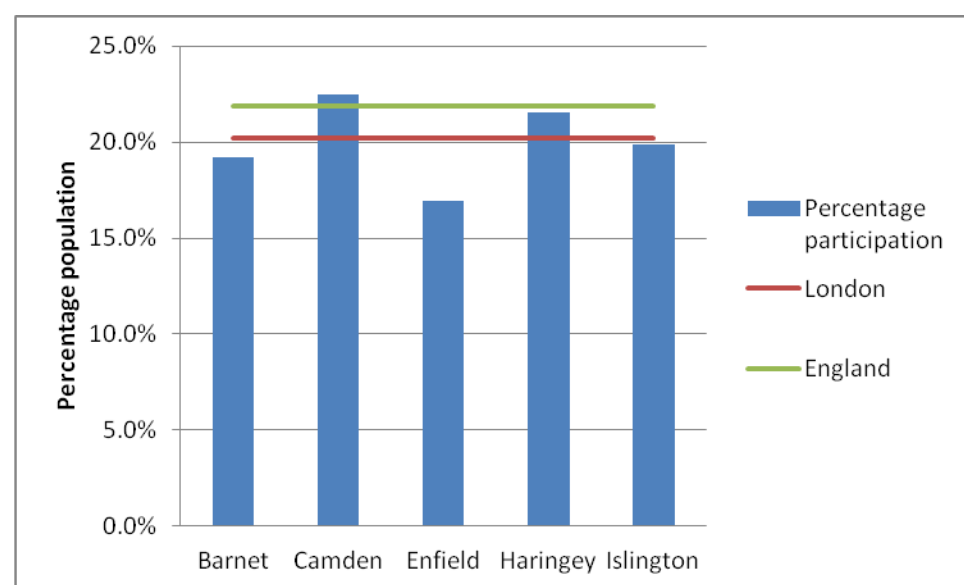
\*Includes the following light intensity activities for those aged 65 and over: yoga, pilates, indoor and outdoor bowls, archery and croquet. For people of this age group these activities place increased physical demand and can be considered moderate intensity.

Source: Explanation of different sport participation indicators. Sport England

### 3.2 Overall participation in Barnet

Only 19% of Barnet residents participate in three 30 minute sessions of moderate intensity physical activity per week<sup>43</sup>. This percentage is lower than for both London and England.<sup>44</sup> Barnet residents are also less active than all other boroughs in North Central London with the exception of Enfield. This suggests Barnet is underperforming its peers.

**Figure 2: Graph showing percentage participation NI8 in Barnet compared to other boroughs, London and England**<sup>4,5</sup>



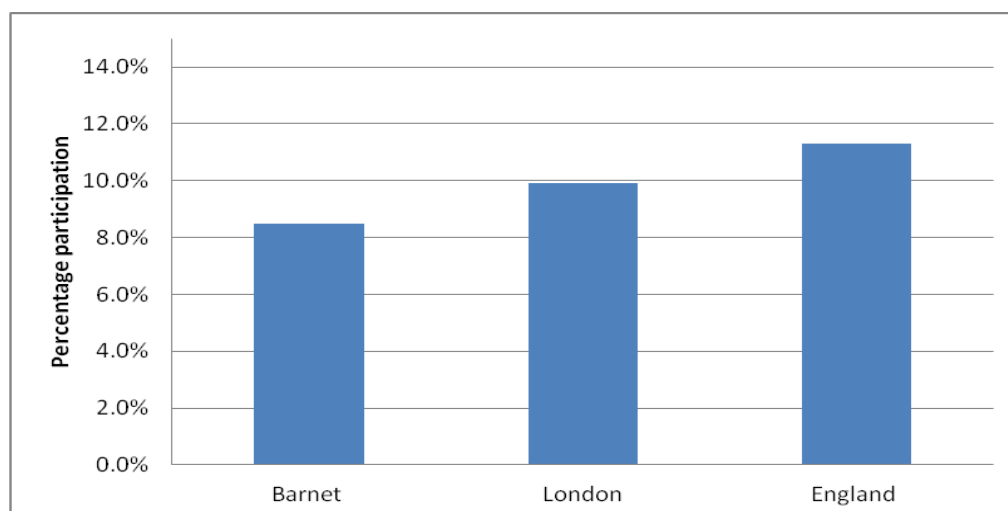
Source: Active People Survey, Local Sports Profile Tool, Sport England

Figure below shows that participation in 5 x 30 minute of physical activity in Barnet is 8.5%. This percentage is also lower than that for both London and England.

<sup>43</sup> Active People Diagnostic. Sport England. Available at: <https://www.ipsos-archway.com/apd/login.aspx?ReturnUrl=%2fapd%2f> Accessed July 2012 (Data source APS 4/5 October 2009-Nov 2011)

<sup>44</sup> Local Sport Profile Tool. Sport England. Available at: [http://www.sportengland.org/research/local\\_sport\\_profiles.aspx](http://www.sportengland.org/research/local_sport_profiles.aspx) Accessed July 2012 (Data source APS 4/5 October 2009-2011)

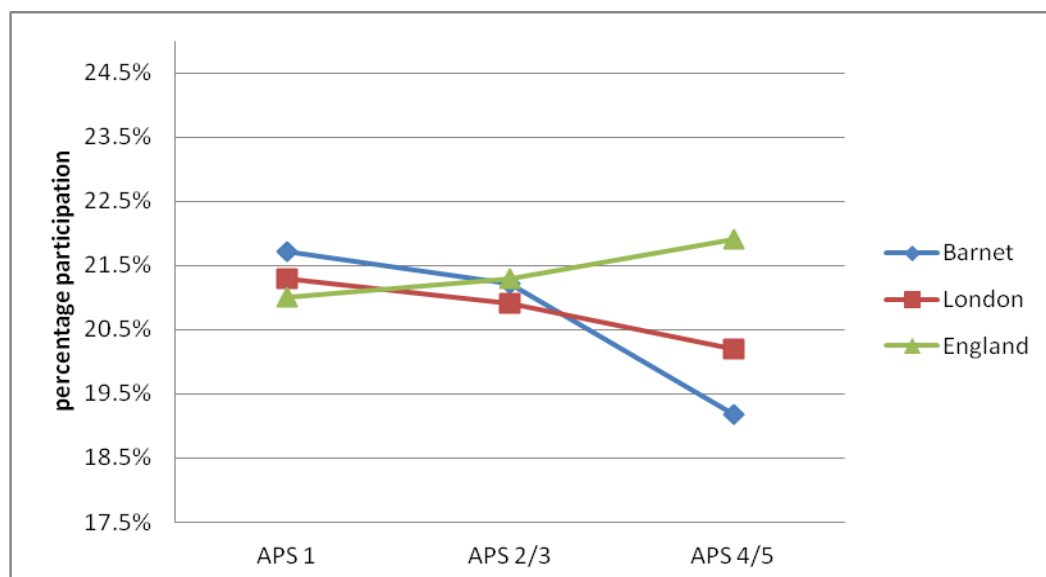
**Figure 3: Graph showing percentage participation in 5 x 30 minute sessions per week for Barnet, London and England**



Source: Active People Survey, Local Sports Profile Tool, Sport England

Perhaps more worrying than the low levels of participation in Barnet, is the downwards trend in participation in the borough. This trend is in contrast to the steady upwards trend in national levels of participation and similar to the downwards trend in the London levels.<sup>45</sup> Decreasing levels of participation in physical activity seem to be a problem local to London. This might be a reflection of the busy lifestyle of many London inhabitants, including Barnet residents, which leaves little time for physical activity. We should seek to reverse this trend before physical activity levels fall even lower.

**Figure 4: Graph showing trend in participation in NI8 for Barnet, London and England<sup>46,47</sup>**



Sources: Local sport Profile Tool, Active People Diagnostic, Active People Headline Results London, Sport England data request. Sport England

<sup>45</sup> Data request to Sport England July 2012

<sup>46</sup> Active People Survey Headline Results: London Region. Sport England. Available at: [www.sportengland.org/.../active\\_people\\_survey/active\\_people\\_survey\\_1/doc.ashx](http://www.sportengland.org/.../active_people_survey/active_people_survey_1/doc.ashx) Accessed July 2012

<sup>47</sup> Active People Survey 2 Results. Sport England. Available at: [http://www.sportengland.org/research/active\\_people\\_survey/active\\_people\\_survey\\_2/national\\_results.aspx](http://www.sportengland.org/research/active_people_survey/active_people_survey_2/national_results.aspx) Accessed July 2012

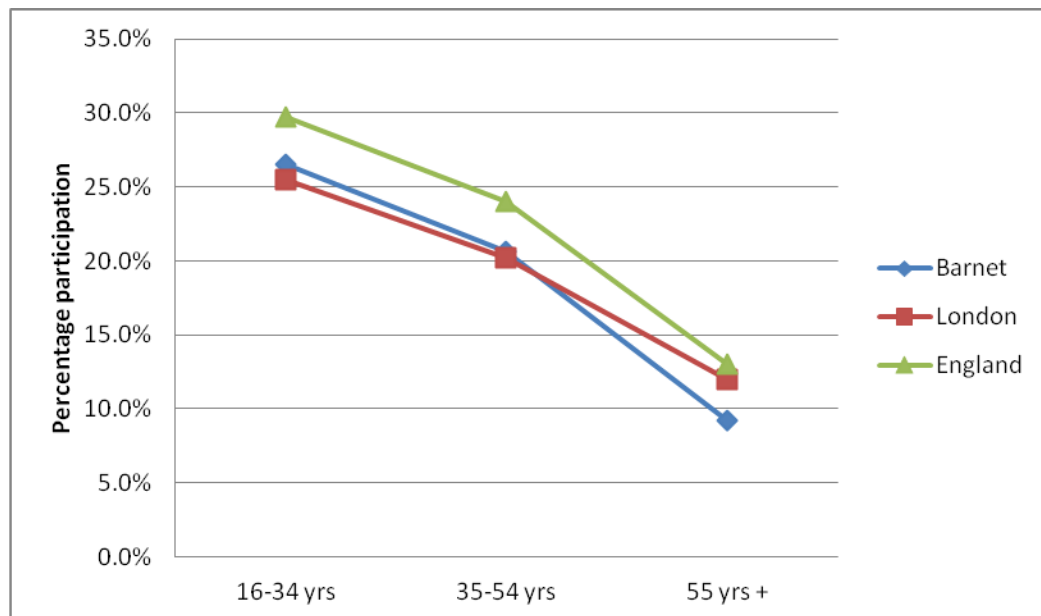
### 3.3 Participation among different groups

Participation in physical activity varies among different groups within our society. It is important to identify groups with low levels of participation as these groups will need more support and intervention to increase their levels of physical activity to recommended levels.

#### 3.3.1 Age

According to APS survey results from 2009-11, the most active age group in Barnet is aged 16 to 34 years. 26.5% of the individuals in this age group are estimated to participate in three 30 minute moderate intensity sessions of physical activity per week. The survey results also demonstrate that people do less exercise as they get older. Only 9.2% of people age 55 and over participate in regular moderate intensity physical activity. This reduction in physical activity with age locally is consistent with trends in physical activity with age at the national level. However, older people in Barnet are less active than equivalent age groups at the national level.

**Figure 5: Graph showing participation in NI8 by age group for Barnet, London and England<sup>7</sup>**



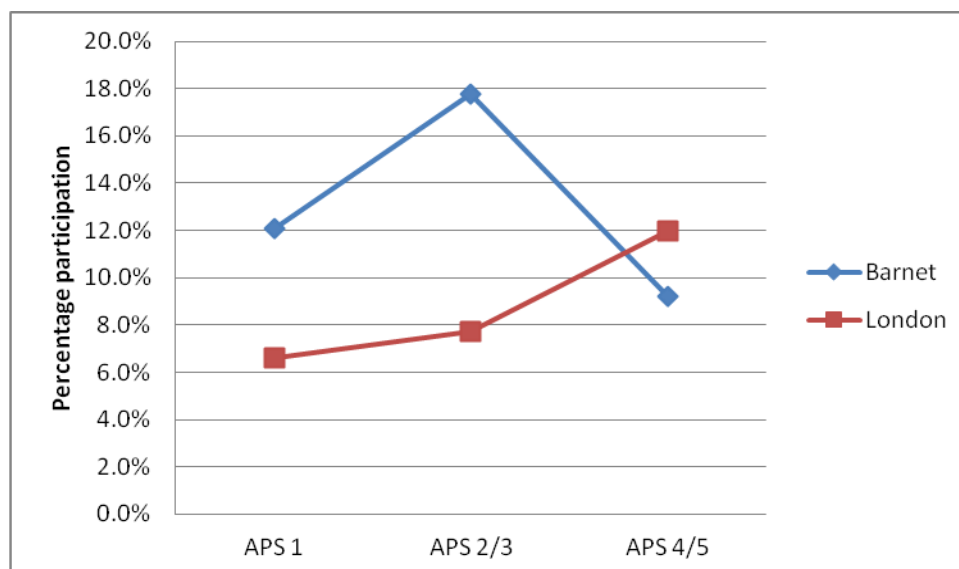
Source: Data request. Sport England

It is more difficult for some older people engage in physical activity due to ill-health and frailty. However, it is important to enable older people to be as active as they can. The Department of Health recommends that older people should undertake 150 minutes of physical activity per week<sup>48</sup>. This is the same recommendation as for adults at other ages. It is likely older adults will need more support and intervention to achieve these recommendations than younger adults. However, there are many benefits of physical activity specific to this age group including reduced risk of falls, improved mental health and better cognitive function.

<sup>48</sup> Department of Health (2011) Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers: Department of Health.

There is a decreasing trend in percentage participation for over 55 year olds in Barnet<sup>49</sup>. There was steep drop between the APS 2/3 cohort in 2007-9 and the APS 4/5 cohort in 2009-11 from 17.8% to 9.2%. This downwards trend is in contrast to the upwards trend in participation in this age group for London.

**Figure 6: Graph showing trend in participation in NI8 in 55 + year olds for Barnet and London**<sup>4, 5</sup>



Sources: Local sport Profile Tool and Active People Diagnostic. Sport England

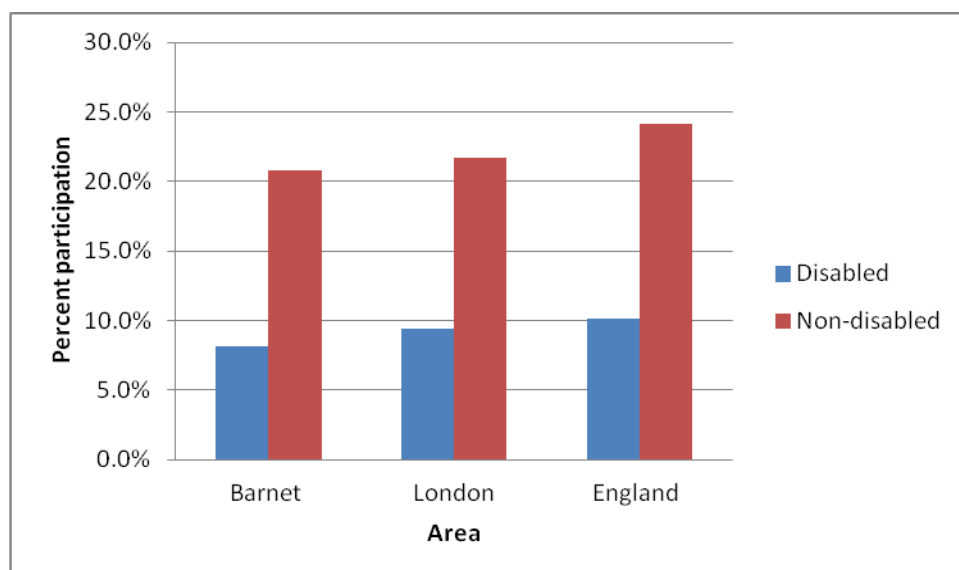
### 3.3.2 Disability

National and Barnet specific data indicates that participation in sports is significantly lower among disabled people than among non-disabled people. Barnet residents with a life-limiting illness or disability were significantly less active than those with no disability or life-limiting illness. Only 8% of those with a life limiting illness or disability participate in three 30 minute sessions of moderate intensity activity per week compared to 21% of those with no disability. Barnet residents with a disability appear to be slightly less active than at the national level. Ten percent of those with a life-limiting illness or disability in England undertake three 30 minute sessions per week compared to 8% in Barnet according to active people survey results (APS 4/5).<sup>50</sup>

<sup>49</sup> Active People Survey Headline Results: London Region. Sport England. Available at: [www.sportengland.org/active\\_people\\_survey/active\\_people\\_survey\\_1/doc.ashx](http://www.sportengland.org/active_people_survey/active_people_survey_1/doc.ashx) Accessed July 2012

<sup>50</sup> Active People Survey 5 results. Available at [http://www.sportengland.org/research/active\\_people\\_survey.aspx](http://www.sportengland.org/research/active_people_survey.aspx) Accessed July 2012

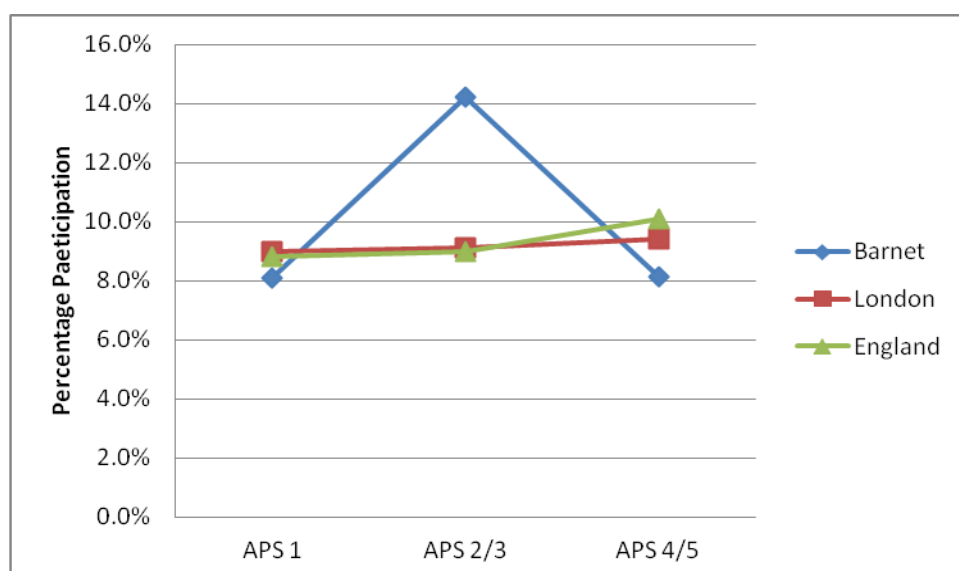
**Figure 7: Graph showing percentage participation in NI8 by those with life limiting illness or disability**



Sources: Local sport Profile Tool, Active People Diagnostic and Active People Headline Results London. Sport England

The percentage participation in three 30 minute sessions of physical activity among disabled Barnet residents decreased from 14% in 2009/10 (APS 2/3) to 8% in 2010/11 (APS 4/5). This level is similar to that 6 years ago. We do not know the cause of the spike in physical activity among this group in 2009/10 but it may be an artifact resulting from small sample size.

**Figure 8: Graph showing trend in percentage participation in NI8 by those with life-limiting illness or disability**



Sources: Local sport Profile Tool, Active People Diagnostic and Active People Headline Results London. Sport England

There are an estimated 17,100 people living with disability in Barnet which accounts for 6.2% of the population. This is a significant number of people who have a significant barrier physical activity that can be overcome. In order to achieve this there are many factors that need to be considered including appropriate activities, facilities, access and

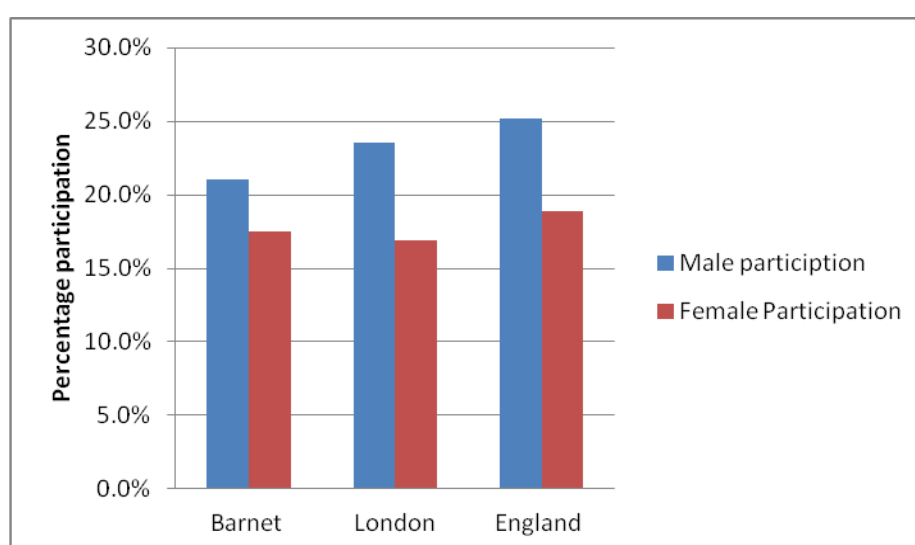


transport. Interventions should consider that disabled people are more likely to be excluded from sport if they have a low income<sup>51</sup>.

### 3.3.4 Gender

Levels of participation in physical activity vary by gender, with men participating more than women at both the national and local levels. According to the latest APS results, 21% of men in Barnet participate in at least three 30 minute sessions per week compared to 17.5% of women. Women are consistently less active than men at both national and local levels according to NI8 results of all Active People Surveys. The trend in NI8 participation in physical activity among female Barnet residents is a downwards one in contrast to a very gradual increasing trend in participation at the national level. London also has a downwards trend in female participation suggesting this is a local problem.

**Figure 9: Graph showing participation in NI8 by gender for Barnet, London and England**

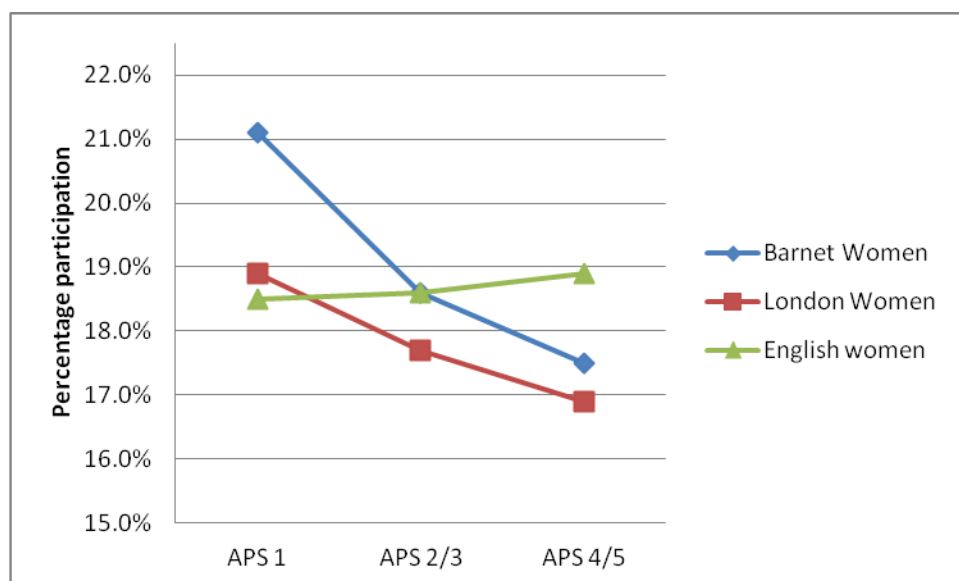


Source: Local Sport Profile Tool, Sport England.

Although participation is higher for men than it is for women, the percentage participation in NI8 for men living in Barnet is still 4.2 percentage points lower than for men at the national level. This difference is much greater than it is for women (1.4%). The trend in participation of male residents in Barnet is unusual with a peak for APS 2/3 results (October 2007-October 2009). This may be due to a small sample size. However, the most recent results from 2009-11 show participation among men were lower than it was in 2006 in the first Active People Survey. This suggests an overall downwards trend which is concerning. Additionally, men are more at risk than women of some obesity-related diseases such as coronary heart disease. Thus, both men and women are targets for increasing physical activity. It is important to recognise the different preferences of both genders when seeking to increase participation.

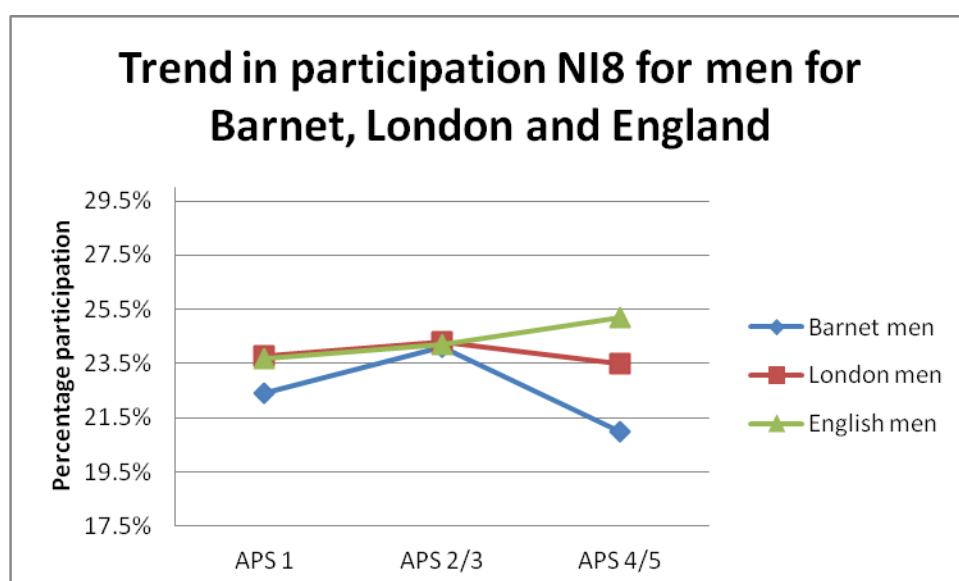
<sup>51</sup> Adults with a Disability and Sport National survey. Sport England. 200-2001. Available at: <http://www.sportengland.org/search.aspx?query=Adults+with+a+Disability+and+Sport+National+survey>  
Accessed July 2012

**Figure 10: Graph showing participation in NI8 for women in Barnet, London and England**



Source: Data request Sport England : APS 1 (2006/7), APS 2 (2007/8), APS 3 (2008/9), APS 4 (2009/10), APS 5 (2010/11)

**Figure 11: Graph showing participation in NI8 for men in Barnet, London and England**



Source: Data request Sport England : APS 1 (2006/7), APS 2 (2007/8), APS 3 (2008/9), APS 4 (2009/10), APS 5 (2010/11)

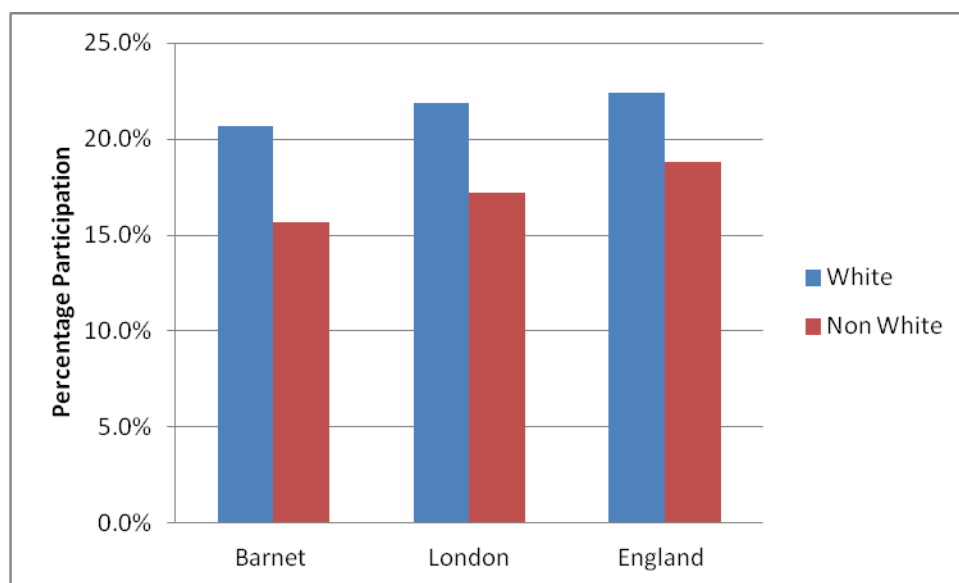
### 3.3.5 Ethnic groups

Certain ethnic groups are known to have lower levels of physical activity. In England physical activity is lower in black or minority ethnic groups with the exception of African-Caribbean and Irish populations.<sup>52</sup> In Barnet, 20.7% of white residents participate in three 30 minute sessions of moderate intensity sport or active recreation per week compared to

<sup>52</sup> Let's Get Moving - A new physical activity care pathway for the NHS. Commissioning guidance. Department of Health 2009. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_105945](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105945) Accessed July 2012

just 15.7% of non-white residents. This represents a difference in percentage participation of 5%. At the national level 22.4% of white people participation in three 30 minute sessions per week compared to 18.8% of non-white people. This represents a difference of 3.6% which is slightly less than the difference in participation between white and non-white people in Barnet. Percentage participation in three 30 minute sessions of physical activity among the non-white population in Barnet is significantly lower than at the National level.

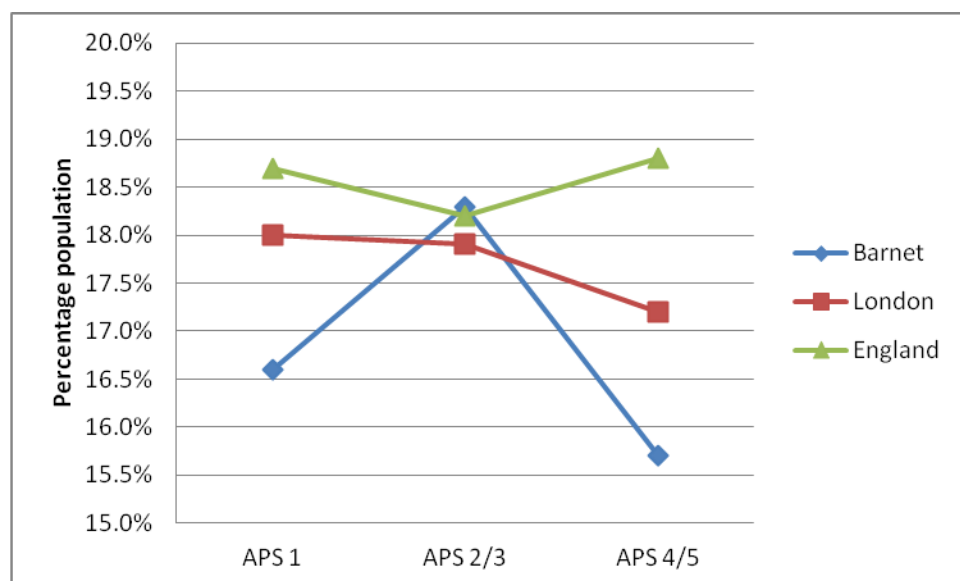
**Figure 12: Graph showing percentage participation in NI8 in the white and non white population fir Barnet, London and England**



Source: Local Sport Profile Tool. Sport England (APS 4/5, October 2009-November 2011)

There is an unusual trend in participation among the non-white population in Barnet with a spike in participation in 2007-9 (APS 2/3). This may be due to small sample size. However, the overall trend is a decreasing one, with participation among non-white populations now even lower than it was in 2006 (APS1). Participation among the non-white population in London has also decreased. These decreasing trends in participation among this group are in contrast to the relatively stable levels of participation among the non-white population at the national level.

**Figure 13: Graph showing participation in NI8 among the non-white population for Barnet, London and England**



Source: Active People Diagnostic and individual relevant APS results: APS 1 (2006/7), APS 2-3 (2007-9), APS 4/5 (2009-11)

Barnet has a rich cultural diversity which is set to increase. The non-white population of Barnet is set to increase from 33.1% to 35% of the total population.<sup>53</sup> The contribution of sport to community integration and cohesion is especially important in this context. It is important that the benefits of sport and active recreation are available to all sections of society. However, according to a review by Sport England, inequity and discrimination by race remains a barrier to participation by black and ethnic minority groups in England.<sup>54</sup> The barriers to participation for black and ethnic minority groups were described. Key barriers were: material constraints to accessing sport (increased unemployment, low income and poor health), concerns about racial discrimination and access to culturally-appropriate opportunities for physical activity. It is important that interventions to increase physical activity seek to reduce barriers for ethnic minority groups. It is particularly important to encourage participation among ethnic groups with high rates of obesity and obesity related diseases e.g. South Indian are among those ethnicities with the lowest levels of participation.

### 3.3.6 Socio-economic groups

Sport England has used the National Statistics Socio-economic Classification (NS-SEC) to analyse participation by socioeconomic group. NS- SEC is the primary social classification system used in the UK. Sports England has used the analytic version of NS- SEC which has 8 categories.

- Higher managerial, administrative and professional occupations
- Lower managerial, administrative and professional occupations
- Intermediate occupations

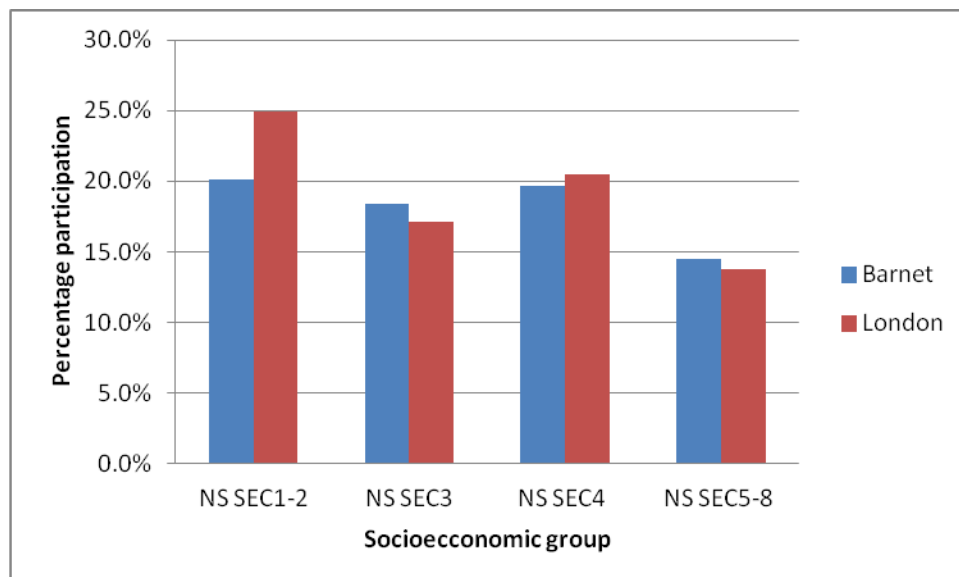
<sup>53</sup> Barnet JSNA 2011-15

<sup>54</sup> A systematic Review of the Literature on Black and Ethnic Minority Communities in Sport and Physical Recreation. Summary. Sport England. Available at: <http://www.sportengland.org/search.aspx?query=A+systematic+Review+of+the+Literature+on+Black+and+Ethnic+Minority+Communities+in+Sport+and+Physical+Recreation.+Summary.+Sport+England>. Accessed July 2012

- Small employers and own account workers
- Lower supervisory and technical occupations
- Semi-routine occupations
- Routine occupations
- Never worked and long-term unemployed

Participation generally decreases with socio-economic group. 20.1% of Barnet residents in the top two socio-economic groups (NS SEC 1-2) participate in three 30 minute sessions moderate intensity physical activity or active recreation compared to just 14.5% of the bottom three socio-economic groups (NS SEC 5-8) according to APS 4/5 results. Participation is lower across all socio-economic groups compared to London as a whole but it is noticeably lower than London among Barnet residents in the two highest socio-economic groups, NS SEC 1-2. There is a dip in participation for NS SEC 3 for both London and Barnet.

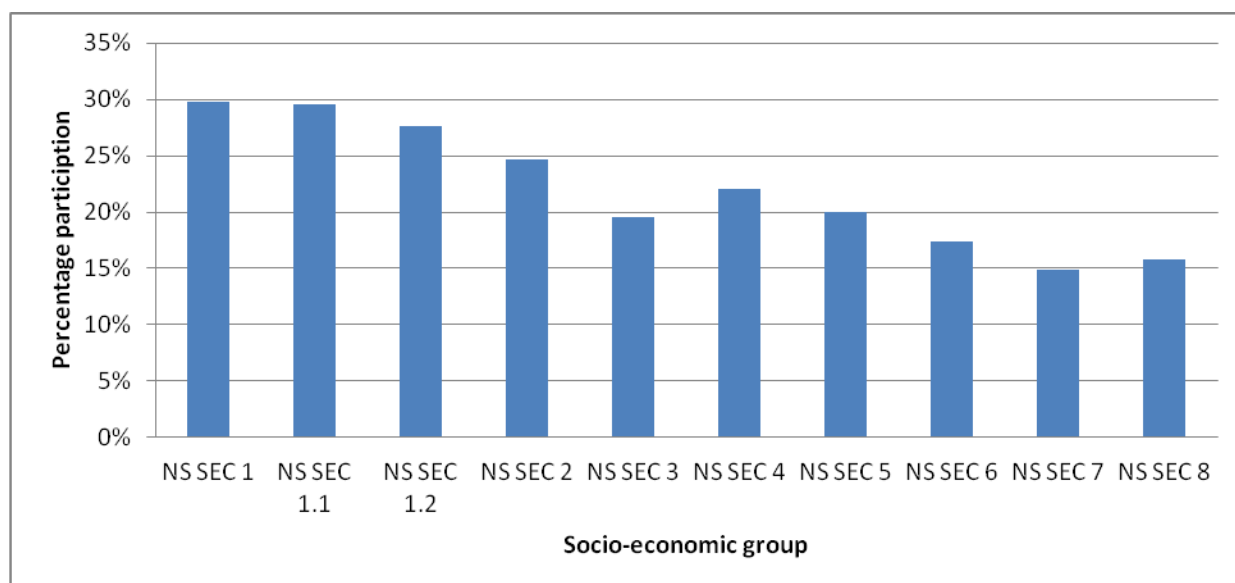
**Figure 14: Graph showing participation in NI8 by socioeconomic group in Barnet and London**



Source: Active People Diagnostic. Sport England (APS 4-5 October 2009-November 2011)

We were not able to provide a comparison with England as APS 5 results on percentage participation in NI8 by socioeconomic group was not publicly available. We have provided a separate chart to demonstrate participation levels at the National level by socio-economic group.

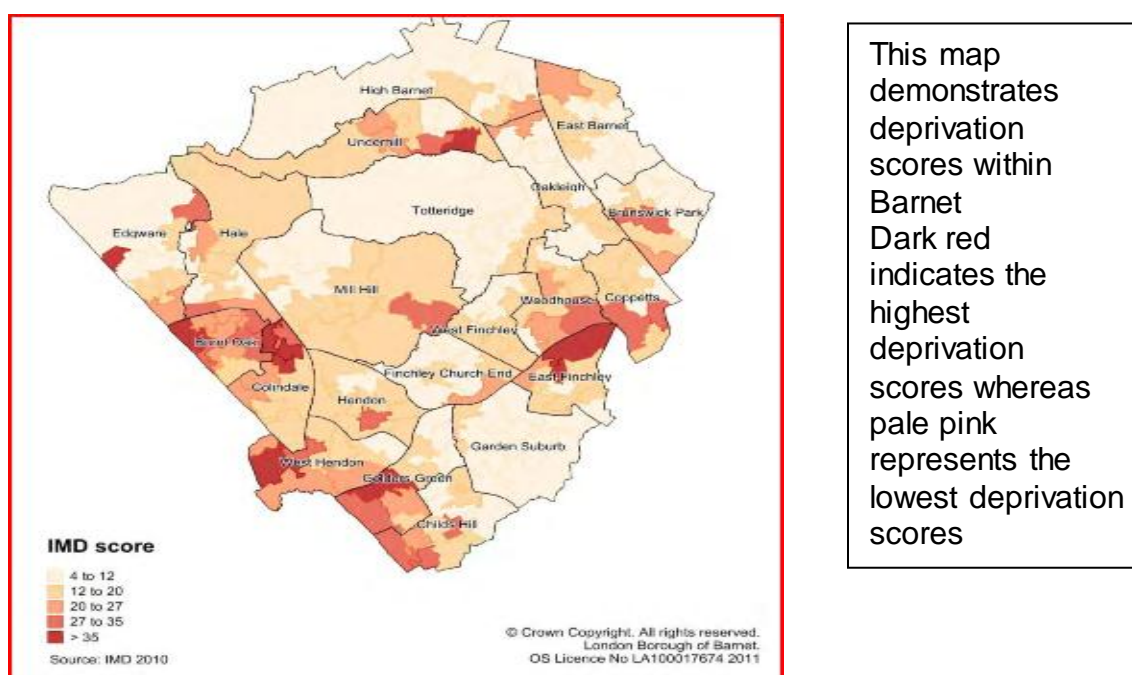
**Figure 15: graph showing percentage participation in NI8 by socioeconomic group in England**



Source: Active People Diagnostic. Sport England

Barnet is a relatively affluent borough compared to other areas of England and London and the affluence of the borough overall is increasing. However Barnet's deprivation levels within the borough are particularly diverse. The map illustrates how the most western and eastern edges of the borough have the highest deprivation scores. These areas match closely the areas with the lowest participation in physical activity. It is again the western and eastern edges of the borough that score the lowest with those living in the centre of the borough being most active. Additionally, it is the Edgware and Burnt Oak areas of the western edge of the borough and the Finchley area that have the highest rates of obesity. It is important to engage those living in less affluent areas of the borough as physical activity can contribute to reducing inequalities through improved health and educational achievement.

**Figure 16: Map showing derivation scores across Barnet borough**



Source: JSNA 2011-2015

### *3.4 Participation in different areas of the borough*

The smallest geographical area in which the Active People Survey can accurately measure participation is the local authority level.<sup>55</sup> Smaller geographical areas have fewer responses meaning the sample size is too small to produce reliable results. Sport England have used modelling to estimate participation in smaller areas using Active People Survey data and other available local data. This data is presented in map form and can be used to analyse variations in participation within the Barnet borough.<sup>56</sup>

There is some variation in level of physical activity by area within the borough which reflects the socio-demographic variations within Barnet. The lowest levels of physical activity are found along the western border of the borough (West Hendon and Burnt Oak Areas) and in the central northern area of the borough (around Underhill). It is estimated that between 12.8% and 14% of individuals living in these areas participate in three 30 minute sessions of moderate intensity physical activity per week. These estimates are based on Active people survey data from 2008-2010.

Intermediate levels of physical activity can be found surrounding the areas with lowest levels of physical activity along the eastern border of the borough and along the eastern edge of the borough (Finchley/Woodhouse area and Brunswick Park areas). It is estimated that between 14.1% and 15.6% of individuals living in these areas participate in three 30 minute sessions of exercise per week.

The highest levels of physical activity are found in the centre of the borough with the exception of the Underhill area which is a more deprived area (see map above). In these areas 15.7-24.4% of residents are estimated to participate in three 30 minute sessions per week.

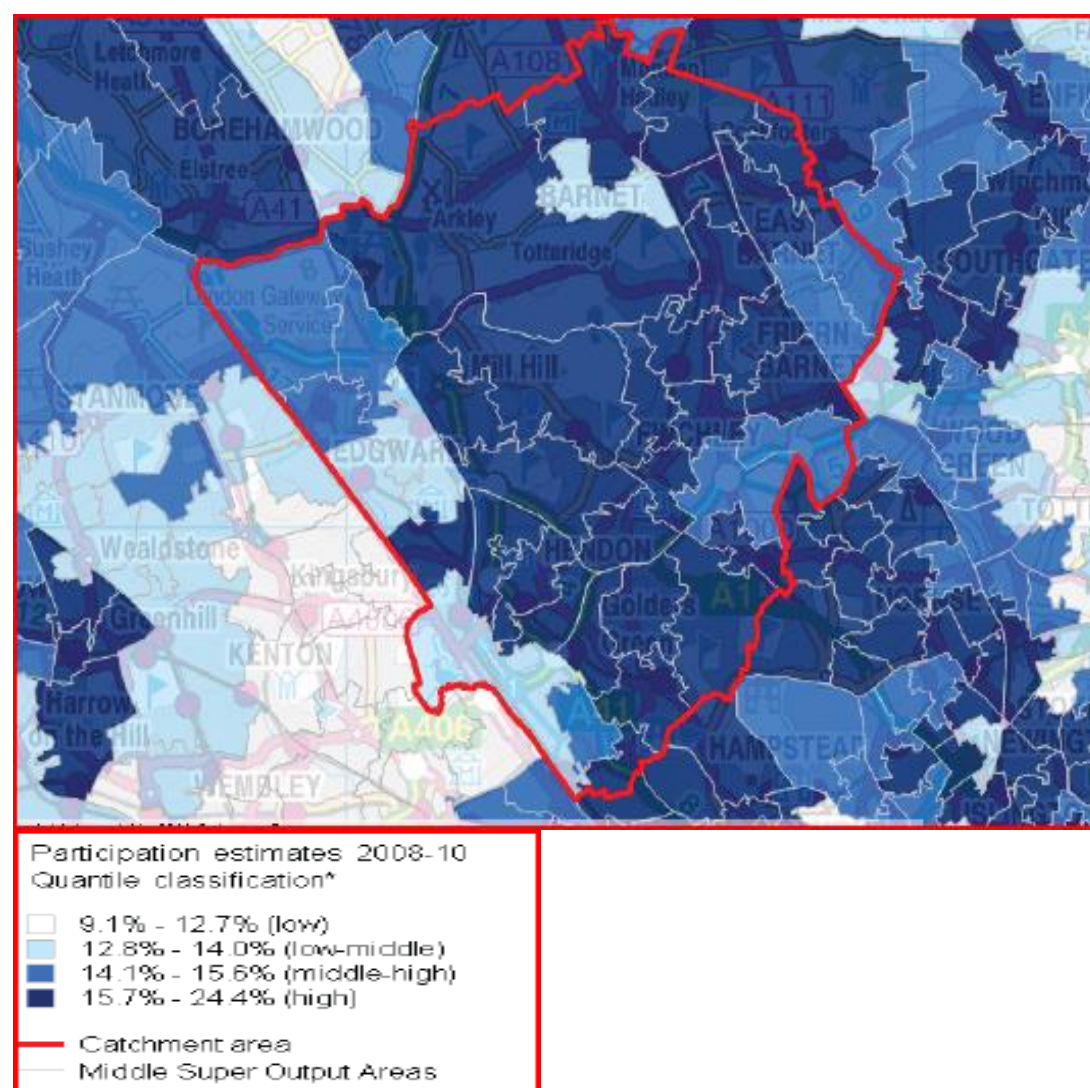
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<sup>55</sup> Small area estimates of participation. Sport England. Available at: [http://www.sportengland.org/research/understanding\\_participation/small\\_area\\_estimates.aspx](http://www.sportengland.org/research/understanding_participation/small_area_estimates.aspx) Accessed July 2012

<sup>56</sup> Small areas estimates web tool. Sport England. Available at: <http://sae.sportengland.org/> Accessed July 2012



**Figure 17: Map showing participation levels in medium super output areas within Barnet borough**



Source: Small areas estimates web tool. Sport England.

### *3.5 Participation by children and young people*

Department of health guidance says that school age children should be active for a minimum of 60 minutes per day. However, very few children meet this minimum requirement. Nationally only 32% of boys aged 2-15 years and 24% of girls the same age were active for 60 minutes per day.<sup>57</sup> Those children who had parents with low levels of physical activity were more likely to have a low level of physical activity themselves. This implies a need to work with the parents as well as children to improve physical activity levels and sustain them into adulthood. There is a growing body of evidence to suggest higher levels of activity in childhood lead to a more sustained level of physical activity later

<sup>57</sup> Statistics on obesity, physical activity and diet: England 2011. Available at: [http://www.ic.nhs.uk/webfiles/publications/003\\_Health\\_Lifestyles/opad11/Statistics\\_on\\_Obesity\\_Physical\\_Activity\\_and\\_Diet\\_England\\_2011\\_revised\\_Aug11.pdf](http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/opad11/Statistics_on_Obesity_Physical_Activity_and_Diet_England_2011_revised_Aug11.pdf) Accessed July 2012

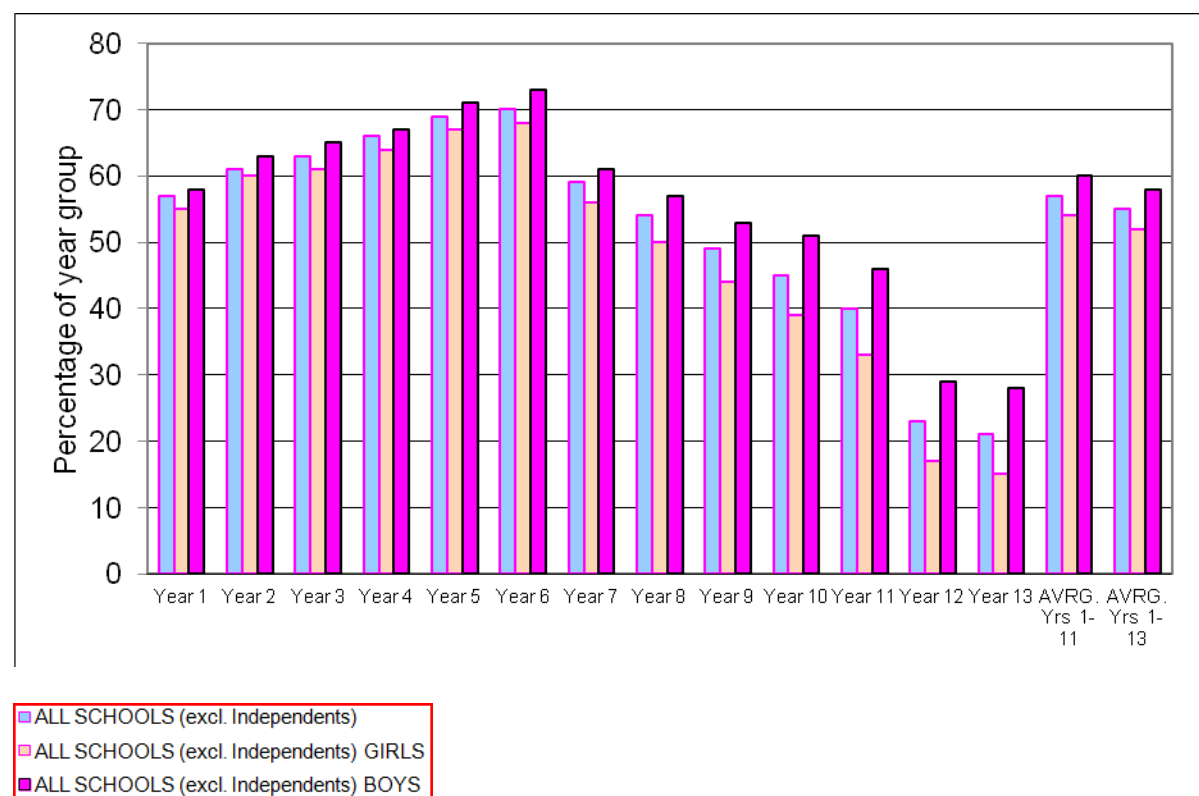


in life<sup>58, 59</sup>. Thus there is a need to intervene early to establish healthy lifestyles and behaviours that have significant health benefits in later life.

Sport England do not collect participation data for children at the local authority level. We have some data on levels of participation in children from the PE and Sport Strategy for Young People (PESSYP) programme which has now ceased. This was a national campaign to improve access to sport for young people through schools which collated a lot of data from schools about physical activity levels in children.

Physical activity decreases as children become older teenagers. Figure 18 shows how participation in physical activity decreased from year 6 when it is highest to very low levels by the time an individual leaves school. It also demonstrates that girls have lower level of physical activity in all year groups and this disparity increases with age. By year 13 only 15% of girls take part in three hours of high quality PE and out of hours physical activity compared to 28% of boys.<sup>60</sup> Thus girls are almost half as active as boys by year 13. This might be because PE is not a compulsory part of the curriculum in later years meaning young people need to participate in more physical activity outside of school to meet their requirements. Perhaps boys are more likely than girls to pursue sport and active recreation outside of school hours. It may be that community sports clubs are more appealing to boys or that they do not offer the sorts of activities that girls want to participate in.

**Figure 18: Graph showing participation in at least three hours of high quality PE and out of hours sport by year group in Barnet**



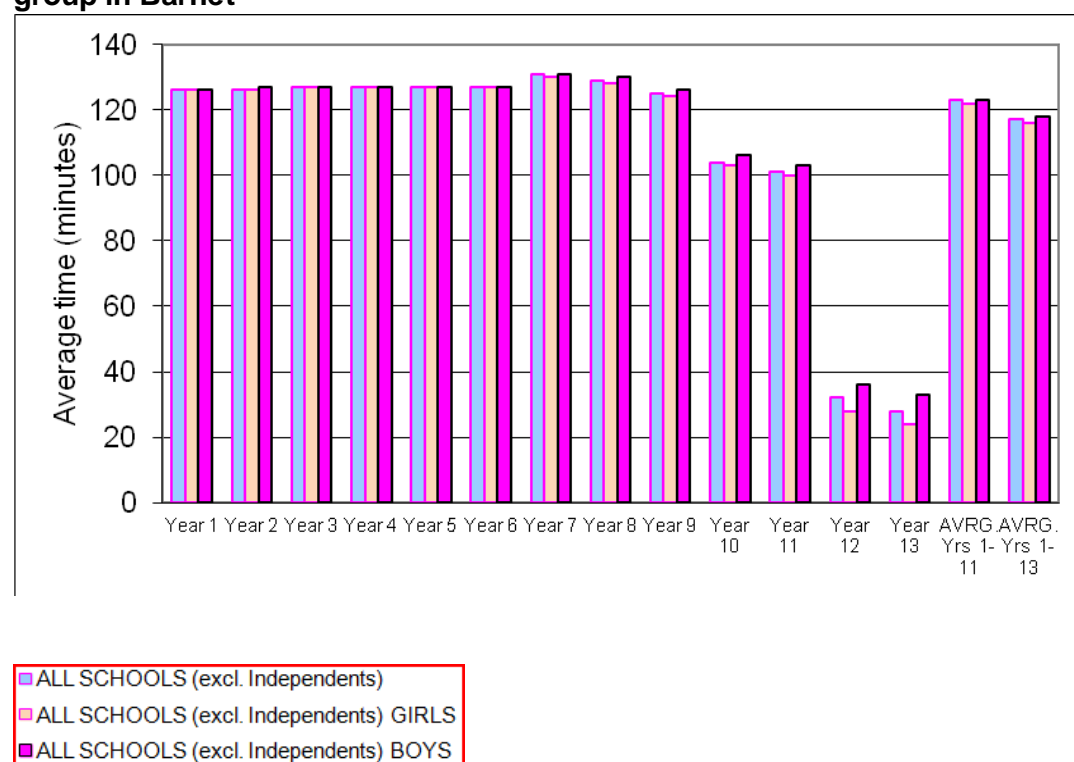
<sup>58</sup> Riddoch CJ (1998) Relationships between physical activity and health in young people. In Biddle S, Sallis J, Cavill N editors. Young and Active? Young people and health enhancing physical activity: evidence and implications. London Health Education Authority 1998 17-48.

<sup>59</sup> Boreham C, Riddoch CJ (2001) The physical activity, fitness and health of children. Journal of Sports Science 2001, 19: 915-929.

<sup>60</sup> PESSYP data obtained from School Sports Partnership

PE is a compulsory part of the school curriculum until age 16 when students are allowed to drop the subject. PE can make a significant contribution to keeping children active and to minimising the gender gap in participation among young people. PE plays an important role in developing competence and confidence in different types of physical activity which builds a habit for lifelong participation in physical activity. It is also an opportunity for all children to learn about the value of a healthy lifestyle and experience the benefits of physical activity. PE also helps young people develop personally and socially by offering the opportunity to develop team skills, leadership and concepts such as fairness and social responsibility.<sup>61</sup> The graph demonstrates that children in years one to nine participate in more than 2 hours PE per week. In years ten and eleven this reduces to around 100 minutes of PE per week. There is a sharp decrease in participation in PE for years 12 and 13 probably because relatively few young people continue the subject at AS and A-level.

**Figure 19: Graph showing amount of curriculum time for PE in a typical week per year group in Barnet**



Competitive sport is a key part of the Governments plans for a lasting sporting legacy from the London 2012 Olympic Games.<sup>62</sup> Competitive sport encourages teamwork and dedication which are beneficial for young people. It provides an opportunity to develop future sporting stars. Many children enjoy competition and it can act to encourage participation but not all children enjoy competition in sport. The majority of children in Barnet participate in intra-school competitive sport up until year nine when participation in intra-school competitions decreases. This might be due to increased time pressures from studying for exams in later school years. The decrease in older age groups might also be due to older children competing at higher levels as their sporting skills improve.

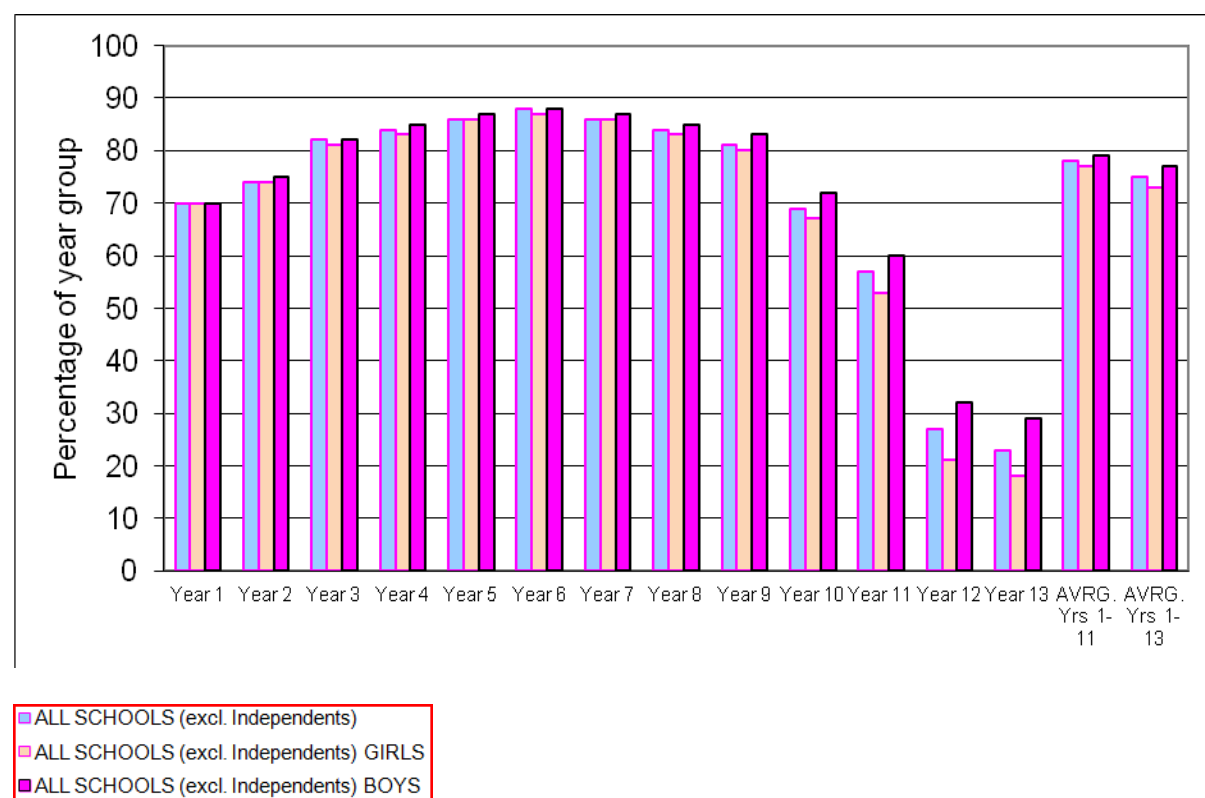
<sup>61</sup> Physical Education. Programme of study for key stage 3 and attainment target. Qualifications and Curriculum Authority 2007. Available at:

<http://www.asc-ih.ch/docs/BSG/Secondary/Secondary%20Physical%20Education.pdf> Accessed July 2012

<sup>62</sup> Olympic-style Sports Competition for young people launched as part of 2012 Legacy. Sport England.

Available at: [http://www.sportengland.org/media\\_centre/press\\_releases/school\\_olympics.aspx?show=true](http://www.sportengland.org/media_centre/press_releases/school_olympics.aspx?show=true) Accessed July 2012

**Figure 20: Graph showing percentage participation in intra-school competitive activities by year group in Barnet**

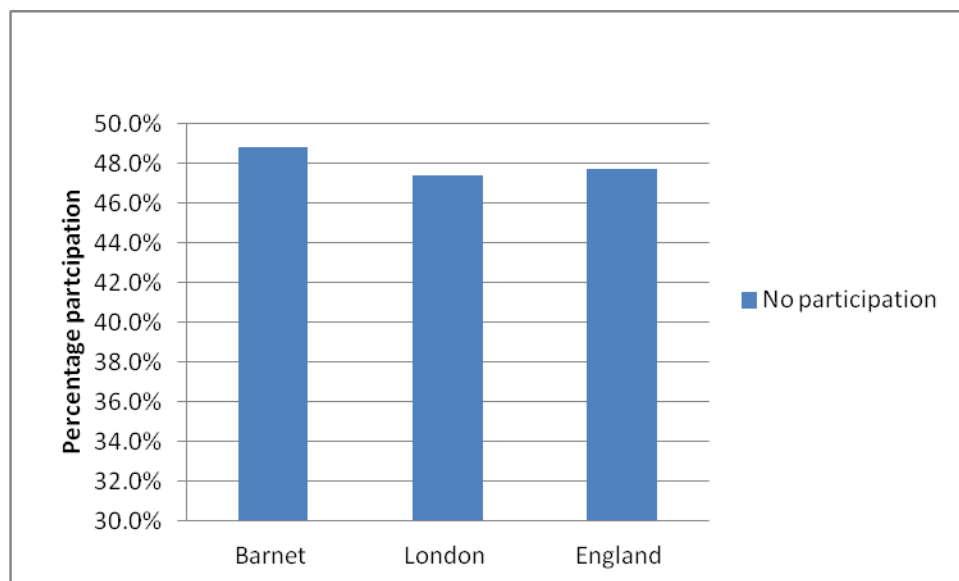


### 3.6 No participation

Despite the benefits of physical activity a large proportion of the population at both the local and national level do not participate in any moderate intensity 30 minute sessions of physical activity at all according to Sport England. 48.8% of Barnet residents had not participated in any 30 minute sessions of moderate intensity during the preceeding 4 weeks.<sup>63</sup> This percentage is slightly higher than for both London and England. However, this does not mean that 48.8% of the Barnet population do no physical activity at all. Of course many of these individuals who have not participated in any 30 minute sessions will have done some physical activity which did not count towards the indicator either because it was light intensity or the session was less than 30 minutes. Despite this, it is still concerning that almost half the Barnet population do not participate in any moderate intensity sport or active recreation lasting longer than 30 minutes.

<sup>63</sup> Active People Survey 5 results. Available at: [http://www.sportengland.org/research/active\\_people\\_survey.aspx](http://www.sportengland.org/research/active_people_survey.aspx) Accessed July 2012

**Figure 21: Graph showing percentage population who had not participated in any 30 minute moderate intensity physical activity sessions in the last 4 weeks<sup>21</sup>**



Source: APS 5 (2010/11). Sport England

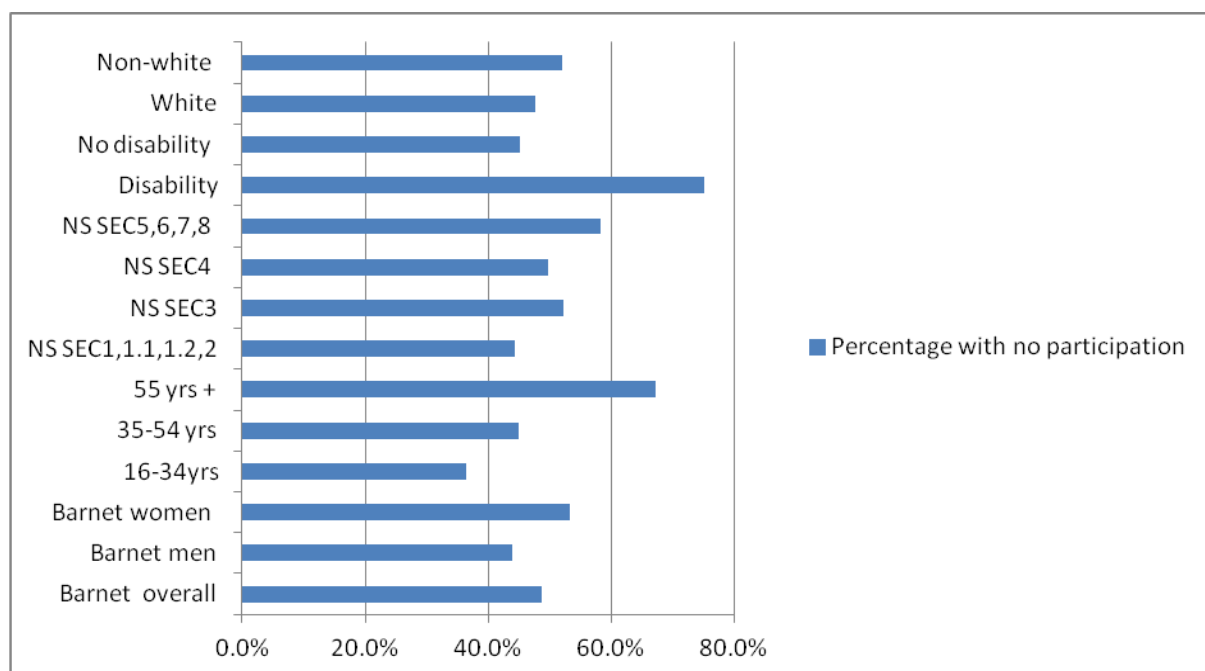
The groups with the highest proportion of individuals who do not participate in any moderate intensity physical activity are those with a life-limiting illness or disability, those older than 55 years, those in social groups 5,6,7 and 8, women and the non-white ethnic groups. The percentage who do not participate in any regular physical activity is shown by the table below. The greatest public health benefit can be achieved by getting these inactive groups at least minimally active i.e one 30 minute session of moderate intensity physical activity per week.

**Figure 22: Percentage population who do not participate in any 30 minute moderate intensity sessions**

Population group	Percentage with no participation
Barnet overall	48.8%
Barnet men	43.9%
Barnet women	53.3%
16-34yrs	36.4%
35-54 yrs	45.0%
55 yrs +	67.3%
NS SEC1,1.1,1.2,2	44.4%
NS SEC3	52.3%
NS SEC4	49.7%
NS SEC5,6,7,8	58.3%
Disability	75.1%
No disability	45.1%
White	47.7%
Non-white	52.1%

Source: Active People Diagnostic. Sport England

**Figure 23: Graph showing percentage of different population groups who do not participate in any 30 minute moderate intensity sessions**

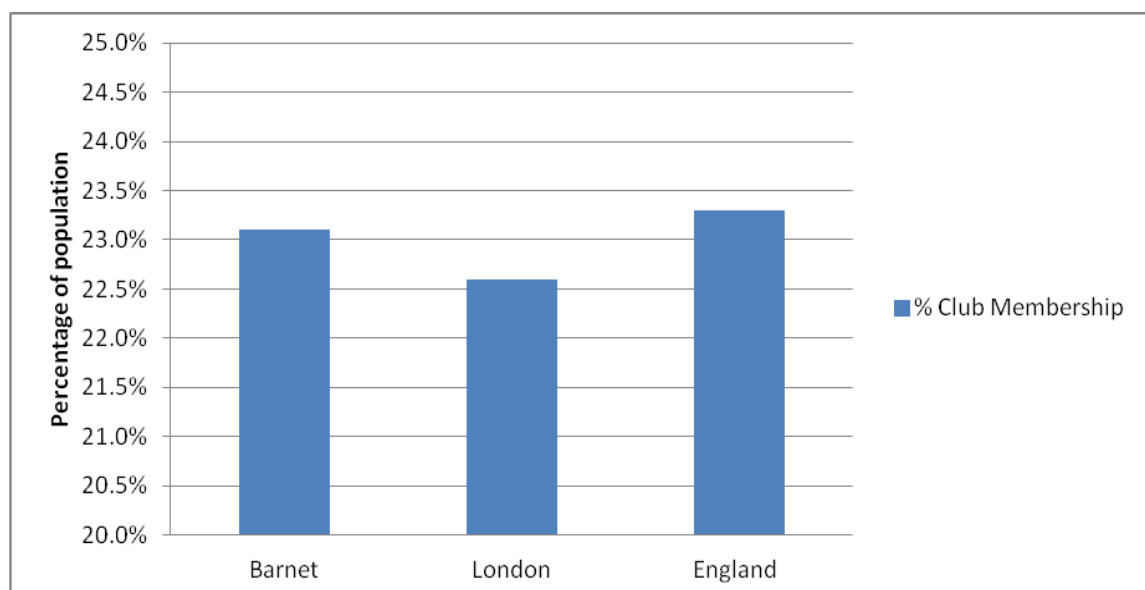


Source: Active People Diagnostic. Sport England

### 3.7 Club membership

23.1% of the Barnet population are a member of a sports club according to Active People Survey 5. This percentage is very similar to that of London (22.6%) and England (23.3%). The Active People Survey asked people whether they were a member of a club that did any sport or active recreation. By definition, this includes health and fitness clubs (e.g. LA fitness). Of the people who are members of a club the majority are members of a health and fitness club and relatively few people were members of a traditional sport club according to analysis undertaken by ProActive North London. Thus the fact that Barnet has higher club membership than for London overall may actually reflect a higher prevalence of gym membership which would fit with the borough's relative affluence.

**Figure 24: Graph showing percentage of population who are members of a sports club**



Source: Active People Survey 5 Results. Sport England

The chart below shows percentage participation in different types of clubs offering sport and active recreation. Membership in sports clubs is by far the highest in the youngest age group levels off to just 7-9% above the age of 20 years. Membership in health and fitness clubs is relatively low in younger age groups but increases to a peak in the 25-34 year old age group then steadily declines with age. It would appear that people who continue in sport transition from traditional sports clubs into health and fitness clubs. One of the reasons for this may be that there is a sharp reduction in participation in traditional team sports from around 16-25 and a slight increase in individual sports (e.g. swimming, gym).

**Figure 25: Chart showing participation in sports clubs by age in London based on APS 2 results**

Type of Club	16-19	20-24	25-29	30-34	35-44	45-64
Health and Fitness	11%	16%	22%	22%	17.50%	13%
Social Club	3%	2%	2%	2%	2%	2%
Sports Clubs	17%	9%	9%	7%	7%	7%
Other Clubs	2%	1%	1%	1%	1%	1%

Source: ProActive North London

This might be explained by the life transitions (e.g. from studying to working) which result in less time being available to commit to physical activity and a greater need for flexibility which is more easily afforded by individual sports. It is also probable that there are fewer sports clubs providing for older adults and that clubs are not providing flexible hours or individual sports. Governing bodies of sport are now developing their sports outside of the traditional club structure to try to address some of these issues. A good example of this is the role of Power League in increasing accessing to football for individuals. Power League makes it easy for anyone to get a group of friends together to play football at a time convenient to them by providing a website for booking pitches and entering teams into tournaments. Traditional sports clubs have an important role in sports provision for

younger people but their role in increasing participation is limited for older age groups. A useful role for sports clubs which could be developed might be around helping people in the younger age bands who are members of a sports clubs to successfully transition into other sports and activities.

Community sports clubs have important financial benefits on sport provision in communities. They are often run by volunteers and are therefore able to offer low-cost or free activities to individuals. They also pay to use facilities regularly and thus support the running costs of these facilities such that they remain open.<sup>64</sup> Sports clubs appeal to external funders and thus can attract funding to improve facilities or equipment or develop increased activity that might not only be accessed by the club but may also benefit the community as a whole. Volunteers who run sports clubs contribute large amounts of their time not only to turn up to training sessions and competitions but also undertake much wider tasks to ensure the club is safe and provides high quality activities e.g. admin, club committee meetings etc. Without this cohort of sport volunteers the majority of community clubs would cease to exist.

Community sports clubs make a significant contribution to providing access to sport and can meet unmet demands. They are generally thought to encourage volunteerism and community cohesion. Community sports clubs often attract families to join together which encourages the whole family to become more active and makes physical activity more convenient. Clubs are often successful in engaging young people that don't engage in other activities or provision. However, clubs are not always inclusive of all members of society as they often arise from a group of individuals with similar interests and values.<sup>65</sup> Clubs also tend to provide team sports often in a competitive context which might not interest particular groups i.e. some women and older people. Despite this, community sport clubs are a significant provider of sport and physical activity and, alongside other wider provision, allow greater access to regular activity.

### 3.8 Volunteering

Voluntary organisations and volunteerism can contribute to improved social cohesion and promote active citizenship. By supporting voluntary organisations we might improve social capital and thus enabling sport as vehicle to effect social change. Volunteering in sport also provides young people with an opportunity to develop new skills and qualifications thus contributing to career opportunities and reducing unemployment. Volunteerism and community cohesions are aspects of sport and active recreation that have clear benefits beyond the health sector to society as a whole.

Volunteerism in sport may also support access to sport for those with disability. Disabled individuals often have complex needs and requirements to enable them to participate and often rely upon volunteers to help them take part in sport. Thus the low levels of volunteering in sport in Barnet may be contributing to low levels of participation by the disabled. Volunteers are also essential to ensure to continuity of many community sports clubs. It is quite surprising that Barnet has relatively high percentage of the population that are club members compared to London and England but a relatively low percentage who volunteer in sport. This may be because in Barnet, more people are members of health and fitness clubs which are run professionally than traditional sports clubs which are run by volunteers. It is not clear whether there are sufficient volunteers to sustain existing clubs and why this disparity exists. It is clear, however, that the majority of community sports clubs rely heavily on the investment of time from volunteers.

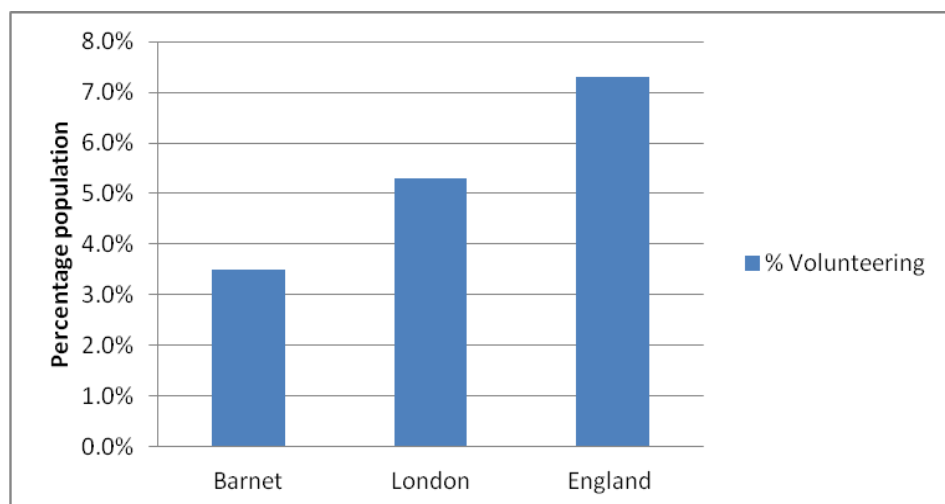
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<sup>64</sup> Based on consultation with Tom Burton

<sup>65</sup> Academic review of Clubs. Sport England. June 2005. Available at:  
<http://www.sportengland.org/search.aspx?query=Academic+review+of+clubs> Accessed July 2012

Very few people living in Barnet volunteer in sport. Only 3.5% of the Barnet population spends an hour or more per week volunteering in sport according to results from APS 5 compared to 7.3% at the national level. Participation is lower in London than it is nationally. This might be attributable to the busy lifestyle of living in London and the diverse range of leisure opportunities available in other sectors. This means people may have less time to volunteer in sport and also makes it more difficult for voluntary organisations to attract participants.<sup>66</sup> It is not clear why volunteering in sport is less common in Barnet than it is for London as a whole.

**Figure 26: Graph showing percentage of population who volunteer in sport > 1 hour per week<sup>22</sup>**



Source: Active People Survey 5 Results. Sport England

### 3.9 Satisfaction

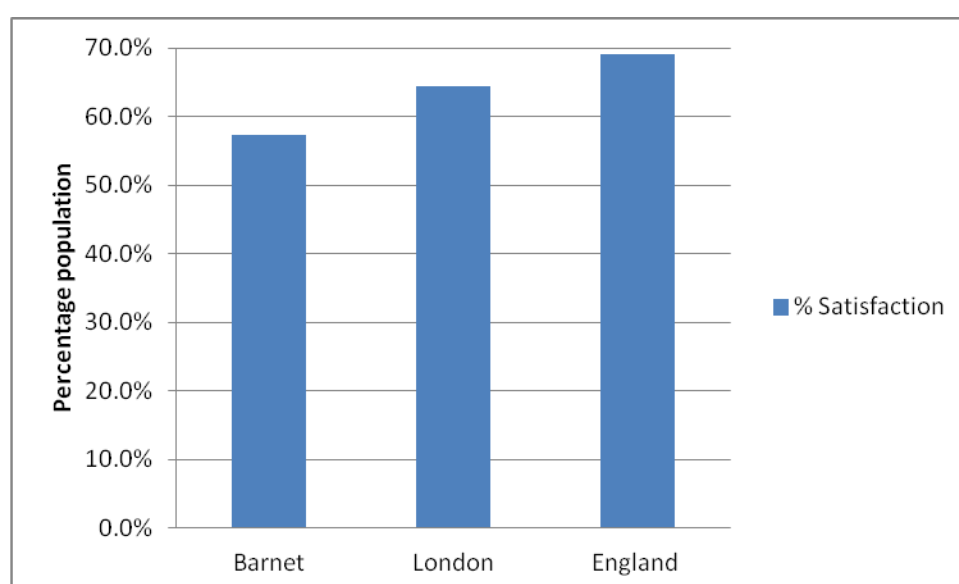
Sport England also measure satisfaction with sports provision at the local authority level as part of the Active People Survey data collection. They report the percentage of people who are satisfied with provision meaning those that responded that they were either 'fairly satisfied' or 'very satisfied'. This is useful feedback for those organising provision at the local level including local authorities.

Satisfaction with sport provision in the borough is significantly lower than at the national level. Only 57.4% of adults living in Barnet are satisfied with sports provision compared to 69% at the national level (APS 4). This suggests that facilities and activities for sport in the borough are not meeting the requirements of Barnet residents.

<sup>66</sup> Sports Volunteering in England 2002. A report for Sport England. Leisure Industries Research Centre, Sheffield. July 2003. Available at: <http://www.sportengland.org/search.aspx?query=Sports+Volunteering+in+England+2002> Accessed July 2012



**Figure 27: Percentage of population who are satisfied with sports provision**



Source: Local Sport profile Tool. Sport England

### *3.10 Summary of key findings*

People in Barnet are less active when compared to those in England and London with only 19% of residents taking part in 3x30min sessions of moderate activity per week. This is also the case when Barnet is compared to local boroughs in North Central London, only Enfield has lower levels of activity.

In addition to low levels of activity there is a downward trend in contrast to national trends which are rising, though London trends are similarly downward. This chapter has commented on the different sub groups in the population – age, disability, gender, ethnicity, socio-economic groups and geographical differences and highlighted that there are lower levels in groups who tend to experience greater difficulties with accessing other services and opportunities and there are a number of reasons for this. There are less women than men accessing leisure in Barnet, less non-white groups and less people who live in the more deprived areas, particular along the west side of the borough, but also in the Underhill area. Those groups who are less active in Barnet are also more likely to be suffering from or susceptible to lifestyle disease. Intermediate levels of activity are to be found along the eastern fringes of the borough – Finchley/Woodhouse and Brunswick Park and the highest levels in the central areas, with the exception of Underhill.

Of those groups who are the most sedentary – which is 48.8% of the population - the pattern is repeated with those with life limiting illness or disability, older than 55 years, in lower socio economic groups, women and non white groups being the most likely to sedentary.

The greatest public health benefit is to get these groups at least minimally active. Data for children and young people levels of activity is poor due to the lack of a requirement to record this information. The data that does exist suggests that Barnet children and young people are less active than the national average but we have to bear in mind the caveats with the data. We do have strong data from the National Child Obesity Measurement Programme however which shows that although levels in Barnet for child obesity are lower than the national average there is still a significant proportion of children who are obese, and the relationships between obesity and low levels of activity have been identified.

Importantly the data suggests young people in Barnet become less active through their school career, thus reducing their propensity to maintain an active lifestyle in to adult hood.

In terms of volunteering and club membership in Barnet, club membership is high but this reflects the affluent nature of the borough since this would include membership of health and fitness clubs. The level of volunteering is lower than the national average at 3.5% compared to 7.3% of people who spend an hour or more a week volunteering in sport. The nature of volunteering in sport is such that many grassroots clubs that support young people in being involved are the key to sustaining an interest in being active.

Overall Barnet participation is high in affluent populations but struggling in those groups where a lifestyle change or lifelong habit would be most beneficial to the long term health of the population. In addition the infrastructure of community based organisations is potentially threatened by low levels of volunteers, this suggests that Barnet has an over reliance on private health and fitness clubs.

# Chapter 4: Market segmentation

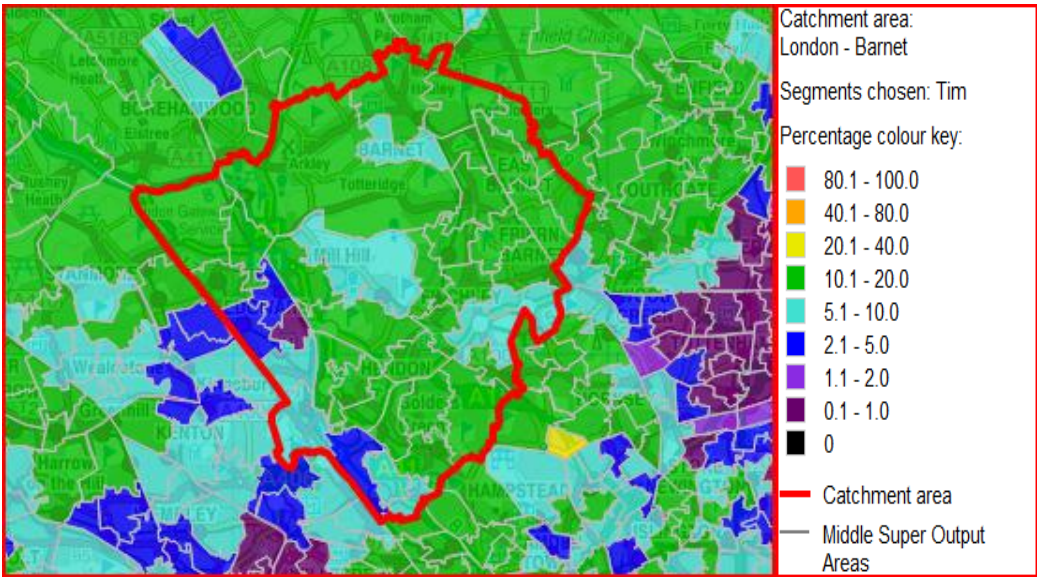
## *Introduction*

In order to increase participation in physical activity it is important to understand the groups of people we have in Barnet and how we can encourage them to be more active. Sport England has developed a web-based tool which splits the adult population of any local authority into 19 segments based on their age, gender and socio-demographic information. They have provided information on sporting activity and preferences for each segment which offers a useful insight into the types of people providers need to target with interventions. In addition, details on motivating factors and barriers for each group also indicates how these groups can be most effectively targeted. They have given each segment a name which is the commonest name among that segment. For full details of market segments see Appendix 1 Chapter 4.

For example, Tims represents the largest segment in Barnet at 12.1% (31,103 individuals). Sport England defines Tim as a 26-45 year old sporty male professional settling down with a partner. Sport England also describes his participation levels, motivators and barriers. Tim is more active than the general adult population with 27% of this segment doing three 30 minute sessions of moderate intensity exercise per week compared to 15% of all adults. Tim is keen to do more physical activity with 66% of the segment saying they would like to do more sport compared to 52% of all adults.

The main motivations for him doing sport are enjoyment, keeping fit, socialising and taking the children. Lack of time due to work seems to be the biggest barrier for Tim. 36% of Tims gave the main barrier to sport as work commitments which was much higher than for the general adult population (19%). Similarly, 58% of Tims said they would do more sport if they had more time compared to 46% of adults as a whole. Money seems to be less of a barrier for Tim than for other segments. Only 11% of Tims said that cheaper activities would encourage them to do more sport compared to 18% of all adults. This suggests interventions to increase the convenience of facilities rather than lowering cost might be more beneficial for this segment. Tims are represented throughout the borough but are less common along the western edge of the borough.

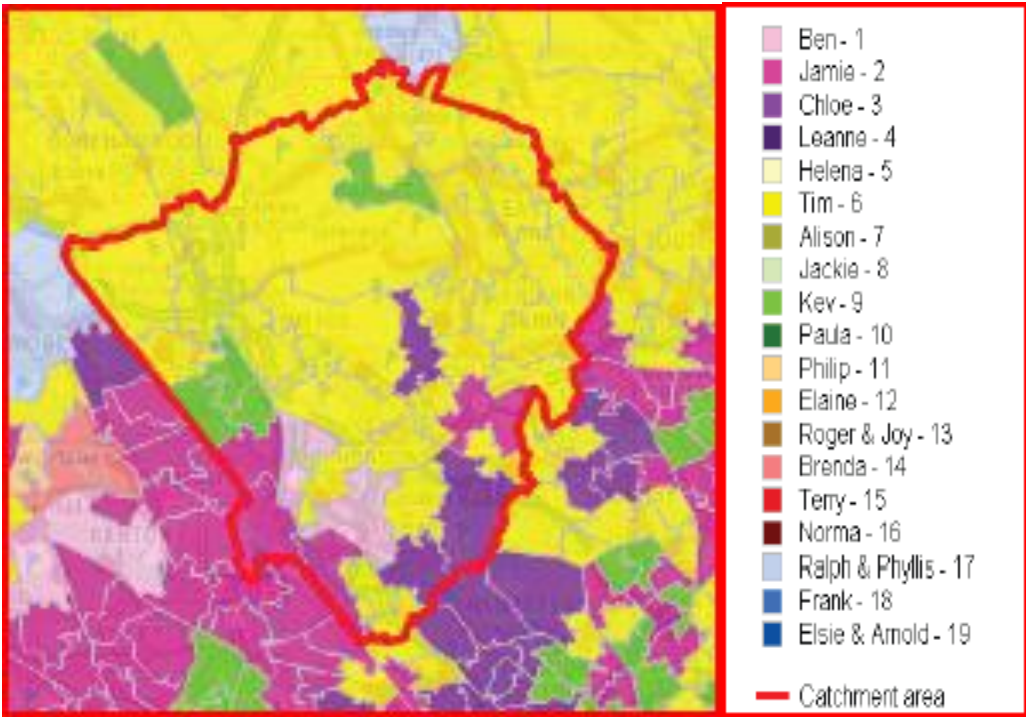
**Figure 1: The largest segment in Barnet**



#### 4.1 Geographical distribution of segments

The map below demonstrates the most prevalent market segment in each ward within the borough. Here we can see that Tim is the most prominent segment in the majority of the wards, but there are also clusters of Kev, Jamie, Chloe and Ben. The Bens, Jamies and Chloes are concentrated in the southern areas of the borough. All these segments are aged 18-25 years of age. Tims and Kevs are more prevalent in the North of the borough and are in older age groups (26-46 years and 36-45 years respectively).

**Figure 2: Map showing most prevalent segment within each ward**



See appendix 2 Chapter 4 for maps showing distribution of other segments across the borough.

## 4.2 Prevalent segments

The commonest segment in Barnet is Tim and has already been described. The second commonest segment is Ben who accounts for 10.4% of the population of Barnet. Bens are present throughout the borough but are most common in the south western and central areas of the borough and less common along the south eastern edges of Barnet borough. Ben is a recent graduate aged 18-25 years of age. This segment is the most physically active of all adult groups with 39% of this segment doing three 30 minute sessions per week. Bens are more likely to be a member of a club to play sport (38% compared to 23% of all adults) Ben is motivated to do more sport with 62% of this segment saying they want to do more, compared to 52% of the general adult population.

The main motivations for Ben playing sport are enjoyment, keeping fit, socialising and improving performance. Similarly to Tim, the main barrier for Ben is time. 35% of this segment cites work commitments as their main barrier. Additionally, 44% of this segment says they would do more sport if they were less busy. As for Tim, interventions that made physical activity more convenient might increase participation for Ben. However, interventions which reduced cost might also help increase participation. 21% of this segment says they would do more sport if activities were cheaper compared to 18% of the general adult population. 18% of Interventions should also consider that socialising was a significant motivator for Ben and that team sports are popular in this group. 18% of Bens would do more sport if they had people to play sport with compared to 14% of all adults.

Chloes account for 10.3% of the population which is only slightly less than Ben. Chloes are represented throughout the borough but are less common along the south western edge of the borough. Chloe is an image-conscious professional aged 18-25 years of age. She takes part in sport on a regular basis with 23% undertaking three 30 minute sessions per week compared to 15% of adults. Chloe is the most active female segment in her age group but she is less active than the male segments in the same age band. She is much more likely to receive instruction in a sport (29% compared to 17% of all adults) and this may reflect attendance at exercise classes. Chloe is very motivated to do more physical activity with 70% saying they would like to do more sport compared to 52% of all adults.

Chloes main motivators for sport are enjoyment, keeping fit, socialising and losing weight. Family is a barrier for 20% of Chloes compared to 7% of all adults. 49% of Chloes say they would do more sport if they were less busy, compared to 46% of adults overall. This suggests making childcare and crèche facilities more available and increasing the convenience of activities might help increase participation in this segment. 24% of Chloes say they would do more sport if activities were cheaper compared to 13% of adults. This suggests that interventions aimed at reducing the cost of physical activity might increase participation.

There are a similar number of Philips (6.5%) and Helenas (6.4%). Philips are 46-55 year old men with older children and have more time for themselves. Philips are present relatively uniformly throughout the borough, representing between 5-10% of the population. They are less common along the south western edge of the borough and the Finchley area. Philips sporting activity levels are above the national average. 51% of this segment undertakes sport at least once per week compared to 40% of all adults. Philip is motivated to do more physical activity with 68% of the segment saying they want to do more sport. Philips main motivators to do more sport are enjoyment, keeping fit and

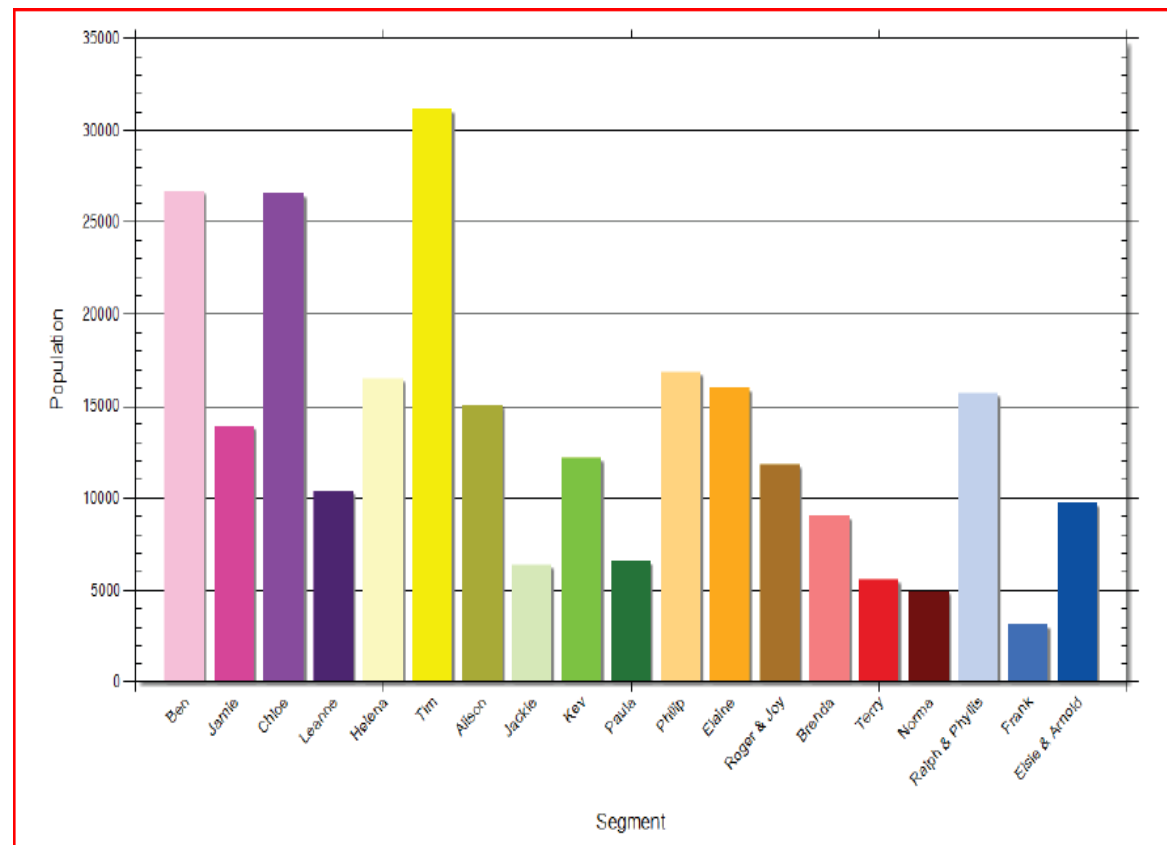
socialising. 31% of this segment cites work commitments as the main barrier to doing sport compared to 19% of all adults. 59% of this segment says they would participate more if they had more time compared to 46% of all adults which suggests busy lifestyle is the barrier for this segment.

Henas are present at about 5-10% of the population throughout the borough. They are less common along the south western edge of the borough and around the Totteridge area. 26-45 year old professional women who are career focused but part in sport on a regular basis. 19% of this segment does three 30- minute sessions of moderate intensity sport per week, compared to 15% of all adults. 26% of Henas receive sports instruction compared to 17% of all adults and they are also more likely to hold club membership. This may represent attendance at fitness classes and health club memberships. Keeping fit is a big motivator for Helena (51% compared to 30% for all adults). Her other main motivators are enjoyment and losing weight. 27% of Henas gave the main barrier to physical activity as work commitments compared to 19% of all adults. 55% of Henas said they would do more exercise if they had more time compared to 46% of the general adult population. Longer opening hours would encourage 11% of this segment to undertake more physical activity compared to 6% of the overall adult population.

**Figure 3: Prevalence of different segments within Barnet**

<b>Segment</b>	<b>Catchment %</b>
Tim	12.1
Ben	10.4
Chloe	10.3
Philip	6.5
Helena	6.4
Elaine	6.2
Ralph & Phyllis	6.1
Alison	5.8
Jamie	5.4
Kev	4.7
Roger & Joy	4.6
Leanne	4
Elsie & Arnold	3.8
Brenda	3.5
Paula	2.5
Jackie	2.5
Terry	2.2
Norma	1.9
Frank	1.2

**Figure 4: Population numbers for all segments within Barnet Borough**



The five commonest segments in Barnet:

1. Tim
2. Ben
3. Chloe
4. Helena
5. Philip

When we look at the overall population of Barnet, the five most prevalent market segments are Tims, Bens, Chloes, Helenas and Phillips. All of these groups are relatively active compared to the general population. Ben is the second commonest group and represents the sportiest of all the groups. These groups need less input to achieve regular participation in physical activity. However, in addition to these prevalent and relatively active groups there are less-active segments present in smaller numbers.

### 4.3 Less active segments

Sport England has provided physical activity levels for each segment using data from 2010. It is useful to compare physical activity level of different segments to the average of all segments (i.e. the national average) in order to identify priority groups to target with interventions. We have used both NI8 indicator which includes active recreation such as walking and cycling and 1 x 30 indicator which does not include these activities. Both indicators highlight almost exactly the same segments as less active than the overall



population. These can be divided into older people above 66 years (Elsie and Arnold, Ralph and Phyllis, Terry, Frank and Norma), People in middle age (Roger and Joy, Brenda) and Paula which is the only segment under 45 years of age who has lower participation than the national average. The 1 x 30 indicator also highlighted Brenda as having lower participation than the national average.

**Figure 5: Participation by segment in NI8 (three 30 minute sessions of sport or physical activity per week)**

Segments	Participation NI8
All segments	21.4%
Elsie and Arnold	6.9%
Frank	11.3%
Norma	11.3%
Ralph/Phyllis	13.2%
Terry	13.6%
Brenda	14.6%
Roger/Joy	18.9%
Paula	19.0%
Kev	22.3%
Leanne	22.3%
Elaine	23.0%
Jackie	25.0%
Philip	27.2%
Alsion	29.5%
Helena	30.1%
Chloe	31.6%
Jamie	34.0%
Tim	34.1%
Ben	42.9%

**Figure 6: Participation by segment in 1 x 30 (one 30 minute session of sport per week)**

Segment	Participation 1x30
All segments	40.40%
Elsie and Arnold	16.60%
Frank	21.40%
Norma	22.80%
Terry	25.90%
Ralph/Phyllis	27.90%
Brenda	29.40%
Paula	36.40%
Roger/Joy	37.80%
Leanne	42.30%



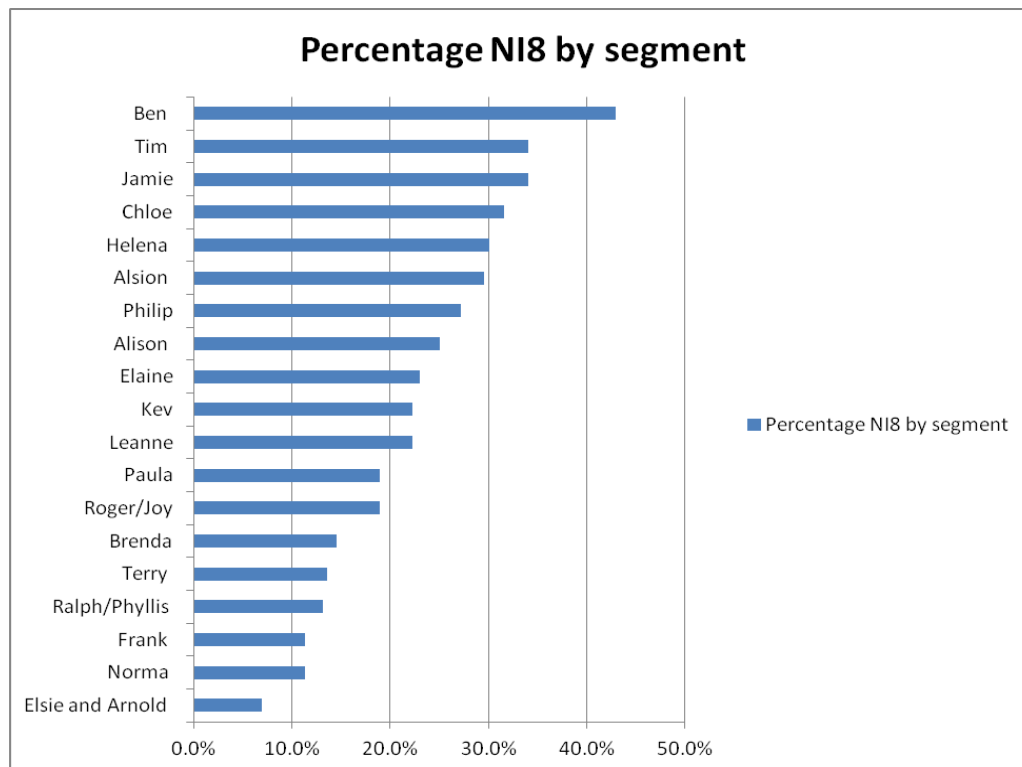
Kev	42.50%
Elaine	43.40%
Jackie	46.90%
Philip	51.20%
Helena	53.20%
Alsion	54.80%
Chloe	55.80%
Jamie	58.60%
Tim	62.10%
Ben	68.70%

There is wide variation on levels of physical activity by segment. Only 6.9% of Elsie and Arnolds participate in sport and active recreation for 30 minutes three times per week compared to 42.9% of Bens. The segments highlighted in pale pink represent those with the lowest levels of physical activity (less than 25% NI8). Those highlighted in deeper pink have low levels of physical activity and a prevalence of at least 2.5% in Barnet. Together these less active segments with a prevalence of at least 2.5% account for 38% of the population of Barnet.

**Figure 7: Participation in NI8 by segment and percentage population of Barnet**

Segments	Percentage NI8	Percentage population
Elsie/Arnold	6.9%	3.8%
Norma	11.3%	1.9%
Frank	11.3%	1.2%
Ralph/Phyllis	13.2%	6.1%
Terry	13.6%	2.2%
Brenda	14.6%	3.5%
Roger/Joy	18.9%	4.6%
Paula	19.0%	2.5%
Leanne	22.3%	4.0%
Kev	22.3%	4.7%
Elaine	23.0%	6.2%
Jackie	25.0%	2.5%
Philip	27.2%	6.5%
Alison	29.5%	5.8%
Helena	30.1%	6.4%
Chloe	31.6%	10.3%
Jamie	34.0%	5.4%
Tim	34.1%	12.1%
Ben	42.9%	10.4%

**Figure 8:**



## Percentage NI8 by segment

It is also useful to compare the physical activity levels of a segment to that of the average for their age group. This participation data relative to age group is presented in the table below. Those segments that are less active than their peers (relative participation <100%) are highlighted in pale pink. Those segments less active than their peers and with a prevalence of at least 2.5% in Barnet are highlighted deeper pink.

Leanne is the segment with the lowest participation relative to her age group average with a prevalence of 2.5% or higher. This is much lower than her overall participation where she had the sixth lowest participation level of segments with more than 2.5% prevalence. Similarly, Paula has the second lowest participation relative to her age group whereas she had the fifth lowest overall participation. For younger female segments their participation relative to their age group is much lower compared to their overall participation. Even Chloe is less active than her peers despite being the fourth most active of all segments. This demonstrates that there are gender inequalities even among the segments with high levels of participation. However, Chloe is only marginally less active than others of her age group.

Conversely, there are two segments with low overall participation but relatively high participation compared to their age group. Ralph and Phyllis had the second lowest overall participation of the segments with at least 2.5% prevalence in Barnet. However, they are more active than others in their age group. Similarly, Elaine had the eighth lowest participation overall but she is more active than others in her age group. These groups still need to increase their overall participation levels but they need less intervention than other segments in their age group to achieve this.

**Figure 9: Participation NI8 relative to average participation age group**

Segments	Relative participation	Prevalence
Norma	58	1.9%
Leanne	64	4%
Paula	64	2.5%
Terry	68	2.2%
Elsie and Arnold	69	3.8%
Brenda	73	3.5%
Kev	79	4.7%
Jackie	88	2.5%
Chloe	94	10.3%
Roger/Joy	96	4.6%
Jamie	100	5.4%
Alison	105	5.8%
Helena	106	6.4%
Elaine	115	6.2%
Frank	118	1.2%
Tim	121	12.1%
Ralph/Phyllis	128	6.1%
Ben	129	10.4%
Philip	137	6.5%

### 4.3.1 Prevalent less active segments in Barnet

Although less active segments have a low prevalence in Barnet, together they account for a significant section of the population. Segments which have less than 25% participation in NI8 and a prevalence of at least 2.5% account for 38% of the population of Barnet. These segments can be divided into older people (above 66 years), individuals of middle age (46 -65 years) and young women/mothers (bellow 45 years and female).

### 4.3.2 Prevalent less active segments in Barnet include

1. Elaine (6.2% of Barnet population)
2. Ralph and Phyllis (6%)
3. Kev (4.7%)
4. Roger and Joy (4.6%)
5. Leanne (4%)
6. Elsie and Arnold (3.8%)
7. Brenda (3.5%)
8. Paula (2.5%)
9. Jackie (2.5%)

### 4.3.3 Older people

Older people participate less in physical activity as they get older. It is important to understand the barriers and motivators for this group in order to increase their levels of physical activity. Older segments with low levels of physical activity that are relatively prevalent in Barnet include Ralph and Phyllis and Elsie and Arnold.

Ralph and Phyllis are the second commonest of the prevalent less active segments in Barnet and account for 6.1% of the population of Barnet. This segment is found mostly in the central areas of the borough and less towards the south eastern and south western edges of Barnet borough with the exception of the Golders green area where they are relatively prevalent. Ralph and Phyllis are above 66 years of age and are a comfortable retired couple. They are less active than the average adult. 71% of this segment has done no sport in the past four weeks, compared with the average of 60% of all adults. However, they are more active than other segments in their age group. 28% have participated in sport at least once a week compared to an average of 12% of the other segments in their age group. They are less motivated than the overall adult population to increase their physical activity. 27% of this segment would like to do more sport, compared to 52% of all adults.

The main motivations to take part in sport for Ralph & Phyllis are enjoyment, keeping fit and socialising. Poor health is by far the most important barrier for this age group. 76% of this segment cite their main barrier as 'health, injury or disability' which reflects the age group of this segment and the increased frequency of medical problems. 40% of this segment has a long standing illness or disability. There are no clear interventions that would help this group participate more. When asked for factors that would increase their participation the factors were diverse and none were cited significantly more than for the general adult population. Lack of time was less important for this segment. 29% of this segment say they would do more sport if they were less busy, compared to 46% of all adults.

Elsie and Arnold are the sixth commonest of the prevalent less active segments and account for 3.8% of the population of Barnet. They have a patchy distribution across the borough but are generally more common in central regions of Barnet borough. Elsie and Arnold are retired singles or widowers living in sheltered accommodation and are aged 66 years and above. They are much less active than the average adult. 82% of this segment have done no sport in the past month, compared 60% of all adults. 25% of this segment want to do more sport, which is much lower compared to all adults overall (52%)

The main motivations for Elsie and Arnold are enjoyment, keeping fit and socialising. Health is again the biggest barrier to participation for Elsie and Arnold. 83% of this segment cited 'health, injury or disability' as their main barrier. This segment has a high propensity to health problems. 50% of this segment has a long standing illness, disability or infirmity. However, there may be other factors apart from health impacting on levels of participation for Elsie and Arnold. When asked about barriers to participation in physical activity, 10% of this segment cited 'other' which includes 'no opportunity' and economic factors as a barrier. Similarly when asked what would encourage them to do more exercise 20% of this segment said they would do more sport if they had someone to go with and 9% would be encouraged by improved transport. 11% said they would be encouraged to participate by cheaper admission. This suggests that interventions aimed at increasing access to activities and supporting social activities such as sports clubs (e.g. bowls club) might increase participation in this segment.

### 4.3.4 Middle aged individuals

Roger and Joy are the fourth commonest of the less active groups in Barnet and account for 4.6% of the population of Barnet. They are found most commonly in the northern area of the borough but can be found throughout Barnet borough. They are aged 56 to 65 years and are a couple nearing the end of their careers or early retirees. They are slightly less active than the general population. 38% have participated in sport at least once a week compared to 40% of all adults. 44% of Roger & Joys say they would like to do more sport, compared to 52% of all adults. However they are more motivated to do more physical activity compared to other segments in their age group.

The main motivators for Roger and Joy are enjoyment and keeping fit. Health is again the most important barrier in this segment. 50% gave their main barrier as 'health, injury or disability'. Similarly to Ralph and Phyllis, there was no clear factor that would increase their participation and lack of time was again less important for this segment reflecting the more relaxed lifestyle of retired couples. We need to further investigate methods to increase participation in retired couples. Interventions to improve access to activities appropriate for those with long standing medical problems and disability might help improve participation in these segments. However, we need more information about the prevalent types of disability and the specific barriers related these conditions.

Brenda is the seventh commonest of the less active segments in Barnet and she accounts for 3.5% of the population of Barnet. This segment is present to variable degrees throughout the borough but is concentrated in the south western edge of the borough. Brenda is 46-55 years old and is still working. She is generally less active than the average adult. 73% of this segment has done no sport in the month, compared to 60% of the general adult population. Brenda's participation is also lower than her peers. 29% of this segment has participated in sport at least once a week, which is lower than other segments in the same age group (average of 38%) 51% of this segment say they would like to do more sport which is in line with the general adult population (52%).

The main motivations for Brenda playing sport are keeping fit and enjoyment, Meeting up with friends is also an important motivator. Health is again the most common barrier to exercise with 45% of this segment citing 'health, injury or disability' as their main barrier. 36% of this segment has a long standing illness or disability. 51% of this segment say they would do more sport if they were less busy, compared to 46% of the overall adult population reflecting the fact that Brenda is still working. Similarly 9% said they would participate more if they had more free time (9%) and if facilities had longer opening hours (9%). 23% said they would do more if there was cheaper admission compared to 18% of the general adult population. Thus interventions to increase the convenience of activities and reduce cost might help this segment to be more active.

Kev is the third commonest of the less active segments in Barnet and accounts for 4.7% of the population of Barnet. He is 36 to 45 years old with a vocational job. Kev is slightly more active than the overall population. 17% of people in this segment participate in three 30 minute sessions per week of sport compared to 15% of all adults. However levels of physical activity are still very low for this segment. 57% of Kevs have done no sport at all in the last 28 days. Kevs are motivated to do more sport with 62% saying they would like to participate more compared to 52% of all adults.

The main motivators for Kev being more active are enjoyment, keeping fit, socialising and taking the children. 32% of Kevs gave 'work commitments' as their main barrier to participation compared to 19% of all adults. Similarly, 15% of Kevs gave their main barrier as lack of time compared to 12% of all adults, confirming that a busy lifestyle is an important barrier for Kev. 26% of this segment cited 'other' as their main barrier which

includes economic factors and 'no opportunity' compared to 21% of all adults. 48% of this segment said they would do more sport if they were less busy compared to 46% of the overall adult population. This suggests interventions to increase the convenience of accessing activities or facilities might help Kev participate more in physical activity. 21% of Kevs would do more sport if activities were cheaper compared to 18% of the overall adult population. Therefore reduced fees might also improve participation for this segment.

Elaine accounts for 6.2% of the population of Barnet making her the commonest of the prevalent less active segments in Barnet. This segment is represented throughout the borough at between 5-10% of the population. Elaine is less commonly found on the south western edge of the borough and the Finchley area. Elaine is 46-55 years of age and works full time. Elaine is slightly more active than the general adult population and more active than other segments in her age group. However she still has relatively low levels of participation. 62% of this segment have done no sport in the last 28 days compared to 60% of the overall adult population. Elaine is reasonably motivated to do more sport. 55% of this segment would like to do more sport compared to 52% of all adults.

The main motivations for Elaine are enjoyment, keeping fit and weight loss. The commonest barrier for this segment was 'health, injury or disability' which 36% cited as their main barrier. This is below the national average of 41% so even though this is the commonest barrier for Elaine she is less affected than other adults. 25% of Elaines cited 'other' as their main barrier compared to 21% of the overall adult population. This includes 'economic factors' and 'no opportunity' 20% of this segment cited 'work commitments' as their main barrier compared to 19% of the overall population. Similarly 14% Elaines cited lack of time as their main barrier compared to 12% of all adults. This suggests that a busy lifestyle is a barrier to physical activity for Elaine but less important than other issues such as health issues.

### **4.3.5 Young Woman**

The young women include the Leanne and Paula segments. Leanne is the fifth commonest of the less active segments in Barnet and accounts for 4% of the population. This segment is found to variable degrees throughout the borough but is most common along the south western edge of the borough and in the Finchley area. Leanne is a young busy mum and although her participation levels match those of the general adult population she is the least active segment in her age group. Leanne is very motivated to do more sport with 72% of this segment saying they want to do more sport compared to 52% of all adults.

Leanne's main motivations are enjoyment, keeping fit, socialising and losing weight. The main barrier for this segment is 'work commitments' with 35% citing this as the main barrier compared to 19% of all adults. 25% of this segment said their main barrier was 'other' which includes economic factors and 'no opportunity'. 42% of this segment said they would do more exercise if they were less busy compared to 46% of the general population. 28% said they would do more if activities were cheaper which is significantly higher than for the general population (18%) 21% said they would do more exercise if they had people to go with compared to 14% of all adults. 8% of this segment said they would do more sport if there were better childcare facilities compared to 6% of the general adult population. This suggests interventions to increase access to activities both in terms of convenience and cost might help this segment increase participation. Crèche facilities might increase the convenience of physical activity relative to other activities which compete for Leanne's leisure time.

Paulas account for 2.5% of the Barnet population and are the 6<sup>th</sup> most common of the less active segments. Paula is a single mum with financial and childcare issues. Her

participation is lower than the general population. 63% of this segment have done no exercise in the last month. Paula is motivated increase her levels of physical activity with 69% of people in this segment saying they would like to do more sport. Her main motivators to take part in physical activity are enjoyment, keeping fit, taking the children and losing weight. Family commitments are an important barrier for this segment with 25% listing it as a barrier. 33% of this segment say they would do more sport if it was cheaper compared to 18% of the overall adult population and 20% would do more if they had help with childcare compared to 6% of adults. This indicates that reducing the costs of physical activity and providing good child care facilities might help this segment become more active. Providing cheaper family activities may also help.

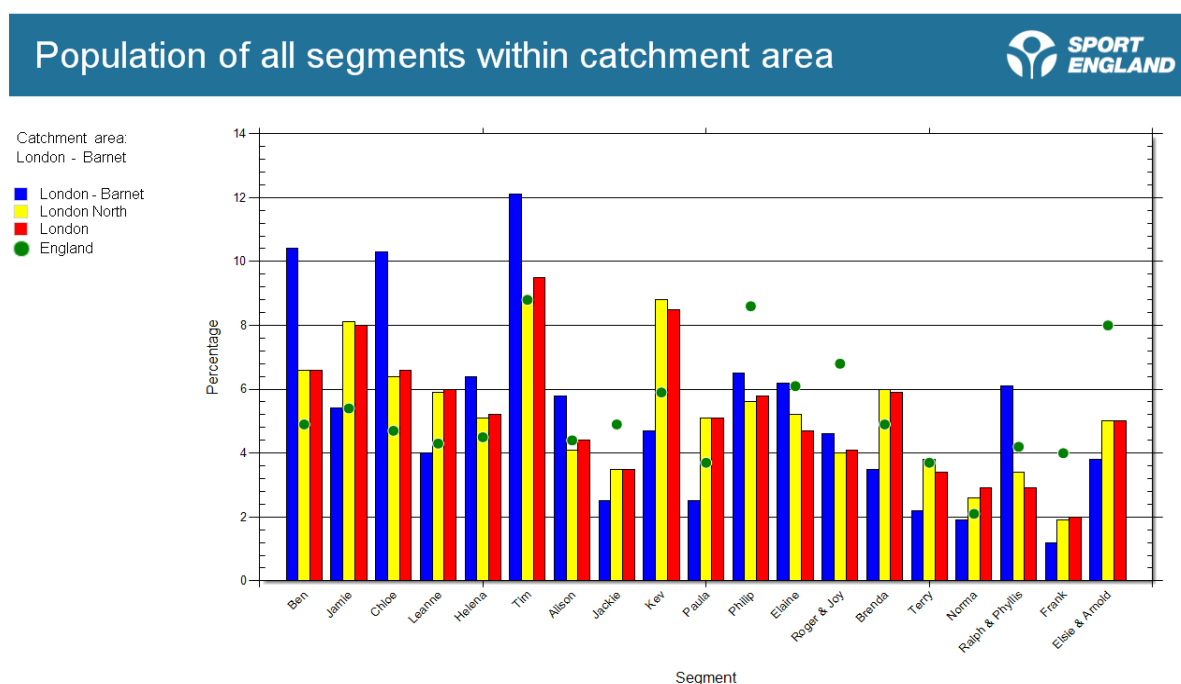
Jackie is the eighth commonest segment in Barnet and accounts for 2.5% of the population of Barnet. This segment is represented to variable degrees throughout the borough but is slightly commoner in the south western edge of Barnet borough. She is 36-45 years of age, works part time or stays at home to care for her children. Her participation in sport is above the national average but she is less active than others in her age group. 56% of this segment participate had not participated in any 30 minute moderate intensity sessions of sport in preceding 8 days. Jackie is motivated to increase her activity. 67% of this segment would like to do more sport compared to 52% of all adults.

Jackie's main motivators to participate in sport are keeping fit, enjoyment, taking the children and losing weight. Jackies main barrier was 'other' which includes 'lack of opportunity and economic factors. 25% if this segment cited 'other' as their main barrier compared to 21% of the general adult population. Work commitments was the second most commonly cited barrier at 21% compared to 19% of all adults. Health injury and disability was cited as a main barrier by 21% of Jackies compared to 41% of the overall adult population. This suggest that while health factors are a significant barrier for this segment it is less of a barrier than for other adults. Interestingly, family was a barrier for 18% of Jackies. While this barrier was less commonly cited than other barriers it was much more of an issue than for the general adult population. Only 7% of all adults cited family as their main barrier.

#### *4.4 Segment comparison with London*

The chart bellow shows that the prevalence of certain segments is significantly different from London as a whole. There are significantly more Bens, Chloes, Tims and Ralph and Phyllis in Barnet compared to the London figures. These represent high socio-economic groups. There are less segments in Barnet from lower socio-economic groups i.e. Paula, Jamie, Leanne, Brenda, Terry, Norma and Frank.

**Figure 10: Population of all segments within the catchment area**



## 4.5 Barriers and factors which would encourage participation

The five commonest segments also had common barriers. 'Work commitments' was the commonest barrier to physical activity for all five segments with the exception of Chloe for whom it was the second commonest barrier. Chloes main barrier was 'other' which were the second commonest barrier cited by Helena, Ben and Tim and the third commonest barrier for Philip. 'Other' includes barriers such as 'economic factors' and 'no opportunity' the second commonest barrier for Philip was 'health, injury and disability' and 30% of this segment cited this as their main barrier. This was a much commoner barrier than for the other four segments. Between eight % and 16% of the other segments cited 'health, injury and disability' as their main barrier. This probably reflects Philips older age group relative to the other four common segments.

Young mothers (Paula, Leanne and Jackie) all have similar barriers to physical activity. Family was a significant barrier for these segments. 25% of Paulas cited family as their main barrier to participation compared to 7% for the general adult population. For Leanne and Jackie the proportion citing family as their main barrier was 17% and 18% respectively. Work is also a significant barrier for these segments. For Leanne 'work commitments' were the commonest barrier with 35% of the segment citing this as their main barrier above family which was the fourth most commonly cited barrier. 'Work commitments' was the second commonest barrier for Jackie (21%) and the third commonest barrier for Paula (21%). It seems that for these segments balancing family life with work can leave little time for physical activity. Between 36-50% of these segments said they would do more sport if they were less busy and it was the most commonly chosen response to the question 'What would make you do more sport?' for all three segments. Between eight and 20% said help with childcare would encourage them to be more active. Childcare was the third most commonly selected encouraging factor for Paula and Jackie and the fourth commonest for Leanne. In order to target young mothers it is essential to increase the convenience of activities and consider provision of childcare. In addition to work and family young mothers also have to consider the affordability of



physical activity in the context of supporting a family. 'Other' which includes 'economic factors' was a commonly cited barrier for all three segments. It was the second commonest barrier for Leanne and Paula and the commonest barrier for Jackie.

Middle aged individuals (Brenda, Roger and Joy, Kev and Elaine) all have similar barriers and motivators for participation in physical activity. 'Health, injury and disability' was the most commonly cited main barrier for all segments in this age group with the exception of Kev for whom it was the third most commonly cited factor. We do not know the nature of the health conditions that impact on these segments ability to participate in physical activity. Further work will need to be undertaken to investigate health and disability as a barrier for these segments in order to increase participation in this age group.

Work was also a relatively common barrier for segments in the middle age group which reflects the fact that most individuals in these segments are working. 'Work commitments' was the commonest barrier for Kev and 32% of this segment cited this as their main barrier compared to 19% of the overall population. Work was the third commonest barrier for Brenda and Elaine and was cited as a main barrier at similar frequency to the overall adult population. For Roger and Joy 'work commitments' was less of a barrier this might be because this segment are from a higher socioeconomic group and are more likely to take early retirement. Between 44% and 56% of segments in this age group said they would be encouraged to do more sport if they were less busy compared to 46% for the overall adult population. This suggests that this age group have a busy lifestyle, mostly due to work commitments, which impacts on the time they can make available for physical activity. Interventions to increase the convenience of activities might help this age group participate more.

'Other' which includes economic factors was also a commonly cited barrier. 22-26% of all segments in this age group cited 'other' as their main barrier which is similar percentage for the overall population (21%) 23% of Brendas and 21% of Kevs said cheaper admission would encourage them to do more sport compared to 18% of the overall adult population. This suggests that interventions aimed at reducing the cost of activities might help these segments to become more active. Conversely, for Roger and Joy and Elaine cheaper admission was an encouraging factor for 14% and 15% respectively. Roger and Joy and Elaine are from higher socioeconomic groups so money may be less of a barrier for these segments.

Segments Elsie and Arnold and Ralph and Phyllis both include individuals age 66 years and above. They have similar barriers and motivators to participation in physical activity. Both segments cited 'health, injury and disability' as the overwhelmingly most common barrier to participation. 83% of the Elsie and Arnold segment and 70% of the Ralph and Phyllis segment said this was their main barrier. We do not know the exact nature of health and disability barriers in this age group and more work will need to be done to investigate this and potential interventions to enable physical activity for those affected by health problems and disability.

'Other' which includes economic factors was the second most commonly cited barrier to physical activity for both segments. 10% of the Elsie and Arnold segment and 12% of the Ralph and Phyllis segment cited this as their main barrier to physical activity. Although it is the second commonest factor it was much less commonly cited than for the overall population (21%) This reflects how health and disability is such a significant barrier for this age group and overshadows all other barriers. 11% of both segments said cheaper admission would encourage them to participate more in physical activity compared to 18% of the population 20% of the Elsie and Arnold segment and 15% of the Ralph and Phyllis segment said having other people to go with would help them participate more. Similarly, enjoyment and socialising were important motivators for both these segments.

Interventions should consider these motivators when seeking to attract older people. Improve public transport was cited as an encouraging factor by 9% of Elsie and Arnolds and 6% of the Ralph and Phyllis segment which is similar to the percentage of the overall adult population who cited this factor (6%). Interestingly, despite the majority of this age group being retired 24% if the Elsie and Arnold segment and 29% of the Ralph and Phyllis segment said they would participate more if they were less busy compared to 46% of the overall adult population. Although this is a much less common encouraging factor than for the overall adult population it was still the most common factor for both these segments.

Another possible barrier to physical activity among the segments of middle age and older age groups is a lack of motivation. Only 44% of the Roger and Joy segment said they wanted to do more physical activity compared to 56% of the overall adult population. Motivation was also slightly lower than the overall adult population for Brenda (56%) and Elaine (55%). Kev was the only segment in the middle age group that was more motivated than the general adult population to do more physical activity (62%). Motivation to do more physical activity was even lower in the older age group. Only 25% of the Elise and Arnold segment and 27% of the Ralph and Phyllis segment want to do more physical activity. It is likely that ill-health impacts on motivation in the middle age and older age groups. People experience more health problems as they get older and this reduces their participation in sport. Individuals with health and disability barriers may not see the potential they have to participate in sport and might lack the means to access physical activity. It is likely that these factors active to demotivate them from participating in physical activity. Due to lower levels of motivation, it may be more challenging to encourage older people to increase their participation in physical activity. However, there are specific health benefits from physical activity in this age group which older individuals may not be aware of. It is possible that if they were aware of these benefits (i.e. prevention of dementia and reduced risk of falls) they might be more motivated to participate. It should also be stated that there are a significant number of older people who do wish to become more active and interventions to improve levels of participation should seek to include them and meet their specific needs.

## *4.6 Summary of key findings*

The five commonest market segments in Barnet are also amongst the most active. All of these segments are more active than the overall adult population and more active than other segments in their age group. All of the five commonest segments are in the top five segments for participation in NI8 with the exception of Philip who is the seventh most active. These common segments are all motivated to do more sport with between 55% and 70% saying they want to do more sport. Thus these segments are relatively active and very motivated to participate more. It will probably require less input to enable these groups to become more active. Additionally, these groups are from a higher economic group and have both the financial and educational resources to seek opportunities for physical activity.

Conversely the least active segments have more barriers to physical activity including health and disability, family/childcare issues and economic barriers. While it is beneficial for all segments to increase their levels of physical activity, the biggest public health benefit is achieved by getting those who undertake no regular physical activity become at least minimally active. Thus the groups which should be a priority for intervention to increase physical activity are:

1. Young mothers

- Paula
  - Leanne
  - Jackie
2. Individuals of middle age
- particularly Roger and Joy and Brenda
  - Also Kev and Elaine
3. Older adults
- Elsie and Arnold
  - Ralph and Phyllis

# Chapter 5: Stakeholder responses

## *Introduction*

The involvement of stakeholders was based on a methodology which used elements of Delphi<sup>67</sup> and snowballing<sup>68</sup>. In essence both of these methods focus discussion on stakeholders identified by the process and as the process progresses enabling more people to be included and ensuring that these are the most appropriate people to have dialogue with. As common with Delphi methods an open ended questionnaire was used initially with stakeholders who then were invited to lead further discussion.

Stakeholder's conversations were held with a range of professionals, community leaders and representatives and officers from across the borough. It was agreed that this would not include private providers at this stage for several reasons, these were predominantly that there was no offer to discuss with them at this stage, the Olympics were about to commence, and it was prime holiday time. It was determined that it would be more effective to discuss an offer with private providers once the needs assessment was complete and a direction of travel for leisure in Barnet had been determined in order to fully inform the responses that private providers were able to give.

The following sections give an outline of the key issues raised by stakeholders, and these have been summarised by section rather than individual so there are a number of responses from a range of individuals in each section, rather than feedback from one person. There was keenness from stakeholders to be kept informed about the progress of the leisure review and to see how their contributions had been used.

It is also important to note that the level of understanding and awareness among stakeholders of the benefits of physical activity and the needs of their client groups/members was generally very high and that there was a degree of consensus regarding how leisure and physical activity should be organised, what the barriers were and common themes for the expectations from the review.

## *5.1 Schools and Youth*

### **5.1.1 Schools**

#### **Key issues:**

- Key stage 1 is neglected area in sports. School Games are for Key Stage 2+. There is a need to develop targeting Key Stage 1 for example family interventions.

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<sup>67</sup> The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise. The technique is designed as a group communication process which aims to achieve a convergence of opinion on a specific real-world issue. The Delphi process has been used in various fields of study such as program planning, needs assessment, policy determination, and resource utilization to develop a full range of alternatives, explore or expose underlying assumptions, as well as correlate judgments on a topic spanning a wide range of disciplines, (Hsu and Sandford, Aug 2007, The Delphi Technique: Making Sense Of Consensus, Practical Assessment Research and Evaluation, Vol 12, No 10)

<sup>68</sup> Snowballing – is a quantitative method to identify harder to reach participants. It was used in this context to find stakeholders who were knowledgeable in Barnet but may not have been widely known outside their sphere of influence or for whom the team may not have been aware of – it is often used for sampling and so was adapted in this context to combine with Delphi. Vanderstoep and Johnston, Research Methods for everyday life: Blending Qualitative and Quantitative Approaches, Wiley 2009, USA

- Schools do not have transport and are not willing to pay. Getting schools to and from events and competitions is an issue.
- Time release for Primary Subject Leads has been removed and lack of time for staff has become an issue.
- Curriculum- demands on other core subjects. PE is not always prioritised.
- Funding needs to sought for extra-curricular activity e.g. after school clubs.
- Short staff and lack of sustainable funding for the partnership.
- KS5 (year 12/13) PA levels goes down dramatically for girls, reasons for this are likely to reflect national and London trends and the literature base.
- BPSS will be covering colleges and 6<sup>th</sup> Formers from next year onwards. This will increase workload.
- Jewish schools are not prioritising PE due to religion and academic commitment
- Underperforming schools are using PE/Sports as a vehicle to engage kids in learning in deprived areas.
- Free schools have greater flexibility in terms of what they undertake and as they become established may focus more on academic subjects than sport and physical activity.

#### **Barriers to participation:**

- Attitude of schools and PE teachers
- Variety of activities on offer, a lack of variety.
- Lack of awareness of provisions
- Existing activities not inclusive and can be gender and stereotypical

#### **Expectations from the leisure review**

- Leisure Centres can open up their doors to schools who don't have sports facilities during off peak hours
- Schools can open up their facilities e.g. football pitches, sports halls.

### **5.1.2 Youth**

#### **Key issues:**

- Sports Development Team's narrow remit
- Community Sports and Physical Activity Network (CSPAN) in Barnet is no longer active.
- Sports Development Service is facing another funding review. Not having a clear direction of travel may result in loss of staff and expertise
- Teams and individuals who are inputting towards leisure development are disjointed

#### **Barriers in participation**

- Travel - Cost and distance (not wanting to travel to certain areas)
- Too much going on in their lives – troubled families
- PA is not a priority
- For disables young people distance/access is a big issue
- Not being aware of activities

- Completely relying on the referrals and the knowledge and awareness of the referring professionals
- Lack of training on how to broach the subject and where to call

### **Expectations from the leisure review**

- Much wider understanding of leisure/physical activity as being part of a daily life not just about buildings
- Improving public perceptions of leisure
- Improving cabinet members and policy makers perceptions of leisure
- Recognition that current delivery is great within the limited resources made available but more needs to be done

## **5.2 Community**

Many of the community groups identified that physical activity had huge mental and physical benefits. The groups that were included had accurate and up to date knowledge of the benefits for their clients. They wished to be able to assist their clients/members with accessing physical activity. There was a general view that the council had a facilitating role in doing this and although there was a need for provision the greatest gap was in knowledge and ways to help organisations to assist their own clients/members rather than a wish for it to be done for them.

### **Key Issues:**

- Leisure is not commercialised / advertised enough. Library offers limited information. Not good for disabled people i.e. changing rooms facilities.
- Some activities which particular client groups might wish to access – school facilities or parks are not well advertised
- Some clients do not wish to look at council website for information, would prefer organisations they know well and sometimes we cannot help on these issues as it is not an area of expertise
- People like to feel that there are always fully experienced coaches and peer support, particularly for people with disabilities
- Most women from BAWA are of the opinion that the leisure provisions in Barnet are not suitable for women from BME communities, i.e. swimming pools allocated for Muslim women, may have a male attendant. This may deter many Muslim women to come.
- Attending any physical activities sessions is very important for the client's group physical and mental well being. A lot of women came from an abusive background and have mental health problems. For them, being able to participate in those activities means to get away from the negative environment, meet with other women from the same background, socialise and enjoy themselves.
- Some of the activities that some groups with disability would like to do require transport but others could be provided locally and with minimum effort with some help
- Low level of awareness of concessionary rates or how to get them
- Some groups – the deaf – for example are highly mobile in accessing physical activity in order to be able to take part with other people in similar circumstances

and would not therefore make themselves known to local facilities as they would not see that there was anything there for them.

- Insufficient facilities- could be better, particularly in East Barnet (South Hall School sold land and sport hall; facilities lost. North Middlesex University provided some facilities but this is now closing + moving to Trent park)
- Limited opening hours (Church farm swimming have short opening hours)

### **Barriers to participation**

- Lack of information
- Someone to go with
- Body image
- Confidence
- Quality of facilities
- Child care
- Cost, lack of concessions
- Transport – particularly where there is a special need
- Absence of facilities to enable disability to be taken into account - for deaf users for example
- Reliance on internet for information – not suitable for many people
- Many people find council website difficult to navigate.

### **Expectations from the Leisure Review**

- To give more information in convenient local places.
- Cheaper activities and more accessible near transport.
- Cleaner facilities.
- To include a Walking Group and a Gardening Project
- We expect the leisure review will give more opportunities to our client group members to improve their health and well being, to be less isolated, and to integrate better with others in the community.
- A greater emphasis on those with greatest need to ensure that there are opportunities regardless of income, special needs and personal circumstances
- That the council is more adaptable to meeting need, facilitating provision in non traditional and a wider range of activities, not just traditional or young people focused sport.

## ***5.3 Environment, regeneration and transport,***

### **Key issues:**

- Cycling and walking routes: Cycling routes were removed. Only parks have cycling routes away from the roads. Regeneration areas are exempt from this rule.
- Cycling routes, walking footways, new foot bridges, zebra crossing and traffic lights are planned to increase sustainable travel in the regeneration areas.

- External review of our regeneration showed that Barnet do not provide sustainable transport. So that the transport strategy should be reviewed.
- Car parking: Policy is that every house must have a car park space. Barnet's relationship with cars does not support cycling.
- Allotments: Management of allotments were handed into the owners. No future plans on increasing allotments.
- Regional park opportunity: Mayor of London has identified regional park opportunity area for North West London similar to Lee Valley in east. As there is no Open Spaces strategy there are not much plans on it. Copthall falls into the middle of it. Big opportunity to be missed as this area also serves most deprived section of the borough.
- There are vast amount of open spaces but we do not know if these spaces are near where people live and public have limited knowledge of how to access some of these – ie farmland with rights of way.
- Access – little things can improve access. Bear in mind that wildlife charities are against families using parks. CSPAN used to work on improving access to open places.
- Quality of open spaces
- Community Buildings Needs Assessment – poor response rate, didn't give much information. It needs more strategic view.
- Sustainable Food Products – not taking place due to capacity and lack of political direction
- Copthall: Copthall is near Middlesex University and there is a potential that the Uni can make investment. Copthall has a potential to become elite sports hub for the borough.
- Copthall has been transferred to Saracens. The survey on how people travel to Copthall has been undertaken. Saracen's travel plan will be a public document soon. Plans include measures to stop people accessing playing fields in an unsustainable way for example, parking restrictions.
- Transport Department is partly funding and using funding available from Transport for London (TfL) to improve paths, playgrounds and the green in Dorris Valley Green Walks Project. The TfL sliced was used to widening the paths so that people can cycle. The cycle routes will be extended and signage will be provided for quiet roads.
- In areas outside of regeneration the Transport Department is improving walking footpaths – surface improvements, lightning, making routes safe and attractive.
- In 2006, one of the consultations showed that young people complained about the poor transport links to access Finchley Lido.

### **Expectations from the leisure review**

- Open Spaces Strategy - clear plans and hierarchy of costing in relation to changes that we are planning to make
- Significant impact on deliverability of regeneration
- Addressing parking policy
- Not just producing new strategies which will sit on the shelves but focus on delivery
- Assessment of sports and leisure facilities.
- Moving leisure centers to town centers so that more people can access due to better transport links.
- People in New Barnet want to have a swimming pool.
- Consider Community Building Needs Assessment.



- Acknowledgement of travel plans
- Joined up working
- Mindful about workload
- The need to work on the Green Grid. Existing routes needs to be looked at and to be developed.
- The Transport Department is keen to fund the improvement of walking and cycling conditions.

## *5.4 Parks and open spaces*

### **Key issues:**

- Green spaces team is under resourced. A total of four staff members are responsible for 202 parks (850 hectares) 2<sup>nd</sup> largest in London.
- Council reduced resources by focusing on delivering core activity.
- Sports Development based in the Youth Services – wider scope is needed for sports development
- There are not any plans in relation to Mayor's Regional Park proposal.
- There is no monitoring on the use of outdoor gym equipments

### **Expectations from the leisure review**

- Strategy for leisure across the life course not just focusing on young people
- Using parks as a resource and opportunity for free gyms
- Running intervention programmes
- Come up with a measure of usage of parks
- Monitoring use of equipments in Oak Hill

## *5.5 NHS and Healthcare provision*

### **Key issues:**

- GP understanding of physical activity in terms of how much people should be doing was out dated or non existent
- Many GPs are unlikely to be able to describe benefits of physical activity in a way that sedentary people will understand or be motivated by
- There is a low level of knowledge of what activities are available locally and primary care teams find it complicated to understand different providers
- 13% of population see a GP every 2 weeks so big opportunity to engage with sedentary
- Need for specialist physical activity input into primary care to refer to as GPs and primary care teams unlikely to pick this up
- Disinvestment in prevention programmes such as MEND and GP exercise referral has been difficult
- Little PCT support for this area

### **Barriers to participation**

- Patients worried about cost, entering a strange environment, not fitting in
- Knowledge of professionals about what and how to recommend

### **Expectations from Leisure Review**

- Coordinated approach to inclusion of healthcare and primary care where possible to ensure that targeted approaches used where possible.
- Development of ways to ensure primary care are better informed about opportunities
- Potential to develop specialist input into PHC teams.

## ***5.6 Summary of key findings***

In collecting stakeholder views through a range of conversations several themes have emerged from all parties, the responses were well informed and consistent. These ranged from personal concerns about using facilities to broad views from a policy and resident perspective.

### **Personal Concerns:**

- There are shared personal concerns about not having someone to exercise with, body image or being shy about entering an unknown environment and not knowing what to do when getting there. Not knowing about the facilities in detail in advance puts some people off from attending – these were sometimes basic details about what to wear, where to go, how to find your way around a new environment. Childcare was also raised as an issue as parents felt it was very hard to access facilities at an affordable time if there were no childcare facilities. The cost of swimming for example with a child often means the parent has to pay full price even though they may be splashing in a shallow pool with a child rather than making full use of the pool. This put parents off going as it became very expensive.
- There was a strong interest in alternative activities – not just those based in leisure facilities. Dancing, Keep fit classes, using parks, cycling, and walking were all raised as activities people felt that they might like to do if they could overcome some of the personal barriers and had the opportunity
- There are common concerns overall about the cost of using local authority facilities, older people and those with disabilities raised this. The quality of what is provided was also raised by a number of stakeholders, referring to cleanliness and the modernity of some facilities. The lack of transport to reach some facilities was an issue raised by all of the community stakeholders, it was felt that a car was essential to reach some places.
- In addition to this the lack of information about what was available came up in each sector. The use of the council's website seemed to be an issue and there was a reluctance to ask the council about leisure facilities if people were not aware of what was available. Knowledge of professionals in a position to advise on

becoming active was raised in addition to no one viable source of information on which to base this.

## **Broader Concerns:**

- The stakeholders had a broad perspective about what would encourage people to be more active and in addition to better transport to venues, regeneration, play areas, use of parks and sustainable planning, in particular with regards to car parking and lack of safe cycling, was raised. There was some feeling that physical activity needs to be incorporated across the borough and that a review of provision was only one component of this. There was some frustration at the opportunities that Barnet could be taking but was not able to access due to some key policy or strategy missing in the council complement of strategy.
- The use of community facilities particularly schools was raised as a barrier since it was often not possible to use these most local and accessible of locations.
- The lack of co-ordination of Barnet policies in the context of physical activity and leisure was seen as a significant issue for promoting physical activity and was viewed as ultimately the key to effectively promoting physical activity and use of leisure facilities. There needed to be a consistent view on the strategic direction for physical activity across all areas of the councils business. It was also felt that this would enable other key policy decisions to be informed about the purpose of some roles and would assist in accessing future funding and forming more effective relationships with the private sector and community providers.

## Chapter 6: Current physical activity services

### *Introduction*

In this chapter, current provisions for physical activity in different settings will be looked at. This will include programmes in schools and targeted activities within the community. It will also examine how physical activity is addressed within the existing open spaces regeneration and transport plans. If we are to develop environment conducive to physical activity we need to understand opportunities available outside of the leisure facilities.

### *6.1 Schools and Youth*

The provision of physical activity for children and young people is almost entirely the responsibility of Barnet Partnership for School Sports and Sports Development Team of Barnet Borough Council.

#### **6.1.1 Barnet Partnership for School Sports**

The Barnet Partnership for School Sports (BPSS) is a “not for profit” organisation that has been established as a mechanism to retain the outcomes achieved by the School Sport Partnerships, including the organisation of events, competitions, festivals and leadership opportunities with a generic outcome of increasing participation at all levels.

BPSS is primarily funded by the Central Government (Sport England and Department of Health) and is currently based at Queen Elizabeth School. The partnership also applies for additional funding. School Games Organizers (formerly known as School Sports Co-ordinators) organise activities, competitions, leadership, volunteering, clubs and out of hour activities.

**The School Games:** As part of the new Sport England's Strategy aims to enable every school and child to participate in competitive sport, including meaningful opportunities for disabled youngsters.

**Bikeability:** Bikeability has been developed by Cycling England with a range of partners. It is not just about teaching children to ride a bike and equipping them with the necessary skills and knowledge needed to ride a bike safely throughout the rest of their life. It's also about introducing them to cycling as an everyday activity – an alternative mode of transport, an enjoyable pastime, which brings a healthier lifestyle and ultimately lots of fun. Bikeability will give children a life skill that once they've learnt, they will never forget.

**National School Sport week:** School Games Organizers support schools who want to take part in the sports week. It is for 3 – 19 year olds.

**Young Ambassadors:** Young Ambassadors are selected as role models by their schools and BPSS. They are striving to promote the benefits of sport and sharing the Olympic and Paralympic Values through assemblies, workshops and events.

**London 2012 GET SET Project:** The Get Set network is a community of schools and colleges which are demonstrating a commitment to the Olympic Values (friendship, excellence and respect) and the Paralympic Values (inspiration, determination, courage and equality) and using the London 2012 Games to inspire learners of all ages to get involved in Values-based projects and activities.

Any school or college in Barnet can become a member and receive rewards and recognition from London 2012.

**Top Up Swimming:** This is an intervention designed to enable every child to achieve the Year 6 standard in swimming. By the end of Key Stage 2 children are expected to have the confidence and ability to swim 25 meters. The Partnership offers 5 half hour swimming lessons within one week for each student in Years 4,5,6 who cannot currently swim 25 metres to improve their confidence and safety in the water.

**Virtual challenges:** The Virtual Challenges are alternative and innovative means of providing intra and inter school competitive opportunities for schools, without them even leaving the school site. One of the main barriers to participation is the transport and the personnel issue. By providing virtual challenges both these problems are removed and enable participation on an unlimited scale.

**Sportivate:** The Sportivate programme is part of the Play strand of Sport England's mass participation legacy programme 'Places, People, Play' which was launched in November 2010. The four year programme will target those aged 14-25 who are either not choosing to participate in sport during their own time, or are doing so for a very limited amount of time. This group might be described as semi sporty.

The programme will be implemented through PRO-ACTIVE North London in partnership with Barnet Partnership for School Sports.

**Community use in schools:** The council has a strong track record of encouraging community use of schools on both a lettings basis as well as a more proactive community sports provision. However, a number of schools are not opening up their facilities to the wider public, or are currently constrained to do so. There is an opportunity to explore how these assets can be better utilised.

### 6.1.2 Healthy Schools Programme

Healthy Schools enables and supports schools to plan and implement health and well-being improvements for their children and young people. A healthy school promotes physical and emotional health by providing accessible and relevant information and equips pupils and staff with the understanding, skills and attitudes to make informed decisions about their health. Healthy Schools adopts a whole-school approach, involving the whole-school community, parents/carers, governors, staff and pupils in improving children's health.

This service was stopped following the Comprehensive Spending Review in Oct 2010 so no longer takes place in LB Barnet.

### 6.1.3 School Travel Coordinator

School Travel Coordinator works with all schools including those who are independent and review their School Travel Plans (STP). Each school has STP champions. They are usually PHSE coordinators. School Travel Coordinator provides advice, small grants to promote travel plans, encourages staff as well as pupils. Examples of initiatives including: cycling training, walking clubs, walk to school week, walk4life, scooter rack for primary, parking stride and encourages schools to map routes coming to schools.

Currently they are promoting 'Walk Torch' – 8,000 miles walk as in number of miles that the torch walked in the UK.

#### 6.1.4 Youth Service Sports Development (Positive Activities programme)

Following the Comprehensive Spending Review in October 2010, and then an internal restructure in April 2011, the Sports Development Team's funding was reduced and the team was moved to form part of a new Youth Support Service. This service provides support to disengaged/disadvantaged young people to improve their life chances. The service works primarily with young people between ages of 13-19 and extends up to 25 if the young person has a learning difficulty or disability.

The Sports Development Team develops activities and programmes that targeted young people can access including physical activities, qualifications and work experience. A lot of work is also undertaken to support the local infrastructure of sports clubs/providers.

**Annual Club Conference:** Evening event to provide central support structure to sports clubs. Selection of workshops involves key speakers with lots of experience to provide best practice. Good networking opportunity for clubs and sports providers and to share learning. 2013 conference theme to be around 'Engaging Vulnerable Young People Through Sport'.

**Workshops:** Selection of support workshops for sports clubs/providers. Updates, funding opportunities, training on safeguarding and quality assurance and community development, marketing, social media and preparation for business for clubs.

**Holiday provisions:** A range of activities organised during school holidays at different venues around the borough. These include multi-sports, dance, athletics, tennis and swimming. The sessions are run by clubs and funded through the Youth Support Service. All related providers have to provide minimum operating standards to ensure safeguarding and high quality.

**Door Step Sports Club:** Possible roll-out of multi-sports clubs in areas of high deprivation with an aim to introduce sports qualifications. Areas include Grahame Park, Underhill, Strawberry Vale and Stonegrove Estate.

**Urban Gamez:** Estate-based multi-sport event in Grahame Park. Led by Barnet Homes and supported by Sport Development Team.

**Mini London Marathon:** The team supports the delivery of the programme for 11+ involving running the last 3 miles of London Marathon.

**London Youth Games:** London-wide multi-sport event with competitions in 30 different sports. This is a particularly successful project that engages approximately 500 young people each year to compete for the Barnet Teams. Youth Sports Development team works very closely with local sports clubs to identify talented young people who are eligible to compete.

**Youth Celebration Event:** Young people are nominated and recognised for their achievements. The categories are as follows:

- a. Performance and Achievement
- b. Community Volunteering
- c. Peer Mentoring

Youth Celebration Event highlights achievements/performances of young people and positively publicises their successes.

**Sporting qualifications:** Deliver series of sporting accredited qualifications for young people such as: Football Referee Course for 14+, First Aid, FA Level 1 coaching, Level 2 coaching, Dance Leadership, Level 2 Fitness Instructor, Boxing Tutors Awards.

**Work Experience/Volunteering:** Works with local key providers to offer local opportunities with good outcomes for participating young people.

**Sporting qualifications:** Deliver series of sporting accredited qualifications for young people such as: Football Referee Course for 14+, First Aid, FA Level 1 coaching, Level 2 coaching, Dance Leadership, Level 2 Fitness Instructor, Boxing Tutors Awards.

**Work Experience/Volunteering:** Works with local key providers to offer local opportunities with good outcomes for participating young people.

## 6.2 Community

This section intends to put together the activities community approaches where people live, work and play such as active living programmes, walking and cycling clubs, other local sports clubs, local initiatives, targeted programmes and projects.

**Health Walks:** Currently the London Borough of Barnet organises and runs 7 instructor-led health walks across the borough on a weekly basis. Each one is led by qualified instructors to include additional exercises to challenge your physical fitness and develop strength and conditioning. Due to the time of day the walks take place they are primarily attended by older people and non-working people.

**Sport Makers:** This is a national programme aims to recruit new sports volunteers aged 16 years and over to organise and lead community sporting activities across the country. The project is being lead by PRO-ACTIVE North London who are providing workshops for individuals who wish to become Sport Makers. After the workshop Sport Makers will be volunteering in Barnet to support and encourage people in Barnet to become more active.

**Gold Challenge:** Gold Challenge works in partnership with the British Olympic Association, Paralympics GB and Sport England, and forms part of the official mass participation legacy programme for London 2012. The project is a charity challenge in which people take on Olympic and Paralympic sports to raise money for their chosen charity. It has two main objectives: to inspire people of all ages and physical ability to play sport, and to raise substantial sums of money for charity. Individuals register for challenge through the website.

**Sportivate:** The Sportivate programme is part of the Play strand of Sport England's mass participation legacy programme 'Places, People, Play' which was launched in November 2010. The four year programme will target those aged 14-25 who are either not choosing to participate in sport during their own time, or are doing so for a very limited amount of time. This group might be described as semi sporty.

The programme is being implemented through PRO-ACTIVE North London in partnership with strategic organisations and delivery organisations in Barnet. The programme is currently in its second year.

**Give it a Go:** Give it a Go is London wide project that provides funding to sports organisations to provide 8 hrs of free coaching and is designed to harness the increased enthusiasm and interest in sport by the public after the London Olympic and Paralympic Games. All participating clubs are featured in our London wide marketing campaign - including online, print, social and other media channels. Clubs will also be given their own free materials that can be personalised and distributed locally. The project will run during October and November. Barnet clubs are involved in the project.

**Sports M.A.T.E. :** Sports M.A.T.E (Mentoring, Access, Training, Equality) supports young disabled people into participating in main stream sport clubs/opportunities through provision of a personalised mentoring and referral scheme. Individuals are referred on to the project through disability services, disabled people organisations, local education establishments, families and support workers. Once the individual has been referred on to the project, the Sports M.A.T.E mentors provide up to 6 hours of support.

The Sports M.A.T.E Project was authored by Tottenham Hotspur Foundation and successfully piloted and developed in partnership with the PRO-ACTIVE North London Partnership, Help A London Child and Interactive across North London including Barnet. Additional funding has been secured to continue the project in Barnet.

**Get active website:** Get Active Website is a London-wide database of Clubs, Venues & Activities developed by the 5 PRO-ACTIVE London Partnerships. Clubs and activity organisers can add their activity in the list for free. Based on the Get Active Database the following activities are available in Barnet:

- Women Only Netball
- Women only Badminton
- Football for mixed gender
- American Football
- Hendon Touch Rugby
- Junior volleyball
- No strings badminton
- Sportivate - trampoline club
- Summer fencing training camp
- Track & field athletics
- Give it a go – Dance, Street dance, Trampoline, Tae Kwon Do Diving, Tennis, Table Tennis, Jogging, Triathlon, Belly Dancing, Ballet, Fitness, Ab Attack, Aerobics, Body Attack, Body Blast, Body Conditioning, Body Pump, Body Sculpt, Body Step, Boot Camp, Boxcercise, Boxing Circuits, Circuit Training, Cross-Fit, 50 + Exercise, Boxfit, Boxing, Kickboxing, Outdoor Pursuits, Powerlifting, Strength & Conditioning, Speed Training, Core Strength, Weightlifting, Bell Boating, Canoeing, Canoeing, Kayaking, Cheerleading, Rugby Union, Touch Rugby, Volleyball, Gymnastics.



## 6.3 Environment, regeneration and transport

Barnet is the fastest growing outer London borough with over 32,000 new homes planned over the next 20 years.

Barnet has three major regeneration and development areas. They are Cricklewood, Brent Cross and West Hendon, Colindale and Mill Hill East.

**Table 1. Major regeneration and development areas in Barnet**

Area	Homes	Jobs	Timescale
Cricklewood, Brent Cross and West Hendon	10,000	20,000	2011-2031
Colindale	12,500	2,000	2011-2031
Mill Hill East	2,000	500	2009-2024

Development within the key regeneration areas has a number of implications for the planning of open space outdoor sports and recreational facilities as the additional population will increase pressure on existing open spaces within these areas and create demand for new spaces and facilities. Large scale redevelopment also presents opportunities for creating new spaces.

In addition to the above development major housing estates will also be regenerated in order to tackle poor quality housing and social isolation. These estates (excluding Grahame Park which is counted as part of the Colindale regeneration area) will provide nearly **3,200** new homes by 2026

These estates including:

- Dollis Valley
- Grahame Park
- Granville Road,
- Stonegrove and Spur Road
- West Hendon

### 6.3.1 Walking and cycling in Barnet

Walking is the easiest way for most people to be active, either informally, as part of daily life, or as part of a programme where walking provides safe, social contact as well as physical exercise. Factors such as street design, access to amenities, pedestrian friendliness, attractiveness, safety and security affect whether people walk or cycle there. Living in a highly walkable neighborhood is directly linked to how much walking and cycling adults do<sup>69</sup>.

This contrasts with evidence that people are more likely to be heavier, overweight, or obese if they live in less walkable areas<sup>70</sup>. These environments also provide more access and opportunities for

<sup>69</sup> Van Dyck D et al. (2009) Lower neighbourhood walkability and longer distance to school are related to physical activity in Belgian adolescents. *Preventive Medicine* 48:516-518

<sup>70</sup> Ewing, R., T. Schmid, R. Killingsworth, A. Zlot, and S. Raudenbush. (2003). Relationship between urban sprawl and physical activity, obesity, and morbidity. *American Journal of Health Promotion* 18 (1): 47-57.

children including exploring their local environment on foot and bike<sup>71</sup>. More activity in local areas, more local people on the street and at local facilities benefits mental health, social inclusion and well-being.

Walking is an important mode of travel for short journeys (29% of all trips<sup>72</sup>), and Barnet's network of town centers makes walking a convenient way for many residents to access services in the borough. Levels of walking are already at or above average for Outer London boroughs. Cycling tends to be limited (1%), at least in part due to the topography of Barnet and its rolling landscape of valleys and ridges. There has been a good network of cycle routes signed along quiet roads and some good off-road routes across the borough. Walking and cycling routes are well integrated within regeneration areas.

### **6.3.2 Promoting active travel and improving health**

The upward trend in obesity is seen as the result of a combination of factors such as a less active lifestyle and changes in eating patterns. Transport can impact on health in a number of ways. Active travel through walking and cycling can play an important part in increasing levels of activity to address poor health. Good quality walking surfaces and off road cycle routes can make walking or cycling an attractive option for some people, including children on their way to and from school, who would otherwise be unable to take advantage of them. This approach can help tackle childhood obesity.

Poor air quality, which is concentrated around major roads in Barnet, has particular impacts on the health of people suffering from cardiovascular and respiratory diseases.

### **6.3.3 School Travel Plans**

Barnet has been monitoring the School Travel Plans (STPs) to ensure that they are effective. To date Barnet has been very successful in starting to address this major issue, achieving a 12% reduction in the numbers of pupils driven to school. It is important to note that Barnet is a comparatively safe borough and parents and guardians concerns about child safety are largely unfounded (nearly 2% of accidents in London, which involved the death or serious injury of a child, happened in Barnet in 2009).

However much more remains to be done and some STPs are only partly adhered so this area of work will need to be prioritised. In particular more direct action is necessary through seeking to increase the availability of funding to implement complementary traffic management improvements in the neighbourhoods around our schools including taking positive action to prevent any pupil parking, promoting car sharing and improved cycle parking facilities. This will encourage more children to walk and cycle to and from school.

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<sup>71</sup> Southworth M (1997) Walkable Suburbs: An evaluation of neotraditional communities at the urban edge. American Planning Association, Vol 63(1) 28-44.

<sup>72</sup> London Travel Demand Survey, 2006-09 as reported in Developing a Sub-regional Transport Plan Interim report on challenges & opportunities 18/02/2010 – TfL planning

### **6.3.4 Development Travel Plans**

Travel Plans need to be produced for all developments that exceed the relevant Transport for London thresholds and contain smart targets which are regularly monitored. By drawing-up these plans, organisations such as businesses and educational establishments, can identify ways in which their employees, and in some cases customers, can be helped and encouraged to travel using methods other than the car.

In appropriate circumstances consideration should be given to providing funds for subsidising oyster cards or cycle purchase vouchers or membership of a car club. Travel plans should also be regularly reviewed. Arrangements for enforcement in the event that agreed objectives are not met are also required. In appropriate situations, through the use of S106 agreements and conditions, the council requires occupiers of new development to adopt and maintain Travel Plans.

Travel Plan that aims to reduce vehicle movements needs to introduce a wide range of measures which includes the facilitation and promotion of walking, cycling and public transport use. Developments are expected to incorporate into their design features such as cycle storage and showering facilities and to make improvements to cycling and walking routes. The evaluation and monitoring of the Travel Plans is an on going process through the life of the TP.

### **6.3.5 Council Travel Plan**

The Council's Travel Plan was developed in 2006 and successfully launched in 2007 following which time a number of measures were put in place such as staff showers, video conferencing, improved cycle storage and trialling of staff travel processes. The Travel Plan is currently under review.

## ***6.4 Parks and open spaces***

Parks and green spaces can play an important role in promoting healthy lifestyles and preventing illness. These facilities provides opportunities for informal sports such as jogging, softball and kick-about and less formally organized games of cricket and football; give people the chance to participate in design, management and care of local spaces, fostering local pride. They are places to socialise and because access is free, provide an affordable alternative to other leisure activities.

Barnet is one of the greenest boroughs in London with a large proportion of the area within its boundary lying in the Green Belt (2,466 hectares – 28% of the borough), and Metropolitan Open Land (690 hectares – 8% of the borough). The borough has over 200 parks and open spaces, covering 848 hectares.

### **6.4.1 Barnet's parks**

Barnet has a total of 73 public parks. Overall park provision in the Borough is good although the distribution of parks across the borough is not even and certain parts of the Borough suffer from

poor access. The majority of sites which have poor accessibility are located in residential areas away from the main road where bus routes run.

### **6.4.2 Children's play facilities**

Having more high-quality and safe places to play is important, both in terms of physical health, healthy growth, particularly muscle and skeletal development and emotional wellbeing. Higher levels of physical activity in such places provide clear health benefits. The most understated benefits of activity are psychological. Children learn creativity, physical skills and how to get on well with others from informal play and organised sport.

As with parks, children's play facilities are not evenly distributed through Barnet. There are 49 sites in the borough that provide formal play space for children, this equates to 0.5m<sup>2</sup> of space per child under 15 years. Less than half of the parks in Barnet have play provision for children. Overall 54% of Barnet's area is not within 600m of formal equipped areas for play and a significant increase in facilities is required as Barnet's population gets younger. Accessibility to play sites via public rights of way, the cycle network, bus and rail needs to be improved.

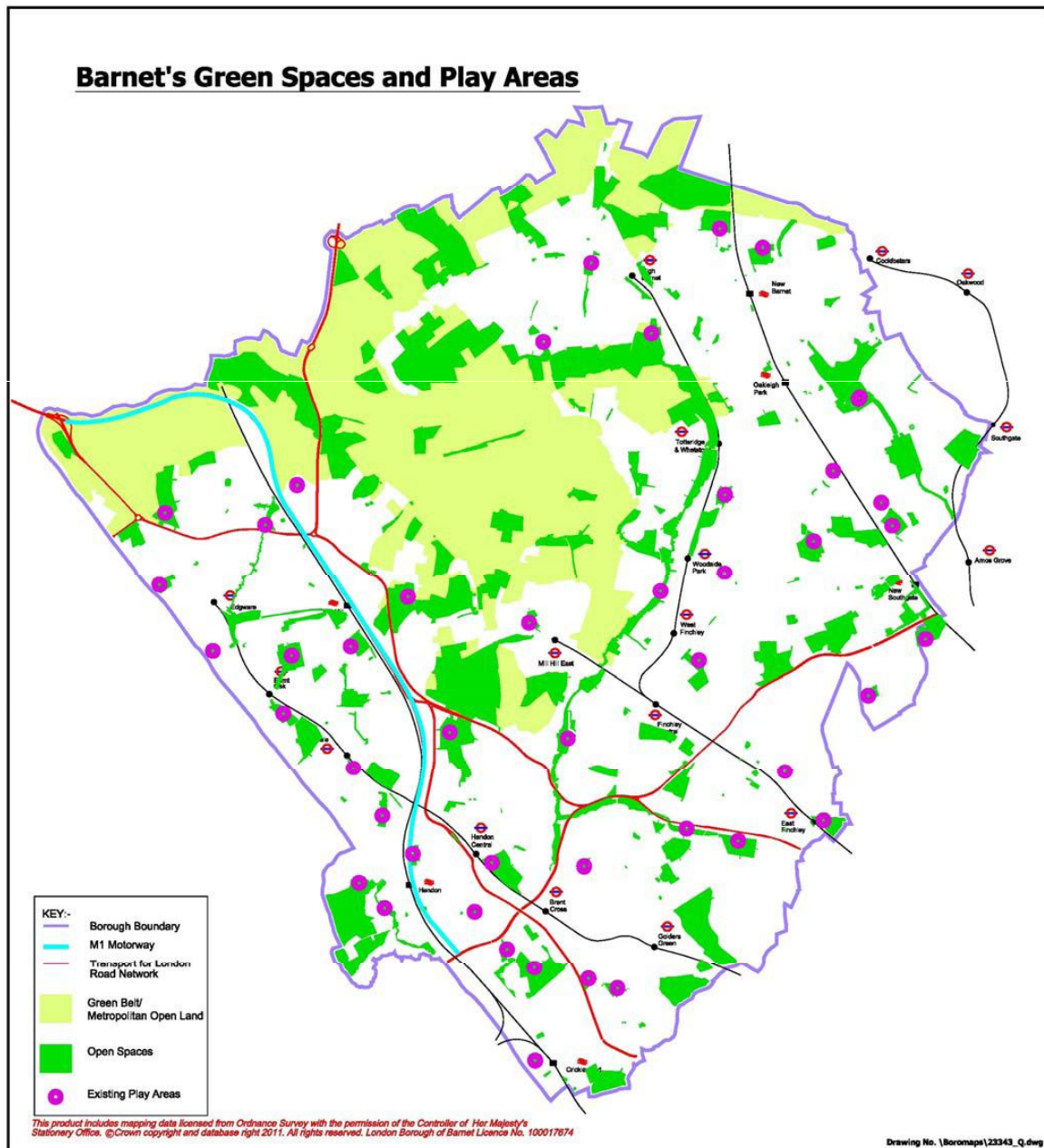
### **6.4.3 Playing pitches and outdoor sports**

Barnet is relatively well provided for in terms of distribution of playing pitches with 277 pitches covering nearly 160 hectares. There is 0.51 ha of playing pitches per 1,000 residents and almost the entire borough is within 1.2km of a playing pitch. Despite good geographical coverage there is demand for additional provision because of issues related to the quality of the existing pitches (mainly due to poor drainage) and the lack of accessibility. 13 sites are not accessible in terms of walking, cycling, bus or rail.

A Playing Pitch Strategy was in accordance with Sport England's guidance 'Towards a Level Playing Field'. This will guide future provision and management of new sports pitches in Barnet.

The borough is considered to have a good distribution of bowling greens and tennis courts mainly within parks. Provision for basketball and netball courts is concentrated in the west of the borough around Burnt Oak. Further work is required on assessing distribution of these facilities outside of open spaces.

### Figure 1. Barnet's green spaces and play areas



Source: Core Strategy Submission Stage: Development Plan Document May 2011

### 6.4.4 Allotments

The Barnet Federation of allotment and horticultural societies lists 46 allotment sites in Barnet providing a total of over 4,000 plots. These are relatively evenly distributed throughout the urban areas of the Borough, but with a slightly increased concentration in the central and northern parts and a lower incidence in the southern areas around Hendon and Hampstead Garden Suburb. They are a popular facility with a high demand for plots and waiting lists for most sites.

## *Summary of key findings*

- There are several programmes supported by the council which offer good access to schools, young people and disadvantaged groups. A number of events and opportunities are provided throughout the year and all those involved work well in providing these. Activities which lead to qualifications and work experience are open for disadvantaged young people.
- School Travel Co-ordinator support schools in reviewing their school travel plans and organises promotional activities to increase walking and cycling to school.
- Community support for physical activity and sport is provided through networks of clubs and via the support of Pro Active North London (the local community sports partnership). Pro Active is influential in providing support and assistance locally to both council officers, community clubs and organisations and the school sports partnership. There is more potential to work with Pro Active North London if Barnet had a more coherent approach to physical activity and sports and could adopt a broader remit and perspective.
- Barnet has three major regeneration areas which will produce 32,000 new homes in the next 20 years. Walking and cycling routes are well integrated within regeneration areas. This provides the ideal opportunity for integrating physical activity and sport into lifestyles.
- The Council requires new developments to produce and maintain 'Development Travel Plans' to reduce vehicle movements.
- Barnet is one of the greenest boroughs in London with 73 public parks. The majority of sites which have poor accessibility are located in residential areas away from the main road where bus routes run.
- As with parks, children's play facilities are not evenly distributed through Barnet. Less than half of the parks in Barnet have play provision for children. Accessibility to play sites via public rights of way, the cycle network, bus and rail needs to be improved.
- Barnet is relatively well provided for in terms of distribution of playing pitches. Further work is required on assessing distribution of these facilities outside of open spaces.
- There is a high level of demand for allotment and yet the Council has no plans to increase provisions.
- Promoting active travel, the use of parks, play areas and open spaces are essential if there is any desire to move away from a wholly provider based landscape for leisure and sport. In addition these promote the integration of activity into lifestyles which is essential for populations where income, transport and access are also a challenge. Many of the policies which guide the development of these have been abandoned or are not currently in date, this proves to be an obstacle to further development.

## Chapter 7. Leisure and Sport Facilities

### *Introduction*

The Facility Needs Analysis has been undertaken to map existing leisure and sports facilities in Barnet to identify and review possible access barriers to existing facilities and compare the location of these to underlying geo-demographic indicators.

Findings contained within previous sections of this Need Assessment identified the importance of physical activity and therefore access to suitable services and facilities. It has also been identified that physical activity rates within Barnet are currently below London and national averages.

The Facility Needs Analysis provides information on the six main Greenwich Leisure Ltd (GLL) operated sport centres, the way in which members of the leisure facilities provided by GLL are distributed across the borough, where facilities – in general – are sited, who accesses these, the pricing structures and the size of facilities.

The GLL sport centres included in the report are:

- Burnt Oak Sports Centre
- Church Farm Sport Centre
- Hendon Sport Centre
- Finchley Lido
- Compton Sport Centre
- Copthall Swimming Pool

The basis of membership analysis and related resident conversion rates at the above centres is based on data provided by GLL (September 2012). It should be noted that firstly, the analysis covers all types of membership, unless stated otherwise, and secondly it has not been possible to incorporate pay and play visitor throughput, as the specific data required for this analysis was not unavailable. Therefore conclusions are based on purely membership data available and should be used only as a guide.

### *7.1 Facility Mapping*

#### **7.1.1 GLL membership distribution**

The table below shows the distribution of members around each centre:

- Burnt Oak Leisure Centre: serves a relatively local catchments' that is predominantly based in Barnet Borough

- Church Farm Swimming Pool: Serves a catchments' that is predominantly located in Barnet Borough. The majority of other members are drawn from Enfield Borough.
- Copthall Pool: Members are primarily drawn from the south west and east of Barnet Borough and the majority travel over 2km to reach the site.
- Compton Leisure Centre: Most members are located to the east of Barnet Borough and few members reside in other areas as the centre primarily serves a local catchments'.
- Hendon Leisure Centre: A relatively wide spread of member origins, the centre has the largest percentage of members from outside of Barnet Borough (predominantly residing in Camden Borough).
- Finchley Lido Leisure Centre: The lowest of all centres in terms of percentage of members residing less than 2km away, users have a higher propensity to travel to the site from across Barnet Borough.

**Maps are available in Appendix 1 Chapter 7.**

**Table 1: Membership distribution (across GLL operated sport and leisure facilities in Barnet Borough)**

Catchments	Burnt Oak	Church Farm	Copthall	Compton	Hendon	Finchley	Average
0-2 Km	61.7%	53.3%	36.9%	50.7%	45.3%	30.6%	43.3%
2 Km-10 Min	31.2%	38.5%	40.0%	43.0%	32.5%	36.8%	38.8%
10-15 Min	2.3%	6.8%	17.3%	4.2%	15.2%	25.8%	12.0%
15-20 Min	2.0%	1.2%	5.1%	1.4%	3.9%	6.2%	2.8%
20-25 Min	1.4%	0.3%	0.5%	0.7%	2.2%	0.4%	0.8%
Outside catchments	1.4%	0.0%	0.1%	0.0%	1.0%	0.2%	2.2%
Outside Barnet	18.5%	18.2%	17.3%	14.8%	32.3%	22.6%	21.2%
Inside Barnet	81.5%	81.8%	82.7%	85.2%	67.7%	77.4%	78.8%
QUEST National Benchmark scores*	Satisfactory (rank 121)	Satisfactory (rank 251)	Satisfactory (rank 182)		Satisfactory (rank 252)	Satisfactory (rank 336)	

\* The National Benchmarking Schemes ranks the overall performance of each centre against all other QUEST assessed centers nationally. The lower the score the better the centre has performed.

## 7.1.2 Facility access

An audit for each facility type has been undertaken for Barnet Borough and a 10-minute drive time catchments' buffer around the Borough has also been audited. The 10-minute peak time buffer catchments' is representative of the 75th quartile of existing travel time propensities (as shown in the membership distribution table). This is in line with recommended planning policies.



The following summarises the access policy of facilities across Barnet Borough:

- Health and fitness (gym): Relatively high supply of pay and play facilities with gaps in provision in the centre and North West of Barnet Borough.
- Sport halls: High proportion of sites that only allow access to sport clubs (generally block bookings). There is limited pay and play provision in the centre, south and west of Barnet Borough.
- Swimming pools: Even distribution of pay and play swimming provision with Barnet Borough. More private facilities are located to the south of the Borough.
- Synthetic turf pitches (STPs): There is limited pay and play provision in the centre, north and west of Barnet Borough.
- Indoor tennis: There are no pay and play indoor tennis facilities in Barnet Borough. Accounting for the buffer catchment area there is limited accessible (based of travel times) provision for residents located in the centre, north and west of Barnet Borough.
- Indoor bowls: There are no pay and play bowls facilities located in Barnet Borough. All provision in neighbouring authorities is located on the east side of the Borough.
- Multi-use Games Areas (MUGAs): It is assumed that there is public access to all sites. The main gaps in provision are within the centre of Barnet and to the North West.

***Maps are available in Appendix 2 Chapter 7.***

### **7.1.3 Facility size**

The following summarises the size of facilities across Barnet Borough:

- Health and fitness (gym): High supply of larger gyms to the south and east of the Borough.
- Sport halls: Generally a wide spread of large sports halls. Main gaps (in terms of facilities with 4+ courts) are in the west and south of Barnet Borough.
- Swimming pools: The only large swimming pool in the north of the Borough is Queen Elizabeth Sports Centre. There is wider access to larger facilities in the centre. There is also likely to be limited access for residents residing on the southern and south-western perimeter of Barnet Borough.
- Synthetic turf pitches (STPs): Generally all STPs are relatively small in size (or number of pitches) with the exception of The Hive Football Centre on the western edge of Barnet. Limited provision of any size in the north and west of Barnet Borough.
- Indoor tennis: The David Lloyd Centre (private members) is a large site (with 10 courts) however access to this site for residents located in the north or west of Barnet Borough may be limited.

- Indoor bowls: The one bowls facility in Barnet Borough is of significant size however access will be limited for those residents residing in the north and west of the Borough.

**Maps are available in Appendix 3 Chapter 7.**

## 7.1.4 Facility pricing

The following summarises the pricing policies for facilities across Barnet Borough:

- Health and fitness (gym): Good distribution of facilities with varied pricing policies, again relatively few low cost facilities in the North West.
- Sport halls: Facilities located in the centre of Barnet Borough are a higher rental price than sport hall courts on the periphery of the Borough.
- Swimming pools: Generally provision in the centre of Barnet Borough is more expensive (on a pay and play basis) than that on and around the perimeter of the Borough.

**Maps are available in Appendix 4 Chapter 7.**

## 7.1.5 Pricing policy review

A benchmarking exercise was undertaken to compare the pricing policy at GLL sport and leisure facilities with those in neighbouring local authorities. The following table details the prices within each authority. The details on specific facilities are available within Appendix 4.

**Table 2: Facility price benchmarking**

	<b>Barnet</b>	<b>Brent</b>	<b>Camden</b>	<b>Enfield</b>	<b>Haringey</b>	<b>Harrow</b>
Number of sport/leisure centres included in the overall membership	All GLL sites across London	One site only	All GLL sites across London	5 sites in the Borough	3 sites in the Borough	All GLL sites across London
Inclusive membership price (per month)	£45.60 (£29.50 swim membership) + £10 joining fee	£35.60 (no contract or joining fee)	£49.80 (£29.50 swim membership) + £10 joining fee	£44.00 + £35 joining fee	£44.00 + £36 joining fee	£41.40 (£29.50 swim membership) + £10 joining fee
Gym session (non member)	Member only £27.95 + £10 joining fee	£5.50	Member only £27.95 + £10 joining fee	£7.50	£4.60 (need joining fee)	Members £27.95 + £10 joining fee (£6.85 for a one off)
Swim session (non member)	£5.65 (£3.45 per junior)	£4.15	£4.65	£4.00	£4.50 (£5.50 for lido)	£3.90
Synthetic turf pitch hire (per hour)	£71.65 (£44.10 for half pitch)	£68	N/A	£80.00	£146 (£75 for half pitch)	N/A
Court hire (within a sport hall per hour)	£15.00	£8.85	£11.75	£12.00	£5.10	£6.70

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The following conclusions can be drawn from the above table:

- The inclusive pricing policy in Barnet is broadly in line with neighbouring authorities.
- There is no one-off pay and play price policy for gym access in Barnet.
- The pay and play cost for swimming in Barnet Borough is relatively high.
- The hire cost for STPs is relatively low in Barnet Borough.
- The price for booking sport hall courts in Barnet Borough is relatively high.

## 7.2 Facility gap analysis

The profiles of different types of GLL members and facility users and the demographic catchments of the six main sport centres are cross referenced with the profile of the Borough. This will be covered within the following sub sections:

- **Demographic priority areas** – a localised statistical analysis of priority groups. This will establish the context for a subsequent hierarchical gap analysis.
- **Facility travel time accessibility** - this approach will identify areas of priority in terms of physical access (travel time) to facility provision.
- **Facility availability** – this will consider **facility size** (as an indicator of capacity) as well as travel time and compare this with underlying demographic indicators to identify whether certain barriers are more prevalent within local areas (where priority community groups may reside).
- **Trend analysis** - this will consider current **usage patterns** of different type of users (based on points of origin), identifying whether certain demographic groups are statistically under-represented at existing GLL sport centres (based on **conversion rates**) and consider the possible reasons for this, using the preceding analysis. We will also identify the travel propensities of different demographic groups to different facilities. Based on this analysis we can further establish potential accessibility gaps across Barnet.

The analysis also considered the following core facilities:

- Health and fitness (gyms)
- Sport halls
- Swimming pools
- Synthetic turf pitches (STPs)

## 7.2.1 Demographic priority areas

The Need Assessment has already identified certain priority groups (demographic and geographic) that are either at a high risk of health issues or are typically under-represented in terms of physical activity participation. This gap analysis will focus primarily on the access of these groups to suitable sport and leisure facility provision. Relevant geo-demographic groups include:

- Under 15 and over 55 years old
- Non British white ethnic groups
- Those with lifestyle related (usually long term) diseases
- Disabled residents
- Within the lower socio-economic groups (NS SEC)/ income deprivation
- Those that live in deprived areas
- Those located across the west of Barnet Borough (including the Underhill area).

The majority of this analysis is based on Lower Super Output Area (LSOA) geographic classifications. This is a standard area classifications with a mean London population size of 1,642 (2010) compared with a Medium Super Output Area (MSOA) of 7,961 residents and ward with an average of 12,640 residents. Therefore we have placed an emphasis on a local level analysis so as to identify specific gaps in provision.

The following table show aggregated ward scores across indicators related to priority groups. The table illustrates the highest priority LSOAs and trends across indicators. These will be compared with accessibility and availability indicators later within this section. The red cells indicate wards that have a high absolute number of individuals in each priority group, the green cells show wards with a low number of residents. These indicators have been selected as they are deemed to be the most current and representative datasets that align with the aforementioned priority groups.

**Table 3: Priority groups at ward level**

		Age		Financial			Ethnicity	Disability/ health		
Ward	Total population	0-15	m65+ f60+	JSA	Income support	Income deprivation (IMD) - avg	Non w hite British	Incapacity benefit	Disability allow ance	Health/disa bility deprivation (IMD) - avg
Brunswick Park	16,699	3,252	2,415	303	410	0.13	5,394	380	610	-1.26
Burnt Oak	18,293	4,347	1,754	524	925	0.27	7,299	680	890	-0.37
Childs Hill	19,209	3,664	2,504	431	605	0.14	8,656	460	520	-0.69
Colindale	15,900	3,539	1,431	377	815	0.28	8,408	580	660	-0.61
Coppetts	16,901	3,136	1,762	422	605	0.17	6,011	490	635	-0.71
East Barnet	17,451	3,327	2,358	374	460	0.12	3,813	400	595	-1.23
East Finchley	14,816	2,792	2,069	326	505	0.17	5,765	460	585	-0.65
Edgware	16,322	3,627	2,347	291	515	0.16	5,334	395	585	-1.06
Finchley Church End	13,896	2,620	2,423	269	225	0.10	5,665	230	315	-1.17
Garden Suburb	14,482	3,091	2,620	130	140	0.05	5,110	130	195	-1.71
Golders Green	17,162	4,762	2,147	337	440	0.16	7,494	405	605	-0.69
Hale	17,680	3,887	2,427	319	550	0.16	6,047	430	650	-1.11
Hendon	17,688	3,679	2,297	295	445	0.14	6,780	435	495	-0.87
High Barnet	15,379	2,695	2,627	215	275	0.08	2,768	320	410	-1.13
Mill Hill	18,520	4,039	2,545	294	460	0.14	5,468	330	530	-1.30
Oakleigh	16,344	3,059	2,683	277	400	0.11	4,366	310	450	-1.21
Totteridge	15,158	2,902	2,624	191	245	0.08	5,438	230	340	-1.51
Underhill	17,275	3,434	2,768	406	610	0.16	3,975	520	700	-0.81
West Finchley	15,204	2,642	2,069	296	355	0.11	7,012	355	470	-0.80
West Hendon	16,677	3,214	1,985	373	515	0.16	8,591	485	595	-0.72
Woodhouse	17,142	3,131	2,384	357	520	0.15	6,869	470	620	-0.81

	High number of residents in each priority group
	Medium number of residents in each priority group
	Low number of residents in each priority group

Source: Population data, ONS 2010 mid-year estimates, Job Seekers Allowance (DWP, 2011), Income Support (DWP, 2010), Index of Multiple Deprivation (IMD) (Communities and Local Government (CLG), 2010), Ethnicity (ONS 2001, 2004 Update), Incapacity Benefit (DWP, 2010), Disability Allowance (DWP, 2010). All data published by the Greater London Authority (GLA, 2012).

Based on the above table the following are key wards that contain a high population of priority groups:

- Burnt Oak
- Childs Hill
- Collindale
- Golders Green
- Underhill
- West Hendon
- Woodside

These are the wards that are most at risk of low levels of physical activity due to perceived and actual access barriers to facilities and services. These findings will be cross-examined with actual physical accessibility for these priority wards to key sport facilities in relation to population projections.

The Needs Assessment has already identified that the population in Barnet is set to grow. The majority of the significant population growth is across the priority wards, including Burnt Oak, Colindale, West Hendon, Golders Green and Childs Hill. This is probably due to regeneration of the area and new housing developments. This will mean further pressure on the existing facilities in these areas.

### ***GLL sport centre catchment analysis***

The break down of resident population for each GLL operated sport centre catchment has been distributed to each centre by priority groups. This has been benchmarked against the local authority average. Each will have an impact on the type of demand for local facilities and services. The analysis of the catchment profile of the six sport centres showed that:

- High percentage of under 15s around Burnt Oak and Church Farm sport centres
- High levels of poor health in the immediate catchment around Hendon Sport Centre
- High levels of long term illness around Finchley, Hendon and Copthall sport centres
- More economically active population around Compton Sport Centre
- High levels of lower socio-economically classifications around Burnt Oak Sport Centre
- Lowest access to cars (therefore on average a smaller catchment) around Church Farm and Copthall sport centres
- Highest levels of deprivation in the immediate vicinity of Burnt Oak Sport Centre.

***See Appendix 5 Chapter 7 for GLL Sport centre demographic catchment profile.***

## GLL sport centre usage analysis

The table below shows that Finchley Lido has by far the largest number of members, compared with Compton Sport Centre, which has the lowest.

**Table 4: GLL member breakdown by sport centre**

	Burnt Oak	Church Farm	Hendon	Finchley Lido	Compton	Copthall Pools
<b>Number of members</b>	3190	2415	4016	12164	159	8155

Source: GLL, 2012 membership data

Table below shows the split of members that reside within the Borough at each centre in terms of gender and age breakdown. The table shows a significantly lower percentage of female members at Compton Sport Centre. When considering the age split at each centre, again very few young members (under 15 years old) are members of the Compton Sport Centre as well as Burnt Oak Sport Centre (both these centres within an immediate 2km catchment have a relatively high proportion of under 15 year old residents). Hendon Sport Centre has the lowest level of over 55 members.

In addition, those members aged 16-34 have the lowest travel time propensity, this may be due to time pressures with respect to work commitments. Older members (over 55) tend to have a higher travel time propensity. This information should be used to inform the required distribution of different type of facilities in respect to resident demographic profiles.

**Table 5: GLL member age and gender profile**

	Burnt Oak	Church Farm	Hendon	Finchley Lido	Compton	Copthall Pools	Avg travel time(for Barnet residents) - mins
<b>Total (gender)</b>	<b>3127</b>	<b>2414</b>	<b>4009</b>	<b>12153</b>	<b>159</b>	<b>8139</b>	
<b>Male</b>	<b>51%</b>	<b>46%</b>	<b>50%</b>	<b>48%</b>	<b>72%</b>	<b>49%</b>	<b>5.82</b>
<b>Female</b>	<b>49%</b>	<b>54%</b>	<b>50%</b>	<b>52%</b>	<b>28%</b>	<b>51%</b>	<b>6.19</b>
<b>Total (age)</b>	<b>3048</b>	<b>2407</b>	<b>3948</b>	<b>12104</b>	<b>158</b>	<b>8137</b>	
<b>Age 0-15</b>	<b>20.4%</b>	<b>66.4%</b>	<b>49.4%</b>	<b>48.6%</b>	<b>10.8%</b>	<b>40.5%</b>	<b>6.48</b>
<b>16-34</b>	<b>46.7%</b>	<b>8.6%</b>	<b>30.8%</b>	<b>23.6%</b>	<b>41.8%</b>	<b>20.7%</b>	<b>5.24</b>
<b>35-54</b>	<b>24.9%</b>	<b>12.8%</b>	<b>16.0%</b>	<b>17.5%</b>	<b>39.2%</b>	<b>18.3%</b>	<b>5.57</b>
<b>55+</b>	<b>8.0%</b>	<b>12.2%</b>	<b>3.8%</b>	<b>10.3%</b>	<b>8.2%</b>	<b>20.6%</b>	<b>6.81</b>

Source: GLL, 2012 membership data

Table below shows the split of membership at each sport centre in terms of ethnicity. The table shows that Church Farm Sport Centre has relatively fewer members from ethnic minority origins, whereby Burnt Oak and Compton sport centres attract a relatively higher proportion. The centres with the highest resident population from an ethnic minority group are Hendon, Church Farm and Compton. Often certain facilities are not appropriate for certain types of ethnic minority groups and are a key barrier to participation. This should be explored further, particularly at Church Farm Sport Centre.

**Table 6: GLL member ethnicity profile**

	Burnt Oak	Church Farm	Hendon	Finchley Lido	Compton	Copthall Pools	Avg travel time (for Barnet residents) - mins
<b>Total</b>	<b>2169</b>	<b>1398</b>	<b>2173</b>	<b>7293</b>	<b>92</b>	<b>5853</b>	
<b>British</b>	<b>43.4%</b>	<b>70.3%</b>	<b>59.3%</b>	<b>64.1%</b>	<b>40.2%</b>	<b>66.3%</b>	<b>6.43</b>
<b>Pakistani</b>	<b>2.1%</b>	<b>0.3%</b>	<b>0.8%</b>	<b>0.6%</b>	<b>0.0%</b>	<b>1.6%</b>	<b>5.69</b>
<b>Eastern European (New EU)</b>	<b>0.4%</b>	<b>0.1%</b>	<b>0.2%</b>	<b>0.1%</b>	<b>1.1%</b>	<b>0.1%</b>	<b>3.24</b>
<b>Mixed Ethnicity</b>	<b>0.5%</b>	<b>0.1%</b>	<b>0.2%</b>	<b>1.7%</b>	<b>0.0%</b>	<b>0.3%</b>	<b>5.86</b>
<b>Black African</b>	<b>3.9%</b>	<b>1.6%</b>	<b>0.7%</b>	<b>1.1%</b>	<b>0.0%</b>	<b>0.7%</b>	<b>5.68</b>
<b>Other Asian / British Asian</b>	<b>2.6%</b>	<b>2.6%</b>	<b>3.0%</b>	<b>2.6%</b>	<b>3.3%</b>	<b>3.7%</b>	<b>6.78</b>
<b>Chinese</b>	<b>2.8%</b>	<b>0.8%</b>	<b>2.3%</b>	<b>1.0%</b>	<b>4.3%</b>	<b>1.7%</b>	<b>3.24</b>
<b>Black / British Black (African)</b>	<b>5.6%</b>	<b>1.9%</b>	<b>3.2%</b>	<b>2.7%</b>	<b>0.0%</b>	<b>3.3%</b>	<b>5.86</b>
<b>White &amp; Black African</b>	<b>1.9%</b>	<b>0.2%</b>	<b>0.9%</b>	<b>0.8%</b>	<b>0.0%</b>	<b>0.7%</b>	<b>5.68</b>
<b>Black Caribbean</b>	<b>2.6%</b>	<b>0.4%</b>	<b>0.2%</b>	<b>0.4%</b>	<b>0.0%</b>	<b>0.2%</b>	<b>6.78</b>
<b>White &amp; Asian</b>	<b>1.9%</b>	<b>0.9%</b>	<b>1.1%</b>	<b>0.9%</b>	<b>4.3%</b>	<b>1.0%</b>	<b>6.32</b>
<b>Antipodean</b>	<b>0.6%</b>	<b>0.1%</b>	<b>0.1%</b>	<b>0.1%</b>	<b>1.1%</b>	<b>0.1%</b>	<b>4.69</b>
<b>White &amp; Black Caribbean</b>	<b>1.5%</b>	<b>0.2%</b>	<b>0.5%</b>	<b>0.9%</b>	<b>0.0%</b>	<b>0.4%</b>	<b>5.69</b>
<b>Other Black / Black British</b>	<b>0.7%</b>	<b>0.1%</b>	<b>1.0%</b>	<b>0.4%</b>	<b>0.0%</b>	<b>0.5%</b>	<b>6.18</b>



Indian	6.7%	2.3%	3.3%	5.2%	10.9%	4.4%	5.37
ALL other	22.8%	18.1%	23.2%	17.4%	34.8%	15.0%	

Source: GLL, 2012 membership data

Table below shows the split of members reporting a medical disability or impairment at each of the six sport centres. The table suggests that Copthall Sport Centre has the highest proportion of disabled members. In terms of actual number of members, Finchley Lido has the highest absolute number of members with a disability. Centres should explore whether the provision at these sites is tailored accordingly, particularly those that have a high level of local residents that are disabled or have a long-term illness (Hendon, Finchley Lido and Compton centres).

**Table 7: GLL member (Barnet) disability/ medical condition profile**

	Burnt Oak	Church Farm	Hendon	Finchley Lido	Compton	Copthall Pools	Avg travel time (for Barnet residents) - mins
<b>Total</b>	<b>1309</b>	<b>1185</b>	<b>2169</b>	<b>7644</b>	<b>48</b>	<b>4762</b>	
<b>Health / Other Impairment</b>	<b>0.5%</b>	<b>0.8%</b>	<b>0.9%</b>	<b>0.7%</b>	<b>2.1%</b>	<b>0.5%</b>	<b>6.98</b>
<b>Learning disability</b>	<b>1.2%</b>	<b>1.0%</b>	<b>0.2%</b>	<b>1.3%</b>	<b>0.0%</b>	<b>1.2%</b>	<b>7.40</b>
<b>Multiple Impairment</b>	<b>0.0%</b>	<b>0.1%</b>	<b>0.0%</b>	<b>0.3%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>6.65</b>
<b>Visual Impairment</b>	<b>0.2%</b>	<b>0.2%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.2%</b>	<b>6.80</b>
<b>Physical Impairment</b>	<b>0.5%</b>	<b>0.3%</b>	<b>0.0%</b>	<b>0.4%</b>	<b>0.0%</b>	<b>0.5%</b>	<b>6.78</b>
<b>Hearing Impairment</b>	<b>0.0%</b>	<b>0.1%</b>	<b>0.1%</b>	<b>0.2%</b>	<b>0.0%</b>	<b>0.0%</b>	<b>6.21</b>
<b>Other disability</b>	<b>1.60%</b>	<b>0.50%</b>	<b>0.90%</b>	<b>0.20%</b>	<b>2.10%</b>	<b>0.90%</b>	
<b>No disability</b>	<b>96.0%</b>	<b>97.0%</b>	<b>97.9%</b>	<b>96.9%</b>	<b>95.8%</b>	<b>96.7%</b>	<b>6.41</b>

Source: GLL, 2012 membership data

These centres that have a relatively lower level of membership amongst particular demographic groups should explore the type of facilities and services being offered and whether they are suitable and are being adequately promoted to priority groups. The level of priority group membership conversion at a localised (ward) level is explored further within this section to identify geographic disparities between centre membership in relation to the wider demographic profile of the Borough.

The distribution of priority group GLL members was compared with accessibility (travel times) to each centres. If the travel time is high then we would not expect a high number of

members, however with low travel times (good accessibility) we would expect to see higher levels of members. Wards that have notably fewer members from priority groups than expected (given their proximity to one or more of the sport centres) include:

- Childs Hill
- Edgware
- High Barnet
- Underhill

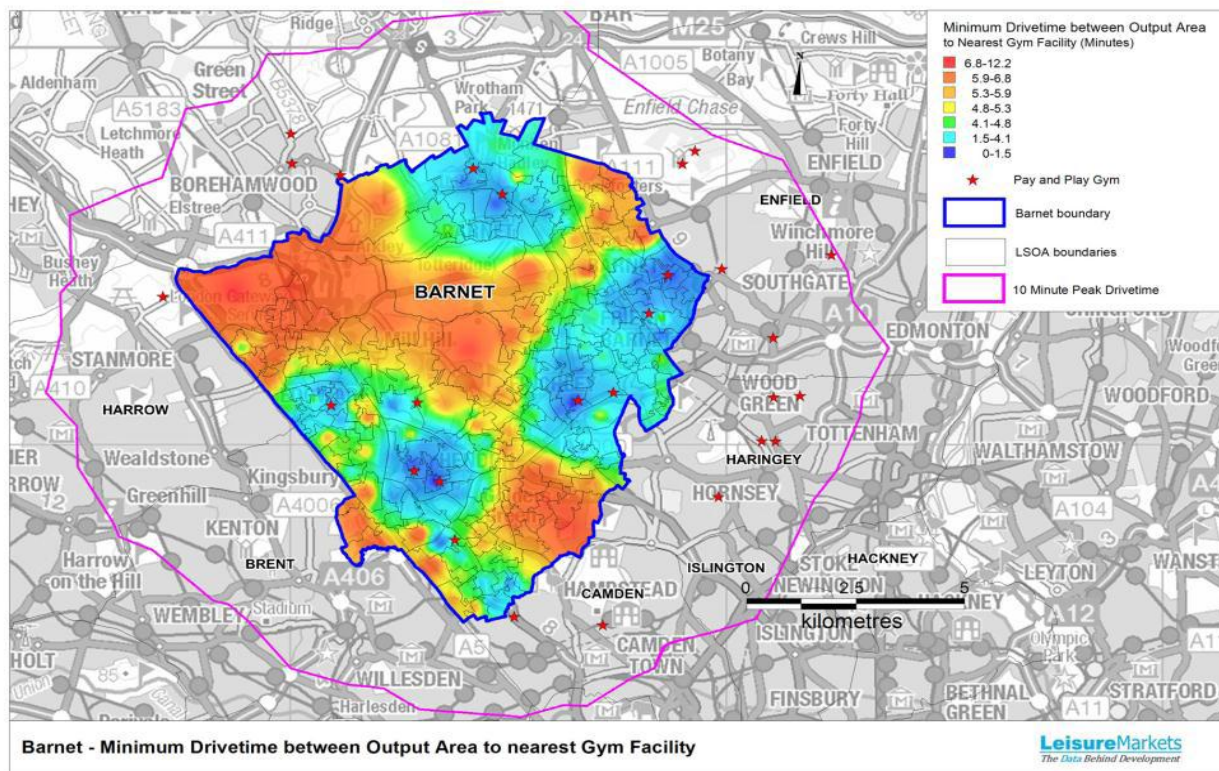
**Further information can be found in Appendix 5 Table 1.**

## 7.2.2 Facility travel time accessibility

As part of a comprehensive gap analysis it is vital to consider physical accessibility and travel times to facilities. The following map illustrates the relative levels of accessibility (travel times) to the nearest pay and play facilities across Barnet. Pay and play provision is the access type associated most with informal casual usage and is the most available to those that cannot afford memberships or sport club fees. The analysis takes into account facilities that fall outside the Borough of Barnet but within a 10-minute peak time buffer.

Map X shows the travel time (by road) to pay and play gym provision. The map shows that areas with poorest access to these gym sites are Edgware, West Hendon, Garden Suburb, Hale, Mill Hill and East Barnet.

**Figure 1: Pay and play gym (health and fitness accessibility)**



**Additional maps for accessibility for sport halls, swimming pools and synthetic turf pitches (STPs) in the Borough can be found in Appendix 6 Chapter 7.**

In summary the key gap areas in pay and play provision are:

- a) Health and fitness: Edgware, Hale, Mill Hill, Totteridge, Garden Suburb and East Barnet.
- b) Swimming: High Barnet, Burnt Oak, West Hendon, Golders Green and Childs Hill.
- c) Sport halls: Edgware, Hale, Burnt Oak, Mill Hill, West Hendon, Childs Hill and Garden Suburb.
- d) STPs: High Barnet, East Barnet, Oakleigh, Brunswick Park.

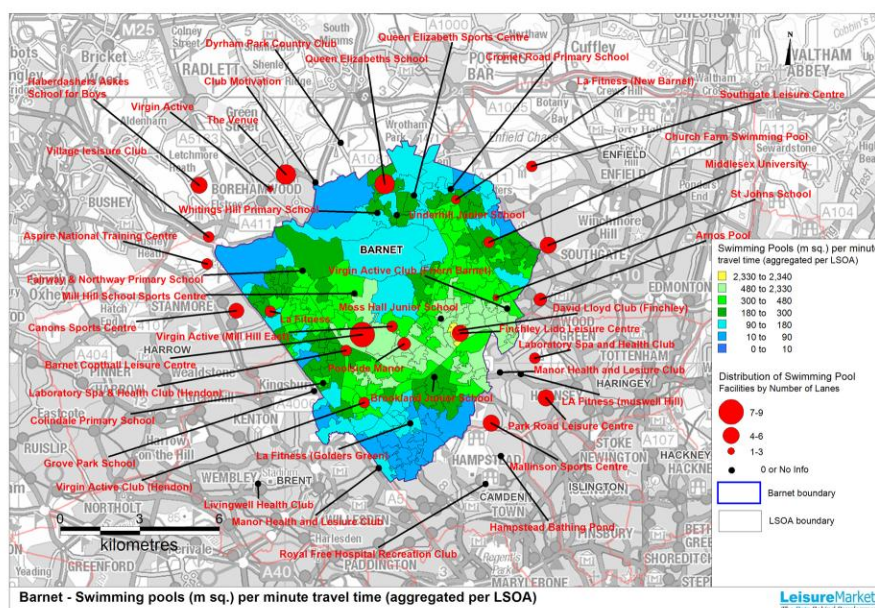
### **7.2.3 Facility availability**

The following section explores levels of accessibility to all facilities (of all access types) and considers the size of facilities (as an indicator of capacity).

The following map consider the size of facilities (as an indicator of capacity) and the travel time to facilities (of all access types and sizes). This is based on a ratio of facility size to unit of travel time and aggregated to a LSOA area for all facilities that fall within a 10-minute drive time catchment from the centre of each LSOA. A breakdown of these scores (averaged to ward level) can be found split by access type within Appendix A. As per the accessibility maps earlier, the availability ratio takes into account facilities that lie outside Barnet but within a 10-minute peak time travel time. The map shows facility location with the size of dots representing the relative facility size.

Figure 2 shows the relative availability of sport halls (number of courts per travel time ratio) across the Borough. Areas of relative low provision are across the south and south east (Golders Green, Childs Hill and Garden Suburb) and around the northern boundary of the Borough (Edgware, High Barnet and parts of East Barnet).

#### **Figure 2: Sport hall availability**



Health and fitness: Edgware, High Barnet, West Hendon, Garden Suburb and East Barnet have the lowest levels of health and fitness availability (number of stations per travel time unit), There are also relatively low levels in the central region around Underhill and Totteridge wards.

Swimming pool: Edgware and parts of Golders Green as having lowest levels of availability of swimming pool provision (water space per travel time ratio).

STPs: Low levels of availability of STPs (pitch area per travel time ratio) are primarily located in Edgware and High Barnet however there is a large area running from the north through to the centre of Barnet that also has relatively poor levels of availability (includes Underhill and Totteridge wards).

**Maps for availability for health and fitness (gyms), swimming pools and synthetic turf pitches (STPs) in the Borough can be found in Appendix 7 Chapter 7.**

Overall across all facility types the area of the Borough that consistently has low levels of availability is the western part of Edgware ward. This analysis only takes into account supply and not demand. Therefore the following analysis aggregates the availability to a ward level (as opposed to LSOAs above) and looks at population changes.

Linked to the above maps, the following table shows the ratio of availability for each ward for each facility type and compares this with population projections and net changes through to 2031. The darker red cells within the table show relatively low levels of availability and high net population increases. There are currently low ratios (facilities capacity per travel time) and significant projected increases in population in the following areas (these should be a priority for the development of additional new facilities):

- Colindale (gyms)
- Golders Green (halls and pools)
- Mill Hill (gyms)

Regardless of population changes, there are also relative low levels of sport halls availability in Burnt Oak and Garden Suburb; swimming pools in Burnt Oak, Childs Hill and Garden Suburb; gyms in Totteridge; and STPs in Totteridge too.

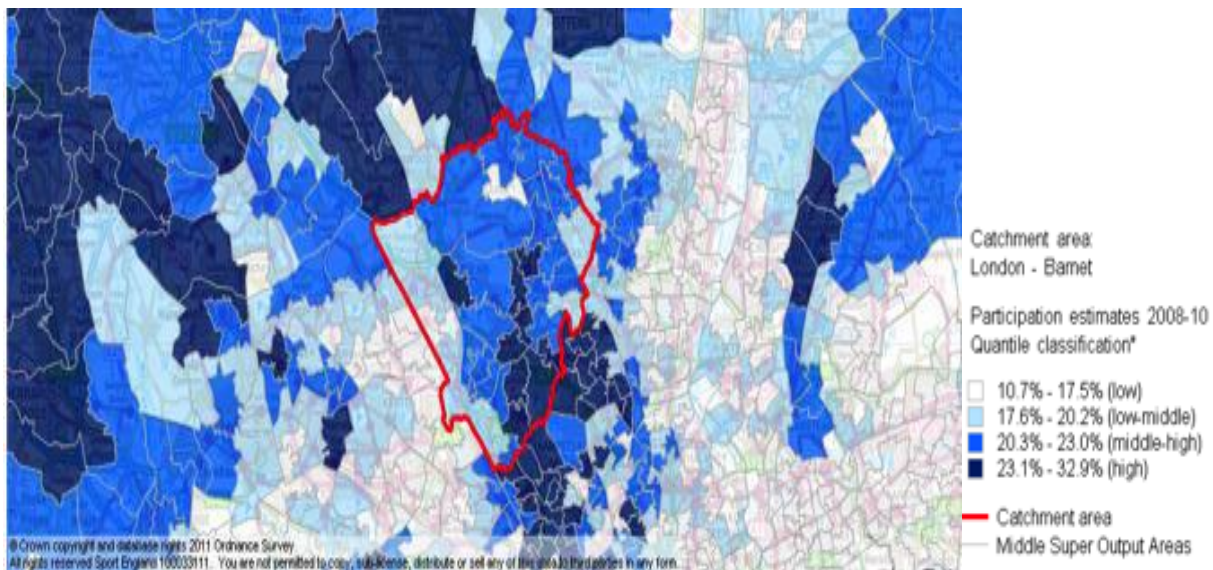
**Table 8: Facility share and population projections**

WARDS	Facility share per minute travelled (Aggregated 10 min LSOA catchments)				Population projections (GLA)		
	Halls (courts/min)	Pools (m2/min)	Gyms (stations/min)	STPs (m2/min)	2012	2031	Net increase
Brunswick Park	7.00	224.81	114.70	5217.05	16617	17354	4.4%
Burnt Oak	3.85	159.41	173.10	4407.56	17507	19346	10.5%
Childs Hill	4.91	184.90	255.87	5024.04	18852	20619	9.4%
Colindale	7.11	344.39	141.96	3894.11	19834	38529	94.3%
Coppetts	8.41	395.56	156.93	5482.70	15728	15795	0.4%
East Barnet	6.67	359.28	147.64	4354.25	16328	17292	5.9%
East Finchley	4.62	348.76	115.41	2985.82	15204	15597	2.6%
Edgware	6.85	391.76	152.22	3866.08	16431	17524	6.7%
Finchley Church End	4.99	294.84	133.65	2750.81	15179	15875	4.6%
Garden Suburb	3.50	142.20	167.82	3720.17	15507	15995	3.1%
Golders Green	4.41	212.48	158.03	6394.49	18533	34104	84.0%
Hale	7.46	362.89	155.94	4385.65	16690	16834	0.9%
Hendon	7.47	305.69	157.74	3482.16	16481	16592	0.7%
High Barnet	5.59	297.44	111.47	2546.55	15451	16075	4.0%
Mill Hill	7.62	361.84	127.35	3606.07	17729	22928	29.3%
Oakleigh	7.18	294.20	117.07	2705.37	15969	16768	5.0%
Totteridge	5.83	252.97	94.29	1880.02	15439	18065	17.0%
Underhill	7.52	371.90	150.67	2274.36	16756	18143	8.3%
West Finchley	6.62	330.16	169.38	3343.19	15232	16202	6.4%
West Hendon	9.68	656.98	261.13	5316.42	16024	22175	38.4%
Woodhouse	7.88	352.41	159.01	3594.44	17157	17869	4.2%

Comparing the above data with current participation rates (following figure) the low levels of gym and swimming provision in the south and west may be impacting on general physical activity rates. This area has some of the most deprived communities (income and health) and has the highest population growth forecasts. Triangulating this participation data with the supply analysis and population projections, key wards that should be a priority are Edgware, Golders Green and Colindale. In addition, despite having Burnt Oak Sport Centre located in its ward, Burnt Oak has some of the lowest participation rates and availability of sport halls and swimming provision in the Borough.



**Figure 3: 3 x 30 mins per week physical activity rates (Sport England, APS4, 2010)**



Source: Sport England, Active People 4 Survey (2010)

## 7.2.4 Trend analysis in relation to priority groups

This section will consider current usage patterns of different type of GLL users and compare them with the overall resident population within each priority group classification in each ward. The results should only be used as a guide as proxy indicators have been used to develop ratios.

Wards that have significantly lower numbers of members than expected given the relatively high resident population (of each demographic classification) include:

- Childs Hill (all priority groups) - also low facility share (availability) of halls and pools
- Colindale (income)
- Edgware (under 15 years old)
- Garden Suburb (ethnic minority groups) - also low facility share (availability) of halls and pools
- Underhill (all priority groups).

The under representative wards with the highest (aggregated) travel time to their nearest GLL sport centre are:

- Underhill (11 minutes drive time)
- High Barnet (11 minutes drive time) – also low facility share (availability) of gyms and STPs

- Garden Suburb (10 minutes drive time)
- Edgware (9 minutes drive time)

As we would expect, there is a direct trend between travel time accessibility and priority group membership conversion although the results suggest that conversion rates in Colindale should be higher (as there is relatively better accessibility in comparison to other wards). The under represented population group is those with income deprivation, therefore the main barrier to accessing provision, particularly at the closest facility (Finchley Lido), may be the pricing structure. This does also emphasise the importance of facility availability (and facility capacity) which is low for all core facilities across Colindale, suggesting this should be a priority ward for more affordable facilities.

***The details can be found in Appendix 8 in Table 1.***

In terms of facility share in addition to the priority areas listed above the following wards should be prioritised:

- Burnt Oak ward: low availability (facility share) of halls and pools and also low conversion levels amongst those reporting a disability
- Brunswick Park: low availability of pools and gyms and low ethnicity conversion rates
- Totteridge: low availability of gyms and STPs and low ethnicity conversion rates.

***The details can be found in Appendix 8 in Table 2.***

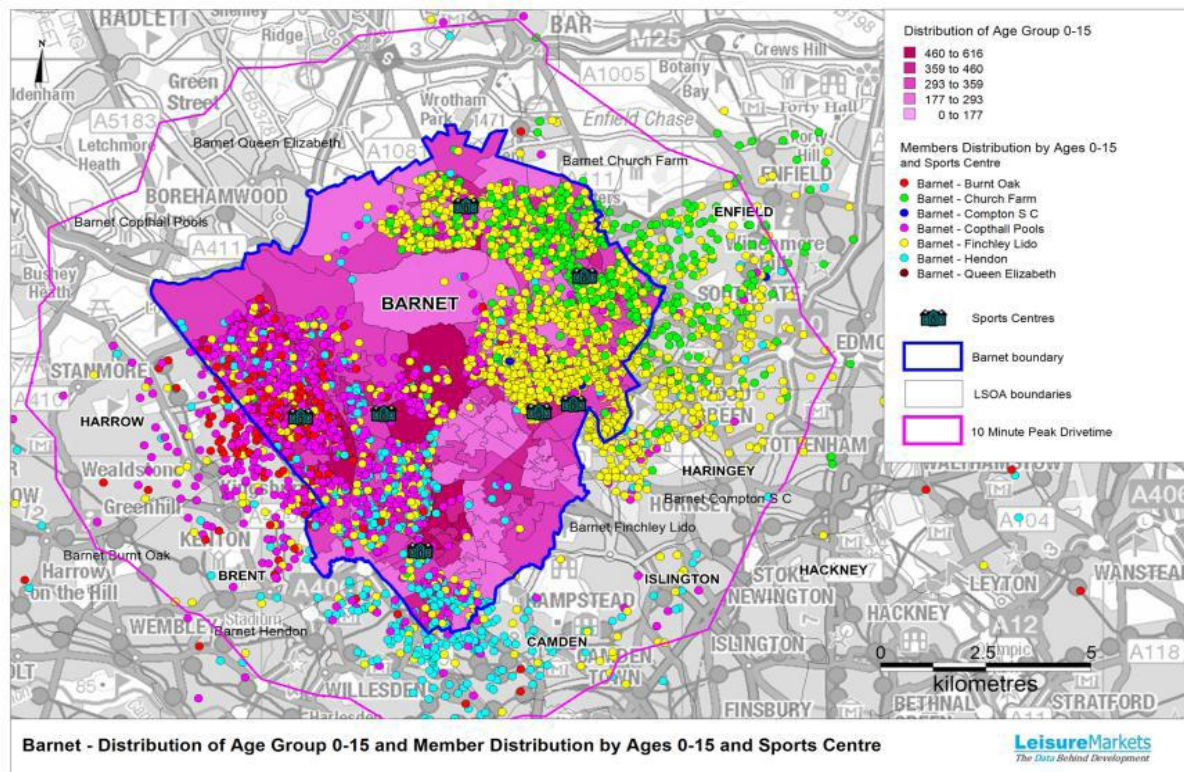
## ***Priority group membership***

The following maps are related to the above membership conversion analysis and illustrate the distribution of priority group GLL members against the priority group resident population (base mapping) for the Borough. Each map also shows the respective home sport centre of each member. Therefore it is possible to firstly identify areas where conversion rates are relatively low (where there are low numbers of priority group members despite having a relative high resident population within the LSOA), often despite being close to a sport centre. Where there is a high population of priority group residents (who are under represented in terms of membership), further investigation should be taken into the availability of their most local sport centre, the type of facilities (and access policies) and to what extent these can be successfully promoted within these local communities to influence participation behaviour. This should be undertaken in line with a review of programming at the sport centres and existing (actual) levels of utilisation and capacity.

**Figure 4** shows the level of residents age 0-15as base mapping (as an indicator of child and youth location) and shows an overlay of where those GLL members aged 0-15 years old reside. The map suggests the following:

- Under represented LSOAs (low membership conversion rates) in the centre of the Borough (Mill Hill) despite Copthall Swimming Pool being located nearby.
- Very few members reside in the south east or north west (possible physical access barriers south of Compton Sports Centre and Finchley Lido).
- Hendon, Finchley Lido and Church Farm attract a high number of young members from outside of Barnet.

**Figure 4: Aged 0-15 (resident population) and aged 0-15 members**



Maps for the GLL members who are on incapacity benefit, income support, disability allowance, older people, ethnic minorities and concessionary members can be found in **Appendix 9 Chapter 7**. Based on the information obtained from these maps, following suggestions can be made:

### **Incapacity benefit (resident population) and disabled GLL members**

- Under represented LSOAs (low membership conversion rates) on the south west borders of the Borough and directly south of Finchley Lido.
- Disabled members travel from a wide area across Finchley Lido to access the facility.
- No disabled members are located in the south east of the Borough despite a significant disabled resident population.

### **Older person (resident population) and older members**

- Significant under representation in across Edgware, High Barnet, Underhill and Totteridge wards. There is also limited GLL sport centre provision in these areas.
- Very few elderly members from the south east of the Borough (south of Finchley Lido).

### **Index of multiple deprivation (resident population) and concessionary members**

- A significant number of concessionary memberships are provided to those travelling from outside of Barnet.
- Few concessionary members in the south east or north west of the Borough.



### **income support (resident population) and concessionary GLL members**

- Parts of Mill Hill and East Finchley have low number of members despite a relative large income deprived population.
- Finchley Lido attracts a wide spread of concessionary members from across Barnet and outside of the Borough.

### **Ethnic minority (resident population) and ethnic minority GLL members**

- Parts of Childs Hill, West Hendon and West Finchley are under represented – this may relate to the type of facility provision and access at Finchley Lido and Hendon Sport Centre.
- Few members reside in the south east, central and north west areas of the Borough.

### **Disability allowance (resident population) and disabled GLL members**

- Under represented LSOAs (low membership conversion rates) in wards such as Mill Hill, Childs Hill, Golders Green, East Barnet and East Finchley.
- Finchley Lido is again the most popular site in terms of attracting members from across the Borough.

## *Supply and demand analysis*

The previous gap analysis focussed on facility provision and geographical access for different demographic groups, considering the availability of facilities for all Barnet residents. It is also important to consider the overall balance of facility provision across Barnet, levels of potential under and oversupply and existing trends that may impact future demand for types of provision. This type of facility planning improves the efficiency and effectiveness by which facilities are developed and ensures that funding is based on objective and quantifiable need.

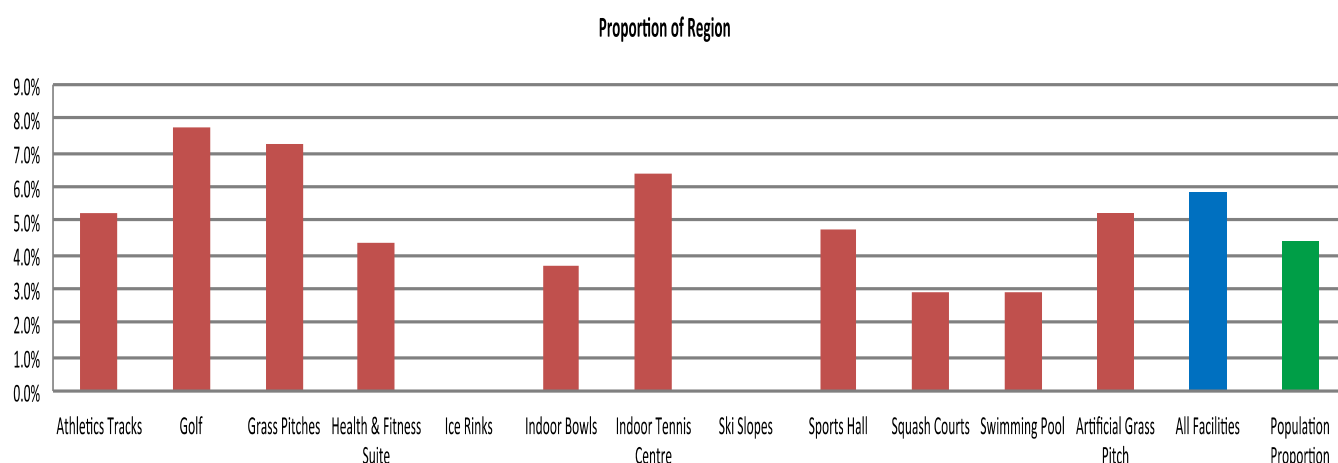
This section covers the following areas:

- Benchmarking facility supply
- Benchmarking demand
- Facility planning model results (Sport England)

### **7.3.1 Benchmarking facility supply**

The figure below illustrates the relative supply of sport facilities across Barnet. The figure suggests a relatively high supply of all sport facilities within Barnet with the exception of indoor bowls, squash courts and swimming pools. This will be compared with participation rates and trends later in this section. There is relatively high provision of golf, grass pitch and indoor tennis courts.

**Figure 5: Sport supply benchmarking**



The following table benchmarks the supply of facilities against neighbouring local authorities and the London average. The table suggests that the supply of facilities in the Borough is generally in line with the average with the exception of gym and swimming pool provision, which is low.

**Table 9: Facility share per 1,000 population – local authority benchmarking**

LOCAL AUTHORITY	Facility share per 1,000 residents population					
	Gym (stations)	Halls (m2)	Pools (m2)	STPs (pitches)	Indoor Tennis (courts)	Indoor Bowls (rinks)
Barnet London Boro	7.15	73.9	17.24	0.03	0.05	0.03
Brent London Boro	5.05	77.89	6.79	0.03	0	0.02
Camden London Boro	13.83	49.42	30.51	0.01	0	0.03
Enfield London Boro	4.23	65.38	12.15	0.04	0.03	0.07
Haringey London Boro	6.64	65.68	15.75	0.04	0.01	0
Harrow London Boro	4.49	54.55	14.95	0.03	0	0.03
Hertsmere	12.24	127.23	37.99	0.07	0.14	0
LONDON	17.66	65.95	28.49	0.03	0.03	0.02

### 7.3.2 Benchmarking demand

The Needs Assessment has already identified that generally physical activity and levels of sport participation in the Borough are low and there is a continual decline across several activities mainly in hall-based and swimming activities.

Table 10 uses Sport England's Market Segmentation tool (2012) to estimate the levels of met demand (residents participating in activities) and levels of latent demand (where residents have indicated a desire to participate in more of a particular activity) for residents within

Barnet and across the North London County Sports Partnership (CSP). The results are based on a sample survey and extrapolated set of demographic and participation indicators. The table suggests that, relative to the size of participating demand, there is relatively large additional demand for tennis, swimming and badminton. In terms of absolute numbers there is a significant amount of potential unmet demand for swimming (across Barnet and North London), gym (health and fitness) and tennis.

**Table 10: Market segmentation sport demand**

SPORT	Barnet			North London (CSP)		
	Participate	Would like to participate more	Latent Demand Percentage	Participate	Would like to participate more	Latent Demand Percentage
Badminton	6717	5534	82%	19842	17515	88%
Basketball	2145	1407	66%	6680	4634	69%
Bowls	1817	412	23%	5718	1345	24%
Football	22627	4286	19%	68508	13426	20%
Hockey	1188	604	51%	3061	1794	59%
Swimming	39660	36788	93%	119181	119319	100%
Tennis	7184	7521	105%	19506	22211	114%
Squash	3796	2241	59%	10755	6892	64%
Volleyball	1407	339	24%	4443	1130	25%
Keep fit and gym	51061	19214	38%	153897	62291	40%

Figure 6 is based on the Active People 5 Survey (Sport England 2010/11) and illustrates the relative participation rates for the most popular sports in the Borough. Considering (as identified above), the supply of swimming provision is currently relatively low, the actual participation rate is high. This (in addition to the market segmentation data above) would suggest there is local demand for further swimming provision. However, gym participation rates are relatively low compared with the London region, despite facility provision being in line with the London average (suggesting a possible oversupply).

**Figure 6: Highest sport participation rates (Barnet)**

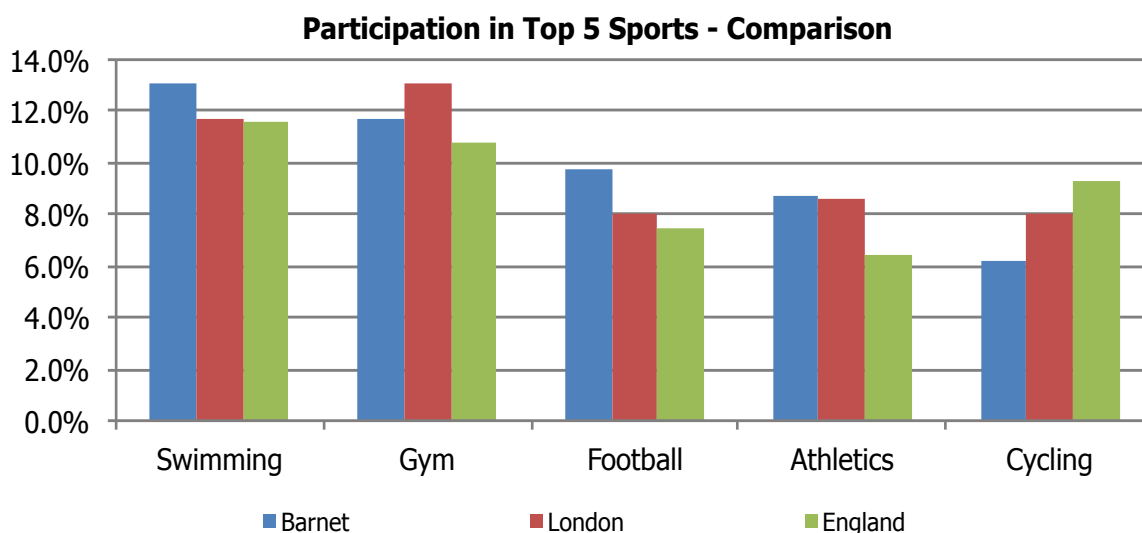
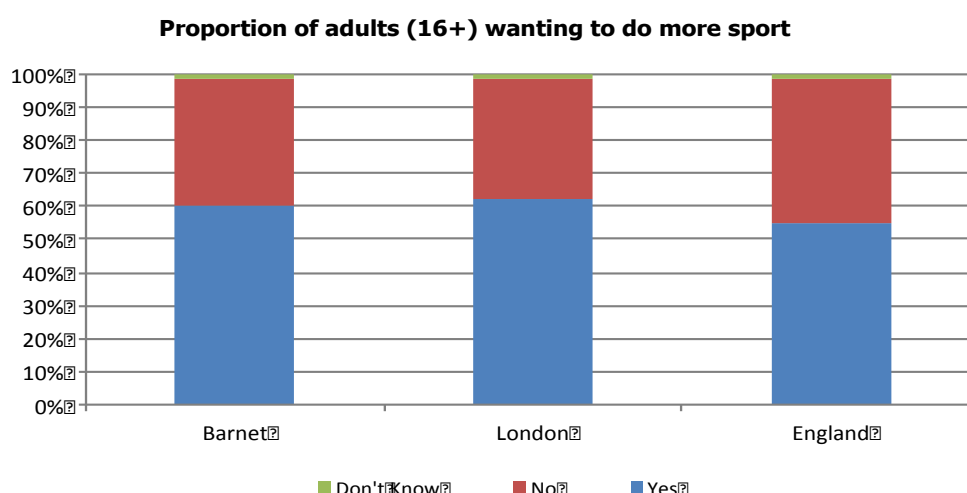


Figure 7 reiterates the relatively high number of individuals in Barnet and London that would like to do more sport but are limited by one or more of a number of barriers (including facility capacity, access, price and available time).

**Figure 7: Latent demand (Barnet)**



Satisfaction with sport provision in the borough is significantly lower than at the national level. Only 57.4% of adults living in Barnet are satisfied with sports provision compared to 69% at the national level (APS 4). This is reflected within the relatively low physical activity levels.

### ***Facility Planning Model results (Sport England)***

The facilities planning model is used as best practice model for identifying latent demand. This demand is based on GLA 2021 population projections and analysed at a local authority level. Assumptions are based on nationwide surveys and consider the following:

- Capacity of different types of facilities of varying sizes – based on a peak time capacity (visits per peak period per week)
- Age of facilities and date of refurbishments (therefore attractiveness)

- Opening hours and access policy
- Travel time decay and resident mobility
- Demographic profile of catchments and population projections
- Cross border migration of users (import and export of demand)
- Supply scaled to account for a comfort factor
- GLA 2021 population projections (Barnet 373,408)
- Minimum size of facilities (3 courts/ 160 sq m water space/ 75x45m STPs)
- North London Sub Region consists of Barnet, Enfield and Haringey.

***Facility Planning Model result tables and maps can be found in Appendix 10 Chapter 7.***

## **Sports Halls**

The results for sport hall provision for Barnet, North London and London are summarised below:

- The 16 sports hall sites in Barnet supply 12,327 visits in the weekly peak period, Enfield's 15 sites supply 12,573 visits and Haringey's 16 sites supply 13,919 visits in the weekly peak period. The 2021 population projections mean an additional 613,914 residents across North London by 2021, this has a significant impact on demand (an additional 22,216 sport hall visits, equating to 27 new sport halls alone).
- A relatively lower percentage of Barnet residents have access to a car (19.1%) compared with the North London average (24.9%)
- In the North sub-region it is estimated that some 75% of all visits to sports halls are by car, 4% by public transport and 21% of visits by walk to. In Barnet the percentages are much different, with 81% of visits to pools being made by car, only 3% by public transport and 16% on foot.
- Sports halls are comfortably full when at 80% of capacity. Barnet has the highest court shortfall (47 courts) compared with Enfield (23 courts) and Haringey (11 courts).
- Generally high levels of satisfied demand across North London (although lowest in Barnet), meaning that hall capacity, access and location are generally well distributed across the region. In Barnet there is a high level of satisfied demand amongst those with access to a car (and high car ownership rates). A lot of these users prefer to drive to sites outside of the Borough. Satisfied demand by those that walk or use public transport is low.
- To meet the demands of all residents inside Barnet, the Borough would require 14 further courts, equating to 3.5 four-court sport halls. This should be easily realized through greater access to school sites. The highest levels of aggregated unmet demand are between Hendon South, through Golders Green and to the Camden border. In this area the values of the 1km grid squares range between 10 - 15 badminton courts as aggregate unmet demand.
- Barnet is a net exporter of demand, mainly due to capacity.

## Swimming Pools

The results for swimming pool provision for Barnet, North London and London are summarised below:

- Barnet has 18 pools on 13 sites. This should provide a network of local accessible pools across the borough especially as this one Borough has 52% of the total number of swimming pool sites in the North sub region.
- Again there is a reliance on high car access within Barnet which increases the catchment of swimming facilities.
- In terms of supply/demand there is a shortfall of approximately one 25mx4 lane pool (212 sqm) in Barnet. There is significant under supply in Enfield and Haringey compared with Barnet. This should represent a commercial opportunity for Barnet facilities to attract more users, subject to available capacity.
- Across the North sub region there is still a high level of satisfied demand. Some 89.3% of the total North sub region demand for swimming is satisfied demand. This means that some 89% of the total demand for swimming is within the catchment area of a swimming pool and there is sufficient capacity at the pools to absorb the demand.
- In Barnet the estimate is that in 2021 some 77.4% of all satisfied demand visits to pools are by car and in Enfield it is 74.5%. The average for the North sub region is 70.9% and for London it is 62.2%.
- Unmet demand is created by two factors (1) there is too much demand for a swimming pool to absorb all the demand in its catchment area and there is no other pool within the catchment area of where the demand is located which can absorb this demand and (2) demand is located outside the catchment areas of a swimming pool and is then defined as unmet demand.
- Of the 91.1% of unmet demand in Barnet due to accessibility, some 86.7% is from demand which does not have access to a car and is therefore the swimming demand which travels to pools on foot or by public transport. These two travel modes have much smaller than car borne catchment areas at 20 minutes/1 mile for walkers and 15 minutes by public transport.

## Synthetic Turf Pitches

The results for STP provision for Barnet, North London and London are summarised below:

- Barnet has the highest net shortfall of pitches (6) compared with Enfield (2) and Haringey (4).
- 84.5% of met demand within Barnet is by car travel (highest in North London).
- Barnet has the lowest level of retained demand within North London (52% of demand is exported).
- **Barnet has an unmet demand of 38.2% of total demand and this equates to just over 4 pitches. The majority if unmet demand in Barnet and across**

**North London is due to capacity. This is predominantly amongst those with cars (77.5%) in Barnet.** This reflects the high levels of car ownership but does show flexibility in terms of locating new sites. It may be feasible to locate a site in a relatively small local population (possibly with high levels of a priority group) but can be accessed across a wider catchment by those with car access.

- **In Barnet the highest levels of unmet demand are in the Hendon area.**

The following table, based on FPM data, shows the relative share (which uses capacity, catchment size and availability of facilities i.e. the share of opportunity for local residents to use a facility type). The table emphasises the need for more sport hall provision in Barnet.

**Table 11: Facility Planning Model – Relative share (based on GLA average)**

Relative share +/- from GLA share	Barnet	North London CSP	London	Enfield	Haringey
<b>Sport halls</b>	<b>-16</b>	<b>-8</b>	<b>0</b>	<b>8</b>	<b>-16</b>
<b>Swimming pools</b>	<b>18</b>	<b>-8</b>	<b>0</b>	<b>-15</b>	<b>-36</b>
<b>STPs</b>	<b>8</b>	<b>6</b>	<b>0</b>	<b>15</b>	<b>-8</b>

## 7.4 Summary of key findings

The leisure facility mapping has identified that leisure services are provided across the borough by GLL. There are several venues and analysis has shown that though these are open to all residents, local populations attend local venues with an average of 43.3% of people attending sports facilities living within 2km distance from these. The main exception on this would be Church Farm Swimming Pool which serves a large number of Enfield residents. In addition, users of Finchley Lido have a higher propensity to travel to the site from across Barnet Borough.

The gap analysis has identified the physical access gaps in provision, relating to both facility size and capabilities. It has also explored the relationship between the resident population across the Borough of Barnet and the current membership profiles of GLL members at the six main sport centres. By examining the demographic profile of the Borough, as well as population projections, it has been possible to relatively compare the nature of gaps in provision and levels of current and future need. This has been considered in line with the priority groups, identified within the wider Need Assessment.

### **Priority groups**

The largest priority group populations are located on the west and south west of the Borough. Key wards include Burnt Oak, Colindale, Childs hill and East Finchley (to the east). The population between 2012 and 2031 is projected to increase most significantly in the west and central regions of the Borough.

## ***Accessibility***

In terms of physical access to sport facilities the most deprived area across the majority of facility types is the west part of Edgware. Other areas that have relatively low accessibility levels to a selection of facility types include Burnt Oak and Colindale (west), Childs Hill (south), Hale and Mill Hill (central), High Barnet (north, particularly gyms access) and East Barnet (north east, particularly STPs).

When considering facility size as well as travel time, as an indicator of overall availability of facilities, priority wards include Edgware, Golders Green, Childs Hill, Garden Suburb and High Barnet (STPs).

From the analysis it is clear that these gaps in provision have had an adverse effect on participation rates, as evidenced by Sport England's latest findings.

## ***GLL membership gap analysis***

The analysis has reviewed the membership conversion rates at GLL centres in terms of catchments around the centres and also geographic trends across the whole Borough to identify gaps or areas in under representation.

In terms of the performance of actual centres, with respect to the profile of the local catchments they serve, Compton Sport Centre has low levels of female and 0-15 year old members. Hendon Sport Centre has the lowest levels of 55+ year old members. Copthall Pool has the widest catchment area and Compton and Burnt Oak sport centre have the lowest relative levels of ethnic minority group members.

The analysis compared the points of origin of members with their individual demographic profiles to identify which areas of Barnet have the lowest membership conversion rates for different types of priority group indicators. Key wards which should be attracting more members from specific priority groups include Childs Hill, Colindale, Edgware, Garden Suburb and Underhill.

## ***Supply and demand***

The supply and demand analysis has benchmarked levels of supply, considered trends in participation and demand (including latent demand) and utilized Sport England's facility Planning Model.

In terms of supply, this analysis has supported the findings from the Gap Analysis. There are generally low levels of provision across all facilities in the west with wards such as Colindale with minimal levels of facility share for all activities.

In terms of participation, rates in Barnet are relatively low compared with neighbouring authorities and the North London County Sports partnership area and across London. These participation rates have continued to fall at a significant rate, suggesting that urgent action is required.

There has been a slight increase in participation rates for swimming, football and tennis but generally all other activities have seen a decline. There are pockets of latent demand, mainly in the south and south east (and small areas of the south west), which supports the Gap Analysis and suggests that these should be areas where capacity and accessibility need to be reviewed as a matter of priority.

Sport England's Facility Planning Model identified that levels of swimming provision are generally acceptable however new provision will be required as the population grows over the



next ten years. The most significant levels of unmet demand are across sport halls. This can be addressed by firstly opening up more school provision for community use and secondly by addressing the programming at existing sites. It may be possible to relocate indoor football (traditionally on sport halls) onto STPs if available. However, there is also a shortfall in STP provision, equating to approximately four pitches across the Borough (unmet demand).

There is clearly a need for new sport facility provision across the Borough of Barnet and this need will only increase given the significant population growth projections. At the same time there is the opportunity to refine certain facility mixes and relocated facilities so they best meet the needs (and address the gaps) of the local resident population. The planning of new facility provision or the rationalisation of existing facilities should balance the areas of priority identified in the Gap Analysis and the levels of undersupply for particular sports identified within the Supply and Demand section.

# Chapter 8: Literature review (including guidelines) on public health interventions to increase participation in Physical Activity

## *Introduction*

This chapter aims to review the literature to determine barriers, motivators and effective interventions and guidelines on increasing the uptake of physical activity.

## *Methodology*

Given the recent large-scale scientific reviews on physical activity, a set of key documents and websites were identified as the primary sources of evidence and used to underpin this work. The key sources were:

- National Obesity Observatory <http://www.noo.org.uk/>
- Obesity Learning Centre <http://www.obesitylearningcentre-nhf.org.uk/>
- Sport England <http://www.sportengland.org/default.aspx>
- The British Heart Foundation National Centre for Physical Activity and Health (BHFNC) <http://www.bhfactive.org.uk>
- Global perspective <http://www.globalpa.org.uk/>
- World Health Organization [http://www.who.int/topics/physical\\_activity/en/](http://www.who.int/topics/physical_activity/en/)
- <http://www.dh.gov.uk/health/search?q=physical%20activity>
- Cochrane Library for interventions to increase physical activity
- <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003180.pub2/abstract;jsessionid=7CE6103399CDFE512C5C5C250F364156.d03t02>
- National Institute of Clinical Excellence <http://www.nice.org.uk/>

Searches were also done on Google (in addition to above sites) initially by searching literature reviews on physical activity/ interventions that increase physical activity/ barriers and motivators of physical activity on above websites and Google. Further searches were done by including search terms; children/ adolescents/ family and community/ adults/ older adults/ sedentary/ Black and ethnic minority groups/ long term conditions/disabilities/ environment, Studies included in this review were from 1990 onwards. To avoid duplication and improve on the quality of results, most of the studies that were included in this review were systematic reviews/meta analysis except in areas where evidence was limited; disabilities and Black and Ethnic Minority Groups.

## 8.1 Summary of key findings

### 8.1.1 Children (see Table 1 in Appendix 1 Chapter 8)

The second of two background reviews for NICE 2007 examining the broader determinants of physical activity for young people<sup>73</sup> summarised the evidence on the views of children about the barriers and facilitators to participation in physical activity, encompassing sport, play and transport, where possible. Twenty five studies (23 UK and 2 international studies) from 1990 onwards were included. Limitations of the review were mainly methodological challenges. Firstly, the overall quality of the qualitative studies was not high mainly due to poor reporting of particular details used in assessing the quality criteria. Secondly, assessment of the type and context of physical activity was by self-report and without appropriate and accurate measures of the behaviour itself, it is difficult to identify clear correlates.

Furthermore, many of these studies were cross-sectional assessments of both psychological correlates and physical activity, thus there is a likelihood of bias. A prospective design, whereby an assessment of psychological correlates at baseline and then assess physical activity objectively at some time in the future would have been better. The assessment of psychological correlates has been varied and the conclusions drawn are based on a review of reviews which in itself has limitations. The tendency to publication bias and the reporting of more positive results cannot be excluded.

Finally, only few of the studies reported a theoretical framework for their study and an absence of such frameworks limits the use of these studies in deriving a theoretical framework for understanding young peoples' reasons for participation and non-participation in physical activity, sport and play.

This review identified five UK studies reporting barriers and facilitators to being active in children aged 8 and under; Boulton, 1992; Griffiths, 1996; Mulvihill et al., 2000a; Mason, 1995; Scott Porter Research and Marketing Ltd, 2002a. Similar themes emerged as important facilitators from this review as the review of quantitative correlates, (Biddle et al., 2007) including parental and peer support, access to facilities and concerns with safety. The key barriers were found to be the emphasis on team sports and limited opportunities for extra-curricular activity at primary school level; gender related attitudes and cultural stereotyping about appropriateness of some sports for particular genders by parents and peers (e.g. parent viewing boys more active than girls; some sports were more "appropriate" for boys to play than girls; boys not allowing girls to play "boys games"); cost of participation in terms of time and money; personal safety; . Common themes for encouraging activity in young children were found to be enjoyment, the attitude of parents and the age of the child. It is worth noting that the reliance is on only five reviews of correlates of physical activity, not all of which address all categories of correlates.

Evidence from only three studies on active travel (Barnardo's et al., 2004; Davis and Jones, 1996; Halden Consultancy, 2003) showed that the key barriers were the fear of traffic (children felt unsafe when playing and walking outside, particularly after school);

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<sup>73</sup> Physical Activity and Children. Review 3: The views of children on the barriers and facilitators to participation in physical activity: A review of qualitative studies. NICE Public Health Collaborating Centre – Physical Activity September 2007

parental restrictions on independent movement including distance/place and destinations; school influence over cycling policy and storage facilities (e.g. absence of any school provision of facilities); limited local play destinations (e.g. too far to travel to independently; access dangers due to traffic; play equipment unsuitable); and adult disapproval of children's outside play.

Only one study reported any facilitators for walking and cycling. This includes that it increases their personal freedom and independence; enjoyment and fun with friends; and the opportunity to explore local surroundings.

In an earlier systematic review by Allender et al. 2006<sup>74</sup> they reported on the findings of 24 qualitative studies relating to sport and physical activity for children and young people 1990-2004 in the UK and it is therefore relevant. The focus was primarily on adolescent girls/young women and younger children (aged 5-15 years old). Only few studies met the basic qualitative research quality criteria of reporting a theoretical framework. It would appear that little theory is being generated empirically and suggests that any understanding of reasons for participation and non-participation in physical activity in the United Kingdom may be limited. Two of the studies had been included in the 2007 NICE review above (Mulvihill et al., 2000a; Scott Porter Research and Marketing Ltd, 2002a) and there were two additional studies by MacPhail et al., 2003, and Bostock L., 2001 in the Allender et al, review. Additional findings were that barriers in younger children 5-15 years included competitive sports and highly structured activities. There were no studies reporting specifically on the barriers to participation in sport and physical activity facing young children.

Motivators were experimentation/unusual activities; providing children with many different types of physical activity, enjoyment and parental support was found to be crucial and safe environment; parents were more supportive in play areas they deemed to be safe.

In conclusion;

#### Barriers

- dislike of a focus on team sports
- gender and cultural stereotyping about appropriateness of some sports for particular genders by parents and peers
- cost in terms of time and money in participating in sports
- Highly structured activities
- Safety issues
- School support for cycling
- Limited extra curricular activities at a primary school level

#### Motivators:

- enjoyment/experimentation/unusual activities
- parental and peer support
- Participation in age appropriate activities
- Safe environment

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<sup>74</sup> Allender et al. Understanding participation in sport and physical activity among children and adults: a review of qualitative studies. *Health Educ. Res.* (2006) 21 (6): 826-835.

### 8.1.2 Adolescent Girls (see Table 2 in Appendix 1 Chapter 8)

The NICE 2007 review above identified fifteen studies in adolescent girls (11-18) including (Biddle et al., 2005a; Brooks and Magnusson, 2006; Brooks and Magnusson, 2007; Coakley and White, 1992; Cockburn and Clarke 2002; Cox et al., 2006; Finch and White 1998; Flintoff and Scraton, 2001; Jones, 1998; MacPhail et al., 2003b; Mason, 1995; Mitchell, 1997; Mulvihill et al., 2000a; Orme, 1991; Porter et al., 2002b).

Key barriers for adolescent girls (15 studies) to participation in sport and physical activity were found to be related to social pressure to conform, negative experiences of the school environment (e.g inappropriate school PE kit, discomfort about sharing showers etc), negative experiences of sports facilities (e.g. public spaces such as gyms or exercise classes), fear of sexual or racial harassment where escorting by family member to places to participate in sports, having to perform (display competence) in public and in front of peers and being forced to compete with others.

Key facilitators were social and family influences (e.g. social sanctioning of activities by peers provided opportunities to gain social standing; having active siblings and supportive parents), enjoyment (fun during sport and physical activity could result in enjoyment outweighing the impact of negative peer pressure not to participate), socialization (sport provides the opportunity to socialize with a friend and extend friendship networks beyond school) and finally, intrinsic and extrinsic rewards (achieving a socially desirable body type; receiving praise and encouragement from PE teachers).

Allender et al, 2006, also reviewed seven (7) studies involved research with teenage girls or younger women (aged between 14 and 24 years). All studies were also included in the NICE 2007 review discussed above. It is not surprising therefore that similar findings were identified.

In conclusion;

#### Barriers

- Negative experiences at school; during physical activity classes
- Peer pressure; impressing boyfriends and other peers was seen as more important than physical activity
- Identity conflict between wishing to appear feminine and attractive and the sweaty muscular image attached to active women
- Ill-fitting PE uniforms had a negative impact on image.
- Disruptive influence of boys in PE classes marginalized the girls. The competitive nature of PE classes and the lack of support for girls from teachers reinforced problems.

#### Motivators

- Body shape/weight management; maintaining a slim body shape which was seen as a popular ideal of beauty
- Enjoyable; fun
- Development of new social networks
- Family support
- Peer support

### 8.1.3 Families and community (see Table 3, Appendix 1, Chapter 8)

The NICE 2007 review identified four studies on families and community (two UK studies, two Australian studies including; MacPhail et al., 2003a, Bramham, 2003, Hume et al., 2005 and Veitch et al., 2006). The barriers were related to safety and fear of crime or injury while playing outside unsupervised. Both parents and children independently reported fear of strangers as well as risks of personal accidents or getting hurt. There were also concerns about the risk of intimidation or bullying by older children and fear of rival gangs for different areas.

There were also issues around quality of places to play which were found to be poor (e.g. presence of drug taking equipment (like syringes) in play areas; poorly maintained toilets, shaded areas and lighting).

The facilitators for children were opportunities for independent outdoor play and preference for activities that emphasise fun, play and enjoyment rather than skills practice.

In conclusion;

Barriers

- perceived stranger danger
- risk of personal accidents
- intimidation from older children
- Poor quality of places to play

Motivators

- valued opportunities for independent outdoor play
- activities that emphasised fun, play and enjoyment rather than skills practice

### 8.1.4 Adults (see Table 4 Appendix 1 Chapter 8)

A paper by the National Obesity Observatory, 2011; analysed and presented national level data on the knowledge and attitudes towards healthy eating and physical activity of adults and children in England<sup>75</sup> It is clear that knowledge of and attitudes towards physical activity are significant determinants of activity behaviour. There were however potential bias due to sampling methodology and study design therefore the data is to be interpreted with caution. Firstly, many of the included datasets were from surveys based on either self-completion questionnaires or interviews and responses to single-choice and closed-list questions may provide a less accurate reflection of an individual's views than an open-ended question. Also, self-report questionnaire are prone to recall and reporting bias. Interview situations could result in the worsening of response bias particularly when specific behaviours are deemed as 'socially desirable'.

The most commonly cited barriers were time pressures and lack of motivation. Also, people were less likely to be motivated if they perceived their local surroundings as unsafe or unpleasant. The most frequently cited reasons for taking part in physical activity are to maintain health and feel fit. These findings are consistent with other tools used to assess involvement in physical activity, such as those used by Sport England.

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<sup>75</sup> National Obesity Observatory; Knowledge and attitudes towards healthy eating and physical activity: what the data tell us. May 2011

Craig et al, 2007<sup>76</sup> was a health survey that explored knowledge and attitudes among 6,882 adults aged 16-64. The data was also analysed by the 2011 NOO's analyses above. The results could be seen in appendix x.

Data from the literature review by Allender et al 2006<sup>77</sup> were also considered in the NOO paper above and included over six studies. Barriers were found to include; negative experience at school, anxiety and lack of confidence about entering unfamiliar settings such as gyms were found to be the main barriers in participating in GP referral schemes. The main concerns were not knowing other people, poor body image and not fitting in with the gym culture. Other barriers were, lack of social network, lack of role models; the adults reported in the studies reviewed did not identify with role model for eg members of the South Asian and Black community did not see physical activity as a black or Asian pursuit, but rather as white, middle-class, male domain.

The motivators were a sense of achievement, skill development and confidence particularly amongst disabled men, medical sanctioning and general benefits of health improvement, support network offered by participation as the real value of physical activity and sport, enjoyment (spending 'luxury time' on themselves away from daily responsibilities).

In conclusion;

#### Barriers

- Time constraints
- Lack of motivation
- Anxiety and lack of confidence
- Poor health
- Lack of money
- Lack of role models

#### Motivators

- To be healthy and fit
- Support network
- Enjoyment /fun/luxury time
- Advice from health professional
- Skill development

### 8.1.5 Older Adults (see Table 5 Appendix 1 Chapter 8)

The evidence reports a literature review of physical activity for 65+ adults, 2012<sup>78</sup>. The barriers were found to be; fear of falling, over exertion and concern for personal safety including crime. The 65+ were more likely than other age groups to be deterred from going out by fear of crime. Traffic safety was also an issue as crossing a road within the time allowed on traffic light controlled crossings requires an average walking speed that is

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<sup>76</sup> Craig R et al. Health survey for England 2007. Volume 1. Healthy lifestyles: knowledge, attitudes and Behaviour. Leeds: NHS Information Centre 2008

<sup>77</sup> Allender et al. Understanding participation in sport and physical activity among children and adults: a review of qualitative studies. Health Educ. Res. (2006) 21 (6): 826-835.

<sup>78</sup> Evidence Briefing; Physical activity for older adults (65+ years). BHF National Centre physical activity + health. March 2012

higher than that achievable by most 70 year olds. Older adults also reported being prevented from taking part in a range of activities because of shortage of transport.

Motivators included self-efficacy (belief in one's own ability to be active), confidence, risk perception as well as beliefs, attitudes and values. Secondly, mutual trust, shared values and solidarity among neighbors (social cohesion) also increased levels of physical activity amongst older adults. Older adults reported that they are also motivated to walk when they had somewhere interesting to go.

Common features found in successful physical activity interventions includes:

- educational components where participants were given information and counseling by health professionals on physical activity and health and encouraged to engage in regular physical activity
- a cyclical design which includes continuous reviews of participant progress towards goals throughout the intervention and provides on-going support and encouragement
- use of a behaviour change model and intrinsic motivation
- cognitive behavioural strategies (including self- monitoring and goal setting)
- assessment and negotiation of social and environmental barriers to physical activity
- the use of support strategies (including telephone, home visits and peer support).
- Additionally, in the short term (12 months), participation in group-based physical activity appears to be effective, although longer term adherence to physical activity programmes is superior in home- based programmes.
- Social support: Physical activity participation is influenced (positively and negatively) by significant others and social support. This includes health professionals (including general practitioners), exercise and physical activity instructors, teachers and leaders, care givers, family, friends and their peers.

A total of 21 focus groups (6-8 respondents per group) were carried out across England in 2006 amongst older people who had recently retired in order to understand what determines their participation in sports<sup>79</sup>. This study of about 160 respondents is small and it is unlikely that the study has enough power and the results should therefore be interpreted with caution. It is also unclear how the respondents were recruited and could be a biased sample and therefore results may not be generalisable. Being that these were focus groups and interviews were conducted, it is likely that there would have been response bias as explained in the discussion of some of the studies above.

The barriers however, were reported to be cost, physical limitations – and for some the belief that an active lifestyle makes recreational exercise redundant, language and mixed sex facilities (traditional Asian women) and a busy schedule(Asian men).

The research found that motivators for participation are partly internally driven and partly, external. Internal motivators include: physical benefits, getting/ keeping fit, getting healthier/ maintaining health, staying supple, controlling weight, prolonging (healthy) life/ staying off old age – older, Social benefits-Meeting/ mixing with other people, Mental/ emotional benefits, enjoyment of activity, having 'own space' (from partner) or more time together for some, for self esteem and retaining independence. External motivators were found to be encouragement/persuasion by the media, doctor & partner.

Common features found in successful physical activity interventions include:

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<sup>79</sup> Understanding Participation in sport; what determines sports participation among recently retired people. Sport England Report 2006



- appeal for taster sessions and moderately priced local activities organised for their age group.
- The social component is also seen as important.
- requirement that staff who administer any interventions have to be in touch with the physical needs and restrictions of this age group.
- fun and enjoyment are seen as the most appropriate platform.
- reassurance in relation to safety and the fact that controlled participation will not result in injury.

A complex interplay of physical, psychological and environmental factors influence participation among older people. In the review by Allender et al, 2006<sup>80</sup>, it appears that while GP referrals encouraged the uptake of exercise in older age groups, participation appears to be maintained through enjoyment and strong social networks. Health benefits of physical activity in terms of reducing the effects of aging and being fit and able to play with grandchildren were also motivators.

However, there were issues around unclear guidance; some older adults were unsure about the 'right amount' of physical activity for their age. As in other age groups, the lack of realistic role models in the community was a deterrent. Exercise prescriptions were perceived as targeted at young people and not relevant to older groups. Also older people were anxious about returning to physical activity and identified cost and time barriers as the main problems.

In conclusion;

#### Barriers

- Fear of falling and personal safety
- Physical limitations

#### Motivators

- Enjoyment
- social interaction with peers as reasons to be physically active.
- Physical activity participation is positively associated with self-efficacy (belief in one's own ability to be active), confidence, risk perception as well as beliefs, attitudes and values.
- Social cohesion
- Keeping fit/healthy

### 8.1.6 Black and Ethnic Minority Group (see Table 6, Appendix 1 Chapter 8)

There are very few studies/research in this subgroup of the population, though it is an important consideration for Barnet populations.

Janet Withall et al., 2007<sup>81</sup> examined the perceptions of participants, non-participants, and exercise leaders in a low-income area (Southmead, a suburb with the lowest life

<sup>80</sup> Allender et al. Understanding participation in sport and physical activity among children and adults: a review of qualitative studies. Health Educ. Res. (2006) 21 (6): 826-835.

<sup>81</sup> Janet Withall et al. Why some do but most don't. Barriers and enablers to engaging low-income groups in physical activity programmes: a mixed methods study. BMC Public Health 2011 11:507

expectancy (75.3 years) in the city of Bristol (UK) regarding barriers, motives, and enabling factors for organized physical activity. A combination of qualitative approach (to reveal the attitudes, beliefs and experience of physical activity) and quantitative (allow enquiry into how and why people do or do not engage and adhere) technique were used.

The triangulation of the data enabled the issues to be viewed from an internal (local residents) and an external view (session deliverers), and pre and post engagement in activity, giving a deeper understanding of the influences at work and corroborating the interpretation of the data. This approach improves the validity of the data and increases its comprehensiveness. The mixed methods of research are likely to have strengthened the evidence through confirmation and substantiation of findings while the different data collection methods may have neutralised each others' biases or weaknesses.

On the other hand, the study had limitations. Some of them include that only organized activity sessions were included and physical activity undertaken individually was not studied. There were a small number of non-white participants and this meant that views of individuals from BME groups were not well represented, however this reflects the predominant ethnicity of the area with BME residents making up only 5.2% of the population. Also, the purposive sampling strategy in the qualitative arm of the study may have impacted the representativeness of the participants. Finally, men were difficult to recruit and therefore underrepresented in the qualitative sample.

The study showed that the barriers were either structural, political, economic, social, cultural or personal. These relate both to joining and/or participating in exercise. Issues of cost have a proportionately greater impact on low-income groups. Where a more affluent individual can re-prioritise exercise ahead of other leisure activities this is likely to be more difficult for people with less financial resource who would have to reallocate funds from what for them are more important or essential purchases.

Others may be denied opportunity by material constraints like income and accessibility, challenges with childcare, time constraints, racism, lack of awareness, confidence and culturally appropriate sport and physical recreation opportunities. Cultural constraints in circumstances where the value of sport is not appreciated (by the individuals, their parents or a wider community) also inhibits uptake of physical activity.

Motivators were found to include low cost sessions and childcare, provision of activities/sessions provided at a wide range of times, sessions that are fun, enjoyable and encourage socializing, well advertised sessions following well designed communication strategies, culturally sensitive facilities/session and improvement in knowledge bases and empowerment.

In a systematic review, Jonathan Long et al., 2009<sup>82</sup> examined a bibliographic database containing 337 entries (largely) from the UK in a ten year period. However, to achieve this number of entries the review has had to include items in which either ethnicity or sport (or both) are subsidiary to the main focus of the investigation. It is likely that in conducting this review, the authors may have erred on the side of inclusion when judging whether contributions passed their quality threshold. Another challenge of this review was accommodating the different understandings of what is meant by BME communities in the various research studies and policies reviewed.

Barriers were found to include material constraints; stemming from long-term unemployment, low income, poor living conditions and poor health. There were also concerns about racial discrimination. Research demonstrates the damaging impact

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<sup>82</sup> Jonathan Long et al. A systematic review of the literature on the Black and Ethnic Minority Ethnic communities in Sport and Physical Recreation. Carnegie Research Institute Feb 2009.

racism has on participation in sport by people from BME communities. It is generally agreed that the experiences of BME communities in sport are mediated by racism. Media portrayals and racial stereotypes held by people in the sporting world worsen the situation. Other barriers include lack of cultural understanding and awareness of the needs of BME communities in sport and physical recreation, and, in some cases, a lack of consultation with BME communities in the development and provision of culturally- appropriate facilities and services. Cultural constraints in circumstances where the value of sport is not appreciated (by the individuals, their parents or a wider community) is another issue; for example, when BME groups are excluded by their own cultural beliefs from what they perceive as the white nature of sport which leaves them with a sense that they are not welcome. Finally, the short-term nature of many projects is identified as a challenge to developing sustained participation

Motivators include; culturally sensitive facilities/services (e.g. same sex changing rooms/sessions) and improvement of knowledge bases and empowerment (active dialogues with the communities on their needs). Research in the field demonstrated the importance of building capacity so that those from BME communities are better able to contribute to the provision of sporting opportunities.

In conclusion;

#### Barriers

- Denied opportunity by material constraints like income and accessibility
- Time constraints
- Lack of awareness
- Lack of confidence
- Lack of culturally appropriate sport and physical recreation opportunities.
- Racism
- Inhibited by cultural constraints in circumstances where the value of sport is not appreciated (by the individuals, their parents or a wider community)

#### Motivators

- Low cost sessions and childcare
- Activities/sessions provided at a wide range of times
- Sessions that are fun, enjoyable and encourage socializing
- Well advertised sessions following well designed communication strategies
- Culturally sensitive facilities/session
- Improvement in knowledge bases and empowerment

### **8.1.7 Sedentary Behaviour (see Table 7, Appendix 1 Chapter 8)**

The evidence briefing 2012 reported a literature review of physical activity in the sedentary. Relatively few intervention studies have been conducted to reduce sedentary behaviour in adults<sup>83</sup>. The review identified six studies in adults which examined the effectiveness of workplace interventions in reducing sitting time and none was found to be effective. One possible explanation for this lack of effectiveness is that all reviewed studies

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<sup>83</sup> Evidence Briefing. Sedentary behaviour. BHF National Centre physical activity + health. 24/05/12

were principally concerned with increasing physical activity; reducing sedentary behaviour was included only as a secondary outcome. The correlates of sedentary behaviour are likely to be different from those of physical activity, and as such, it is unsurprising that no changes in sedentary behaviour were observed. In addition, all studies used self-report methods for measuring sedentary behaviour which may not be sufficiently sensitive to detect changes in this behaviour.

The review identified that in children and young people interventions to reduce sitting have generally been effective, but changes in behaviour have been relatively small. There is however limited information on what characterises effective interventions in terms of intervention content and key target groups.

Finally, there is some evidence that interventions including family/parental involvement are likely to produce greater changes in sedentary behaviour. This is consistent with correlates research indicating the family and home level factors are a key influence on sedentary behaviours in young people.

Foster C et al., 2009<sup>84</sup> was a literature review of 19 self-reported randomized controlled trials up till 2005 with a total of 7598 participants. These trials compared different interventions to encourage sedentary adults not living in an institution to become physically active. The participants were community dwelling adults, age 16 years to any age, free from pre-existing medical condition or with no more than 10% of subjects with pre-existing medical conditions that may limit participation in physical activity. The limitations in the external validity of the studies relate to recruitment and screening of participants and the generalisability of the interventions into everyday practice. Types of interventions included One only or a combination of; One-to-one counseling /advice or group counseling/ advice; Self-directed or prescribed physical activity; Supervised or unsupervised physical activity; Home-based or facility-based physical activity; Ongoing face-to-face support; Telephone support and Written education /motivation support material. The majority of the studies in the review recruited volunteers and the interventions may be less effective in non-volunteer populations recruited. The participants in the studies reviewed were generally white, well educated and middle aged and it is possible that the observed effects may be different in the wider population. Often participants had to agree to extensive screening prior to randomisation and, as a consequence, the people who finally participated in the study were likely to be highly motivated. There was a large drop out of participants between the recruitment, eligibility screening and randomisation phases of studies. This drop out would limit the possible effects of such interventions and the generalisability of the studies. The physicians in the studies based in a primary healthcare setting may have been more motivated to deliver the interventions than might be observed in the non-trial setting. Existing evidence about the effectiveness of physical activity interventions for sedentary adults in the general population is limited by the recruitment of motivated volunteers, and the problems of measuring of physical activity using self report. There is only very limited evidence of the long-term effectiveness of interventions; only four studies reported data at 2 years, with one study demonstrating maintenance of improvement in cardio-respiratory fitness. Most studies had short follow up periods of were 6 months-1 year.

The results however showed that the effect of interventions on self-reported physical activity was positive and moderate. There was significant heterogeneity in the reported effects as well as heterogeneity in characteristics of the interventions. The findings of this review indicate that interventions which provide people with professional guidance about

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<sup>84</sup> Foster C et al. Interventions for promoting physical activity (Review). The Cochrane Collaboration. Published online 21 Jan 2009.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003180.pub2/abstract;jsessionid=7CE6103399CDFE512C5C5C250F364156.d03t02>

starting an exercise programme and then provide on going support may be more effective in encouraging the uptake of physical activity in the short to mid-term. The heterogeneity in reported effects was reduced in higher quality studies, when physical activity was self-directed with some professional guidance and when there was on-going professional support. Due to the clinical and statistical heterogeneity of the studies, only limited conclusions can be drawn about the effectiveness of individual components of the interventions.

### 8.1.8 Long Term Conditions (see Table 8 Appendix 1 Chapter 8)

Macmillan commissioned a systematic review of randomised controlled trials to promote physical activity among cancer patients in 2010<sup>85</sup>. This (and additional searching of the literature) has shown the following evidence for specific categories of physical activity interventions;<sup>86</sup>

In an RCT, Jones et al, 2003<sup>87</sup> investigated the effectiveness of an oncologist exercise recommendation, compared to the usual care of referral to an exercise specialist. This showed that the group receiving the oncologist recommendation reported significantly greater exercise participation than usual care at 5-weeks.

Three randomised controlled trials (Bennett et al, 2007; Street et al, 2009; Rogers et al, 2009)<sup>88,89,90</sup> demonstrated the effectiveness of approaches to promote physical activity using techniques such as motivational interviewing; behavioural counseling based on stages of change; and counseling and behavioural modification. All of these trials demonstrated positive increases in physical activity measured either in terms of regular self- assessed exercise participation, or minutes of activity measured by accelerometer.

In an RCT, Irwin et al, 2008 in an RCT<sup>91</sup>, demonstrated the effectiveness of a supervised exercise group that participated in 150- minutes weekly supervised gym-based and home-based aerobic exercise for 6-months. On average, exercisers increased moderate intensity to vigorous intensity aerobic exercise by 129- minutes per week compared with 44-minutes per week among usual care participants.

A recent review by Knols et al, 2010<sup>92</sup> highlighted five randomised controlled trials( including Rogers et al and Irwin et al above)<sup>93,94,95</sup> that promoted walking among cancer

<sup>85</sup> Davis NJ, Bateup L. Lifestyle-Related Health Behaviour Change: Physical Activity and Diet: Theory and Evidence on Developing Lifestyle-related Behaviour Change Training for Cancer Clinicians. London, 2010.

<sup>86</sup> Interventions to promote physical activity for people living with and beyond cancer: Evidence-based guidance

<sup>87</sup> Jones LW, Sinclair RC, Courneya KS. The effects of source credibility and message framing on exercise intentions, behaviors, and attitudes: An integration of the Elaboration Likelihood Model and Prospect Theory. *Journal of Applied Social Psychology* 2003;33:179-96.

<sup>88</sup> Bennett JA, Lyons KS, Winters-Stone K, Nail LM, Scherer J. Motivational interviewing to increase physical activity in long-term cancer survivors: a randomized controlled trial. *Nursing research* 2007;56(1):18-27.

<sup>89</sup> Street RL, Jr., Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient education and counseling* 2009;74(3):295-301

<sup>90</sup> Rogers LQ, Hopkins-Price P, Vicari S, Markwell S, Pamentier R, Courneya KS, et al. Physical activity and health outcomes three months after completing a physical activity behavior change intervention: persistent and delayed effects. *Cancer epidemiology, biomarkers & prevention : a publication of the American Association for Cancer Research, cosponsored by the American Society of Preventive Oncology* 2009;18(5):1410-8.

<sup>91</sup> Irwin ML, Cadmus L, Alvarez-Reeves M, O'Neil M, Mierzejewski E, Latka R, et al. Recruiting and retaining breast cancer survivors into a randomized controlled exercise trial: the Yale Exercise and Survivorship Study. *Cancer* 2008;112(11 Suppl):2593-606.

<sup>92</sup> Knols RH, de Bruin ED, Shirato K, Uebelhart D, Aaronson NK. Physical activity interventions to improve daily walking activity in cancer survivors. *BMC Cancer* 2010;10:406.

survivors. These showed clearly that combined promotion of walking (mainly through counseling-based interventions) improves daily step activity in breast cancer survivors. Studies that define a step goal appear to be more effective than those that do not

Finally, there is evidence from interventions among patients with other long-term conditions<sup>96</sup> that physical activity can be effectively promoted using a range of approaches, including:

Motivational interviewing, behavioural counseling, tailored interventions based on stages of change/ transtheoretical model, walking promotion including use of pedometers, supervised exercise training (often through referral to an exercise specialist). Most of the effective interventions were based on behavioural theory, such as social-cognitive theory or the transtheoretical model, and offered physical activity that was closely tailored to the patient's needs and capabilities.

In conclusion, the evidence supports the following programmes to be effective in increasing physical activity among patients with cancer and other long term conditions;

- oncologist- recommended exercise programmes or specialist referral to exercise programmes
- motivational interviewing and other types of behavioural counseling;
- referral to supervised gym-based exercise;
- walking (including pedometer programmes).

### **8.1.9 People with disabilities (see Table 9, Appendix 1 Chapter 8)**

There are people with disabilities who have had little or no experience of physical activity or exercise. They need, first of all, to develop their motor skills through adapted physical activity programmes and through physiotherapy where indicated. Other people with disabilities do not have the opportunity to participate in active leisure pursuits and sports that suit and appeal to them. They have had little or no opportunity to engage in physical exercise and sport with others and enjoy their social aspects. In school and in college the experience of children and young adults with disabilities are not always quality ones. Everyone with a disability, including athletes with a disability, need to be adequately catered for and their potential recognised, respected and nurtured.

Positive effects of physical activity in persons with learning and physical and sensory disability that have been demonstrated include improvements in general health, physical fitness, bone metabolism and increased functional independence. There is also increased mobility and a reduction in chronic disease and secondary complications. Physical activity

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<sup>93</sup> Vallance JK, Courneya KS, Plotnikoff RC, Yasui Y, Mackey JR. Randomized controlled trial of the effects of print materials and step pedometers on physical activity and quality of life in breast cancer survivors. *Journal of clinical oncology : official journal of the American Society of Clinical Oncology* 2007;25(17):2352-9.

<sup>94</sup> Matthews CE, Wilcox S, Hanby CL, Der Ananian C, Heiney SP, Gebretsadik T, et al. Evaluation of a 12-week home-based walking intervention for breast cancer survivors. *Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer* 2007;15(2):203-11.

<sup>95</sup> Knols RH, de Bruin ED, Uebelhart D, Aufdemkampe G, Schanz U, Stenner-Liewen F, et al. Effects of an outpatient physical exercise program on hematopoietic stem-cell transplantation recipients: a randomized clinical trial. *Bone Marrow Transplantation* 2010.

<sup>96</sup> Davis NJ, Batehup L. Lifestyle-Related Health Behaviour Change: Physical Activity and Diet: Theory and Evidence on Developing Lifestyle-related Behaviour Change Training for Cancer Clinicians. London, 2010

also has a mitigating effect on challenging behavior (Moon et al<sup>97</sup>, 1982; Nishiyama et al, 1986<sup>98</sup>; Lancioni et al, 1994<sup>99</sup> and 1998<sup>100</sup>; Washburn et al, 2002<sup>101</sup>; Nary et al, 2000 cited by Boland, 2005<sup>102</sup>).

Physical exercise is important in maintaining fitness for daily living, reducing functional limitations, facilitating independent living and preventing, delaying and reducing chronic illnesses and secondary conditions (Fentem, 1994<sup>103</sup>). In people who have acquired a disability, participation in sport/physical exercise can help them come to terms with their disability, regain self-esteem and social integration (Chawla, 1994<sup>104</sup>). In people who have acquired a disability, participation in sport/physical exercise can help them come to terms with their disability, regain self-esteem and social integration (Chawla, 1994<sup>105</sup>).

Persons with learning difficulties appear to gain significant mental, social, spiritual and physical benefits from sport and leisure activities (ibid). Weiss et al (2003)<sup>106</sup> reviewed studies that demonstrated the importance of social participation for the self-concept (self-esteem, self-regard, self-worth) of persons with intellectual disabilities. Weiss et al (2003)<sup>107</sup> citing Sherrill (1993) define self-concept “as the perception and evaluation of the self, and includes the beliefs, feelings, and intentions that a person holds in regard to self”. Edgerton et al (1984)<sup>108</sup> and Landesman-Dwyer et al (1984)<sup>109</sup> showed that individuals with developmental disabilities attribute greater life satisfaction to the presence of family and friends and active social lives than persons without a disability. Thus, while social participation and friendship are important in the lives of everyone they may have particular significance for the self concept of individuals with intellectual disabilities.

For children and young people with disabilities the barriers are not unique – an emphasis on team sports in schools, provision of alternatives to physical education for children with disabilities and parental attitudes with regards to preferences are common. Sport England, the national sports development agency for England, surveyed 2,800 disabled children and young people in England. They found that, in this young population, lack of motivation or desire to take part in sport did not explain the low participation of sport by young disabled

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<sup>97</sup> Moone, M.S. Renzaglia, A. (1982) Physical fitness and the mentally retarded: a critical review of the literature *Journal of Special Education* 16(16) 3: 269-287.

<sup>98</sup> Nishiyama, S., Kuwahara, T., Maatsudea, I. (1986) Decreased bone density in severely handicapped children and adults with reference to the influence of limited mobility and anticonvulsant medication *European Journal of Pediatrics* 144(5): 457-763.

<sup>99</sup> Lancioni, GE. (1994) Procedures for promoting independent activity in people with severe and profound learning disability: A brief review: *Mental Handicap Research* 7(3):237-256

<sup>100</sup> Lancioni, GE O'Reilly, M.F. (1998) A review of research on physical exercise with people with severe and profound developmental disabilities. *Research in Developmental Disabilities* 19(6): 477-492.

<sup>101</sup> Washburn, RA., Zhu, W., McAuley, E., Frogley, M., Figonis, SF. (2002) The physical Activity Scale for individuals with physical disabilities: Development and Evaluation. *Archives of Physical Medicine and Rehabilitation* 83:193-200

<sup>102</sup> Boland, M. (2005) Health promotion and health promotion needs assessment of people attending disability services in the HSE, East Coast Area. Doctorate of Medicine, University College Dublin (under consideration)

<sup>103</sup> Fentem, P H. (1994) Education and debate ABC of Sports Medicine: Benefits of exercise in health and disease. *British Medical Journal* 308:1291-1295.

<sup>104</sup> Chawla, JC. (1994) Sport for people with disability. *British Medical Journal* 308:1500-4.

<sup>105</sup> Chawla, JC. (1994) Sport for people with disability. *British Medical Journal* 308:1500-4

<sup>106</sup> Weiss, J, Diamond, T, Demark, J, Lovald, B. (2003) Involvement in Special Olympics and its relations to self-concept and actual competency in participants with developmental disabilities *Research in Developmental Disabilities* 24: 281-305.

<sup>107</sup> ibid

<sup>108</sup> Edgerton, R. B., Bollinger, M., Herr, B. (1984) The cloak of competence: After two decades. *American Journal on Mental Deficiency* 88: 345-351.

<sup>109</sup> Landesman-Dwyer, S., Berkson, G. (1984) Friendships and social behavior. In J. Wortis (Ed.), *Mental retardation and developmental disabilities: An annual review*, 13.

people. In this study, the most common barriers to participation in physical activity were having no one to go with, unsuitability of local sports facilities, a lack of money, and health considerations. Young people with a self-care related disability and those with a mobility disability were more likely to cite their disability, or gaps in sports provision as reasons for not participating in sport<sup>110</sup>.

Young people with a hearing disability were more likely to cite reasons that were less connected to their disability (Finch et al, 1999<sup>111</sup>).

In a small study of 205 people with physical disabilities, Spivock M et al<sup>112</sup> described the relationship between neighborhood-level active living buoys and the active living practices of adults with physical disabilities living in a large urban area. A sample of 205 people with physical disabilities was recruited via a local rehabilitation center and its adapted fitness center. It is unclear how they were selected and there was any bias in selection. Telephone interviews were administered by senior occupational therapy students. The interview included a modified version of the Physical Activity and Disability Survey, a validated instrument that includes questions on physical activity, active transportation, and other activities of daily living. Individuals were encoded within their census tract of residence (n=114) using their postal codes. Data on neighborhood active living potential were gleaned from systematic social observation.

Multilevel logistic regression analyses showed that the association between the presence of environmental buoys and leisure activity was significant (OR=4.0, 95% CI=1.1-13.8) despite adjustments for individual difference variables while the association with active transportation became no significant (OR=2.9, 95% CI=0.7-7.7) following adjustment for these variables.

The authors concluded that people with physical disabilities who live in neighborhoods with more environmental buoys are more likely to report involvement in leisure-time physical activity. Unfortunately this is a small study and the results may not be generalizable to the entire population.

Other research indicates that the tailoring of physical activity opportunities which are affordable and accessible – via suitable transport to the venue and with adequate facilities, once this has been achieved the attitudes of staff, cost and affordability, choice of activity, lack of companion to go with, and in some cases policy constraints such as residential or school regulations about what people with disabilities can engage with<sup>113</sup>.

Most importantly of all, these factors can be addressed most effectively by the ownership of providers and leisure commissioners rather than the reliance of local communities to provide volunteer solutions to some of the barriers as is often the case at present.

### **8.1.10 Other Factors That Affect Physical Activity (see Table 10 Appendix 1 Chapter 8)**

## **ENVIRONMENT**

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<sup>110</sup> New York: Plenum Press.

<sup>111</sup> Finch, N., Lawton, D., Williams, J., Sloper, P. (2000) Disability Survey 2000: Survey of Young People with a disability and Sport. Social Policy Research Unit, University of York, England (A summary is available on the website by Finch, N., Lawton, D., Williams, J., Sloper, P. (2001) and entitled Young Disabled People and Sport Research Findings from the Social Policy Research Unit. University of York, England) quoted in Promoting the Participation of People with Disabilities in Physical Activity and Sport in Ireland Oct 2005

<sup>112</sup> Spivock M et al. Promoting active living among people with physical disabilities evidence for neighborhood-level buoys. *Am J Prev Med*. 2008 Apr;34(4):291-8.

<sup>113</sup> Promoting the Participation of People with Disabilities in Physical Activity and Sport in Ireland Oct 2005



Informed by data and systematic reviews, briefing paper by NOO 2011<sup>114</sup> states that the aspects of the environment found to be associated with physical physical activity include:

- access to physical activity facilities
- distance to destinations
- levels of residential density
- type of land use
- urban walkability scores
- perceived safety
- availability of exercise equipment
- provision of pavements

Limitations in the research are as follows;

- The bulk of the research has come from the US, where the extent of urban sprawl, environmental conditions and urban forms are very different to those in the UK.
- There is also a general lack of consistency in approaches to measuring the environment for its impact on physical activity.
- There are potential issues in studying the links between the environment and behaviour which include the possibility of making spurious ecological correlations; the challenge of timing (as environmental exposure data and outcome data are usually made at different times); a lack of sufficient variation between different environments to make meaningful comparisons between areas; the need to validate remote measures of the environment; and the existence of individual level confounders such as age or social class. These issues need to be borne in mind when attempting to draw any conclusions about the links between the environment and behaviour.
- There are potential problems with accessing the data for environmental studies: Some secondary data sources may not have been validated and so may introduce bias.

Despite these it is generally accepted that distance to facilities, type of opportunity available, and access to these are key factors in environmental limitations.

### **8.1.11 Interventions that work to improve uptake of Physical Activity (see Table 11 Appendix 1 Chapter 8)**

The recently developed Toronto Charter for Physical Activity outlines a framework for action to advance the physical activity agenda. It is a consensus statement based on extensive world-wide stakeholder consultation and an advocacy tool to support physical activity initiatives. The Charter calls for action across four key areas consistent with the WHO Global Strategy for Diet and Physical Activity including; implementation of national policy and action plans, introduction of policies and regulations that support physical activity, reorientation of services and funding to prioritise physical activity and development of partner- ships for action.

The supporting document of the Toronto Charter states that there are seven “best investments” for physical activity, which are supported by good evidence of effectiveness and have worldwide applicability which are as follows;<sup>115</sup>

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<sup>114</sup> National Obesity Observatory; Environmental influences on physical activity and diet: March 2011

- Whole-of-school' programmes
- Transport policies and systems that prioritise walking, cycling and public transport
- Urban design regulations and infra- structure that provide for equitable and safe access for recreational physical activity, and recreational and transport-related walking and cycling across the life course
- Integration of Physical activity and Non Communicable Disease prevention into primary health care systems
- Public education, including mass media to raise awareness and change social norms on physical activity
- Community-wide programs involving multiple settings and sectors and that mobilize and integrate community engagement and resources
- Sports systems and programs that promote 'sport for all' and encourage participation across the life span

In a systematic review of interventions that are effective for physical activity and diet, the WHO 2009 (2009)<sup>116</sup>, all studies of different study designs between January 1995 and June 2006 were included. A total of 395 peer-reviewed publications met the inclusion criteria, describing 261 different interventions. Of these 261 interventions, 64 focused on disadvantaged communities and 13 took place in low- and middle-income countries.

Most of the findings in the WHO systematic review are in line with the evidence review of the Toronto Charter and the results are as follows;

## **Policy & Environment**

### **Effective interventions**

- Environmental interventions targeting the built environment, policies that reduce barriers to physical activity, transport policies and policies to increase space for recreational activity

### **Moderately effective interventions**

- Multi-targeted approaches to encourage walking and cycling to school, healthier com- muting and leisure activities

This review showed that policy and environmental interventions create a healthy environment and support individuals to make healthy choices. These interventions can reach large populations. Policies targeting the built environment or a reduction in barriers to physical activity showed positive results. Finally, point-of-decision prompts encouraging the use of stairs proved to be simple but effective policies.

## **Mass Media**

### **Effective interventions**

- with community-based, supportive activities such as programmes in schools and local communities; or

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<sup>115</sup> Global Advocacy for Physical Activity; Investments that work for Physical Activity. A complementary document to The Toronto Charter for Physical Activity: A Global Call to Action. February 2011

<sup>116</sup> World Health Organization (2009) Interventions on Diet and Physical Activity: What Works. Geneva, Switzerland: World Health Organisation

- associated with policies to address local environmental barriers to participation.

Characteristics of mass media campaigns for physical activity that have been successful in changing awareness and behaviour include the use of a simple message with frequent exposure. Those that are most likely to be successful are accompanied by appropriate “upstream” policy support and “downstream” community-based activities, and usually involve a community participation approach.

## **School Settings**

### **Effective interventions**

- High-intensity school-based interventions that focus on physical activity, are comprehensive, multi-component and include:
  - curriculum on physical activity taught by trained teachers
  - supportive school environment/policies; - a physical activity programme); - a parental/family component.

### **Moderately Effective interventions**

- A focused approach, for example programmes aimed at reducing sedentary behaviour and increasing participation in physical activity, accompanied by supportive activities within the curriculum.
- A formative assessment that addresses the needs of the school and cultural contexts.

School-based interventions show consistent improvements in knowledge, attitudes and behaviour. There is strong evidence to show that schools should include a diet and physical activity component in the curriculum taught by trained teachers; ensure parental involvement; provide a supportive environment; offer a physical activity programme. However there is lack of cost-effectiveness research in this area.

## **The Workplace**

### **Effective interventions**

Multi-component programmes promoting physical activity, that:

- provide space for fitness or signs to encourage the use of stairs (18, 206);
- involve workers in programme planning and implementation
- involve the family in interventions through self-learn programmes, newsletters, festivals, etc.
- provide individual behaviour change strategies and self-monitoring.

Evidence consistently indicates that including workers in programme planning and implementation brings positive outcomes.

## **The Community**

### **Effective interventions**

- Community development campaigns with intersectoral cooperation and/or focused

on a common goal.

- Group-based physical activity programmes or classes for a homogenous group of individuals.

## Moderately Effective interventions

- Community-wide interventions conducted as part of a national or global campaign in a homogenous community.
- Walking school bus.

The most successful community interventions generally comprised many different activities and usually included both diet and physical activity components. The majority had a strong educational component, were theory-based and focused on facilitating changes in behaviour. However, few interventions have been evaluated in terms of cost-effectiveness and sustainability.

## Primary healthcare

### Effective interventions

Interventions targeting chronic NCD risk groups that:

- include at least one session (health risk appraisal) with a health-care professional, with brief negotiation or discussion to decide on reasonable, attainable goals, and a follow-up consultation with trained physical activity personnel, these should be
- supported by targeted information
- linked and/or coordinated with other stakeholders such as community sports organizations or ongoing mass media physical activity campaigns.

Interventions in the primary health care setting vary greatly in their intensity and thus in their effectiveness. Minimal contact interventions, such as health checks, single visit counseling or information distribution have typically not been effective. However, individual responses may vary depending on stage of “readiness”.

In conclusion, this setting is effective at modifying risk factors with moderately intense interventions that provide chronic NCD consultations with follow-up by trained personnel and targeted information. The potential of this setting in low- or middle-income countries is largely unknown.

## Older Adults

### Moderately Effective interventions

- Physical activity interventions in a group setting using an existing social structure or meeting place. Group physical activity programmes reported improvements in psychosocial outcomes.
- Programmes for older adults must reduce barriers by addressing accessibility, for example by conducting physical activity programmes at venues where older adults regularly meet.

## Religious Settings

### Moderately Effective interventions

- Culturally appropriate interventions targeting weight loss, healthy dietary habits and increased physical activity.

The WHO review revealed gaps in knowledge. Much of the literature only reports short-term outcomes, and therefore little is known on the potential long-term effects, sustainability, and cost-effectiveness of interventions. While grey literature was used to supplement the peer-reviewed research, there is still a lack of information on effective interventions, especially in low- and middle-income countries.

Quality scores for the studies included were generally modest. Therefore, even where evidence was available, the quality of the study was not always high enough to be able to make firm recommendations. There may also have been publication bias in terms of only publishing intervention strategies that are effective.

The restrictions in the search strategy noted earlier mean that potentially valuable information may be missing from the results; Examples include interventions published before 1995, those published in languages other than English, and interventions that had not yet been analysed in the scientific literature at the time of this review.

A recent study after the reviews for the NICE PH Guidance 2 on the impact of exercise referral schemes on physical activity and health outcomes was assessed in a systematic review and meta-analysis of 8 randomised controlled trials<sup>117</sup>. There were a total of 5,190 sedentary individuals with or without medical diagnosis. Six trials compared exercise referral schemes with usual care, two examined alternative physical activity intervention, and one an exercise referral scheme plus a self determination theory intervention. **See Table 12, Appendix 1, Chapter 8.**

This was a large review, all trials generated a random allocation sequence although details of concealment were poorly reported and all trials reported good balance between groups in participant characteristics at baseline. Although blinding of participants and intervention providers was not feasible, the Jolly and Murphy studies reported outcome blinding. For both studies, self reported physical activity using the seven day physical activity recall was assessed via telephone by researchers blinded to group allocation. The reporting and handling of missing data were detailed for most studies, and all studies apart from one reported the use of intention to treat analyses. The level of missing data at follow-up ranged from 17% to 50%. Most studies used imputation methods (that is, the last observation carried forward or the average of complete case values) to replace missing data values at follow-up. Overall, three studies were judged to be at moderate overall risk of bias and five at a low overall risk of bias.

All studies, with the exception of the Gusi study, relied on a self report measure of physical activity. No studies assessed physical activity using objective methods.

The summary of the results showed;

- a weak evidence of a short term increase in physical activity and a reduction in levels of depression of sedentary individuals after participation in an exercise referral scheme compared with usual care was found.
- No consistent evidence in favour of exercise referral schemes in outcomes based on physical fitness, psychological wellbeing, overall health related quality of life, blood pressure, serum lipid levels, indices of obesity, glycaemic control, or respiratory function was seen.

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<sup>117</sup> Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. *BMJ* 2011;343:d6462

- no difference in any outcomes when comparing an exercise referral scheme with an alternative physical activity intervention (for example, walking programmes) or with schemes plus an additional behavioural intervention was found. None of the included trials separately reported outcomes in individuals with specific medical diagnoses. Substantial heterogeneity in the quality and nature of the exercise referral schemes across studies might have contributed to the inconsistency in outcome findings.

The above results appear to be consistent with the results of the reviews done for NICE PH guidance 2, May 2006. A recent Cochrane Review by Priest *et al.* (2008)<sup>118</sup> showed that there are no high quality evidence to support interventions designed and delivered by sporting organisations to increase participation in sport.

## 8.2 NICE What does public health guidance say about effective interventions?

### Guidance

The NHS NICE guidance published to support the use of effective interventions by healthcare commissioners and providers, local authorities and others engaged in the provision of physical activity with populations with an aim of increasing participation in activity and decreasing sedentary behaviour in target and/or population groups.

NICE has produced 4 Public Health (PH) Guidance on Physical Activity and there are two being proposed; 1. Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation due October 2012 and 2. Physical activity - brief advice for adults in primary care May 2013

The 4 NICE PH guidance around physical activity are as follows;

### 8.2.1 Promoting physical activity for children and young people (PH17) January 2009

The recommendations relate to all children and young people up to the age of 18, including those with a medical condition or disability (except where clinical assessment or monitoring is required prior to and/or during physical activity). The recommendations are grouped as follows: national policy, high level policy and strategy, local strategic planning, local organisations (planning, delivery and training) and local practitioners (delivery)

- Those responsible for national campaigns (Department of Health, Department for Children, Schools and Families and Department for Culture, Media and Sport working with: Department for Business, Enterprise and Regulatory Reform, Department for Communities and Local Government, Department for Energy and Climate Change, Department for Environment, Food and Rural Affairs, Department for Innovation, Universities & Skills, Department for Transport, Cabinet Office, Home Office, Ministry of Justice) should deliver a long-term (minimum 5 years) national campaign to promote physical activity among children and young people. The campaign should be integrated with and support other national health campaigns and strategies to increase participation in play and sport and reduce

<sup>118</sup> Priest *et al.* (2008) recently conducted the *Cochrane Review* of interventions implemented through sporting organisations for increasing participation

obesity.

- The best media should be used to deliver the most effective messages in the most appropriate language for different groups. The campaign has to be consistent and sustained and convey that physical activity: is healthy, fun and enjoyable, makes you feel good and can be sociable. It should also address any concerns that parents and carers may have about their children's safety.
- Regional and local campaigns are to be encouraged to use the same messages, as well as promoting examples of local opportunities to be physically active.
- Develop resources for regional and local dissemination of the campaign.
- The Chairs of children's trusts, Chairs of local strategic partnerships, Chief executives of primary care trusts (PCTs), Directors of children's services, Directors of public health should raise awareness of the importance of physical activity by ensuring that the following explicitly address the need for children and young people to be physically active: children and young people's plans, joint strategic needs assessments, local development and planning frameworks, and sustainable community plans and strategies
- All local authority departments and other local strategic partnership agencies responsible for physical activity facilities and services for children and young people. Policy makers and planners working in the public, voluntary, community and private sectors should develop physical activity plans. Identify Groups of local children and young people who are unlikely to participate in at least 1 hour of moderate to vigorous physical activity a day should be identified and involved in the design, planning and delivery of physical activity opportunities, using the information gathered. Consult with different groups of children and young people and their families on a regular basis to understand the factors that help or prevent them from being physically active. Ensure children and young people from different socioeconomic and minority ethnic groups are actively involved in the provision of activities. Also ensure those with a disability (or who are living with a family member who has a disability) are actively involved.
- Use the information gathered to increase opportunities for children and young people to be physically active and to plan dedicated programmes that tackle any inequalities in provision.
- The Directors of children's services, leisure and cultural services, planning and regeneration, Governors and heads of schools and colleges, office managers and other decision-makers involved with buildings and outdoor spaces within the public, voluntary, community and private sectors, Planning and regeneration service managers and project managers and those involved in developing the 'Unitary development plan' (UDP) or other strategic planning documents, Representatives from crime and disorder reduction partnerships should work in partnership with or as part of the local strategic partnership to Plan the provision of spaces and facilities. They should ensure physical activity facilities are suitable for children and young people with different needs and their families, particularly those from lower socioeconomic groups, those from minority ethnic groups with specific cultural requirements and those who have a disability. Children and young people should feel safe taking part in physical activities in these places and facilities and all groups including those with disabilities should have access.
- School facilities available to children and young people before, during and after the school day, at weekends and during school holidays. These facilities should also be available to public, voluntary, community and private sector groups and organisations offering physical activity programmes and opportunities for physically active play.

- Public parks and facilities as well as more non-traditional spaces should actively be promoted as places where children and young people can be physically active.
- Town planners should make provision for children, young people and their families to be physically active in an urban setting. They should ensure open spaces and outdoor facilities encourage physical activity. They should also ensure physical activity facilities are located close to walking and cycling routes.
- Governors and heads of schools and colleges, Local transport authorities and executives, Police casualty reduction officers, Road safety officers, School travel advisers, Transport planners should Ensure local transport and school travel plans continue to be fully aligned with other local authority plans which may impact on children and young people's physical activity. Ensure local transport plans continue to be developed in conjunction with local authority departments and other agencies that provide spaces and facilities for children and young people to be physically active. Ensure local transport plans acknowledge any potential impact on opportunities for children and young people to be physically active. Transport plans should aim to increase the number of children and young people who regularly walk, cycle and use other modes of physically active travel. They should make provision for the additional needs of, or support required by, children, young people and their parents or carers with a disability or impaired mobility. Continue working with schools to develop, implement and promote school travel plans.
- Organise training courses for school travel plan advisers.
- Identify any aspect of transport policies which discourages children and young people from using modes of travel involving physical activity.
- Public, voluntary, community and private sector managers and decision-makers responsible for – or able to influence – opportunities for children and young people to be physically active, Governors and heads of schools and colleges should identify local factors that may affect whether or not children and young people are physically active by regularly consulting with them, their parents and carers.
- They should find out what type of physical activities children and young people enjoy, based on existing research or local consultation and actively involve them in planning the resulting physical activities.
- Remove locally identified barriers to participation.
- Provide regular local programmes and other opportunities for children and young people to be physically active in a challenging environment where they feel safe (both indoors and outdoors). Ensure these programmes and opportunities are well-publicised.
- Ensure physical activity programmes are run by people with the relevant training or experience.
- Employers or supervisors of the People who provide programmes or opportunities for children and young people aged 18 and under to be physically active should ensure informal and formal physical activity sessions for children and young people are led by staff or volunteers who have achieved the relevant sector standards or qualifications for working with children. Ensure staff and volunteers have the skills (including interpersonal skills) to design, plan and deliver physical activity sessions (including active play sessions) that meet children and young people's different needs and abilities. Use community networks and partnerships to encourage, develop and support local communities and volunteers involved in providing physical activities for children and young people.
- Education and training organizations should establish continuing professional development (CPD) programmes for people involved in organising and running



formal and informal physical activities. Monitor and evaluate the impact of training on practitioner performance. Train people to deliver physical activity CPD programmes.

- Public, voluntary, community and private sector organisations involved in designing physical activity projects and programmes, Governors and heads of schools and colleges should identify education institutions willing to deliver multi-component physical activity programmes involving school, family and community-based activities. They should also identify families, community members, groups and organisations and private sector organisations willing to contribute.
- They should develop multi-component physical activity programmes including: education and advice to increase awareness of the benefits of physical activity and to give children and young people the confidence and motivation to get involved policy and environmental changes and new opportunities for physical activity during breaks and after school. It could also include school-based family activity days the community.
- Public, voluntary, community and private sector managers and decision-makers responsible for – or able to influence – opportunities for children to be physically active should ensure opportunities, facilities and equipment are available to encourage children to develop movement skills, regardless of their ability or disability. Provide children with access to environments that stimulate their need to explore and which safely challenge them. Also provide them with the necessary equipment. Ensure children have the opportunity to explore a range of physical activities to help them identify those they can enjoy by themselves and those they can do with friends and family.
- Provide daily opportunities for participation in physically active play by providing guidance and support, equipment and facilities. Keep children motivated to be physically active by updating and varying the way physical activities are delivered (including the resources and environments used).
- Ensure opportunities are available after school, at weekends, during half-term breaks and during the longer school holidays. Activities should be led by appropriately trained and qualified staff (paid or voluntary) and take place in schools and other community settings.
- Public, voluntary, community and private sector managers and decision-makers able to influence physical activity facilities, opportunities and programmes for girls and young women should consult with girls and young women to find out what type of physical activities they prefer and actively involve them in the provision of a range of options in response. Offer school-based physical activities, including extra-curricular ones. Provide advice on self-monitoring and individually tailored feedback and advice.
- Address any psychological, social and environmental barriers to physical activity appropriate changing facilities offering privacy.
- Governors and heads of schools and colleges, those involved in governing or leading pre-school and early years education, school travel advisers should continue to encourage a culture of physically active travel. They should develop a school travel plan which has physical activity as a key aim and integrate it with the travel plans of other local schools and the local community. Ensure schools provide suitable cycle and road safety training for all pupils and encourage children and young people, especially those who live within a 2-mile radius of their school or other community facilities, to walk, cycle or use another mode of physically active travel to get there. Work with local authorities to map safe routes to school and to local play and leisure facilities. Take into account the views of pupils, parents and carers and consult with the local community. Overcome any barriers that are

identified.

- Involve children and young people, their parents and carers, the local community and external agencies in implementing the school travel plan. Use a mix of measures to promote it. Work with the local authority school travel plan adviser to recruit volunteers on a long-term basis to help implement it.
- Develop parents' and carers' awareness of the wider benefits of walking and cycling and other physically active modes of travel.
- Children's centre staff, Early years providers, Parents and carers, Teachers and school support staff and Those providing local opportunities for physical activity in the voluntary, community and private sectors should provide a range of indoor and outdoor physical activities for children on a daily basis, including opportunities for unstructured, spontaneous play.
- Tailor activities according to the child's developmental age and physical ability. Ensure they are inclusive, progressive and enjoyable. Provide opportunities at intervals throughout the day in pre-school establishments. Help children identify activities they can enjoy by themselves and those they can enjoy with their friends and families.
- Practitioners who lead physical activities including youth leaders, teachers, coaches and volunteers should help girls and young women to be active by supporting participants of all abilities in a non-judgmental and inclusive way. Emphasis should be on the opportunities for participation, enjoyment and personal development.
- Encourage those who initially choose not to participate to be involved with physical activities in other ways and help them move gradually towards full participation. It should be practical, affordable and acceptable to them, without compromising their safety or restricting participation.
- Provide appropriate role models.
- Groups and individuals who have regular contact with children, young people, their parents and carers should ensure that parents and carers are aware of government advice that children and young people should undertake a minimum of 60 minutes moderate to vigorous physical activity a day. Make them aware that, at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.
- Provide information and advice on the benefits of physical activity, emphasising how enjoyable it is. Provide examples of local opportunities.
- Encourage parents and carers to get involved in physical activities with their children.
- Encourage parents and carers to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel.
- Parents and carers should also be encouraged to allow their children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances.
- Act as a role model by incorporating physical activity into daily life. Promote physically active travel as an option for all the family. Raise awareness of how it can help children and young people achieve the recommended daily amount of physical activity.

## **8.2.2 Promoting physical activity in the workplace (PH13) May 2008**

The guidance is for employers and professionals in small, medium and large organisations who have a direct or indirect role in, and responsibility for, improving health in the workplace. The recommendations in this guidance aim to help employers and workplace health professionals prevent the diseases associated with a lack of physical activity by encouraging employees to be physically active. The four recommendations cover policy and planning, implementing a physical activity programme, components of the physical activity programme and supporting the employer:

- Employers in organisations of all sizes, Public health professionals, occupational health professionals, workplace health promoters should develop an organisation-wide plan or policy to encourage and support employees to be more physically active.
- Employers in organisations of all sizes, Public health professionals, occupational health professionals, workplace health promoters, Trades unions, other employee representatives, employees should introduce and monitor an organisation-wide, multi-component programme to encourage and support employees to be physically active.
- Employers in organisations of all sizes, People responsible for buildings and facilities, Public health professionals, occupational health professionals, workplace health promoters, Trades unions, other employee representatives, employees, should encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work and help employees to be physically active during the working day by: encouraging them to move around more at work, putting up signs at strategic points and distributing written information to encourage them to use the stairs rather than lifts and providing information about walking and cycling routes and encouraging them to take short walks during work breaks.
- Directors of public health, public health practitioners in the statutory and voluntary sectors, Local strategic partnerships, Private, statutory and voluntary organisations with responsibility for increasing physical activity levels or for occupational health, Trades unions, business federations, chambers of commerce should offer support to employers who want to implement this guidance to encourage their employees to be more physically active by providing information on, or links to, local resources, advice and other information or resources. Focus should be on enterprises where a high proportion of employees are from a disadvantaged background, a high proportion of employees are sedentary, small and medium-sized enterprises.

## **8.2.3 Physical activity and the environment (PH8). Jan 2008**

This guidance offers evidence-based recommendations on how to improve the physical environment to encourage physical activity. The guidance is for NHS and other professionals who have a direct or indirect role in – and responsibility for – the built or natural environment. This includes those working in local authorities and the education, community, voluntary and private sectors. The seven recommendations cover strategy, policy and plans, transport, public open spaces, buildings and schools and are as follows:

- Those responsible for all strategies, policies and plans involving changes to the physical environment are to 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.

- Those responsible for all strategies, policies and plans involving changes to the physical environment, including local transport authorities, transport planners and local authorities are to Ensure that 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.
- Planning and transport agencies, including regional and local authorities are to Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity.
- Designers and managers of public open spaces, paths and rights of way (including coastal, forest and riverside paths and canal towpaths), planning and transport agencies including regional and local authorities are to Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity.
- Architects, designers, developers, employers and planners Work with those involved with campus sites, including hospitals and universities to ensure different parts of the site and new workplaces are linked by appropriate walking and cycling routes.
- Architects, designers and facility managers who are responsible for public buildings (including workplaces and schools) should ensure staircases are designed, positioned, clearly signposted and attractive to encourage people to use them.
- Children's services, School Sport Partnerships, school governing bodies and head teachers are to ensure school playgrounds are designed to encourage varied, physically active play. They should also Create areas that promote individual and group physical activities in Primary schools.

## **8.2.4 PH guidance 2. Four commonly used methods to increase physical activity. May 2006.**

The recommendations of NICE public intervention guidance on increasing physical activity take into account the Chief Medical Officer for England's (CMO's) recommendation that adults should achieve at least 30 minutes moderate activity on five or more days of the week. This guidance is for professionals in the NHS, local authorities and the voluntary sector. It focuses on four methods of getting adults to increase physical active including; brief interventions in primary care (opportunistic advice delivered by GPs and other non-hospital-based health professionals), pedometers (use of a device to measure how far you have walked), exercise referral schemes (referral to a tailored physical activity programme) and community-based exercise programmes for walking and cycling.

The recommendations include:

- Adults who are not physically active should be advised to be moderately active for at least 30 minutes, 5 days of the week. They should be provided with details of local opportunities and the GP or other practitioner should agree goals with them, bearing in mind their preferences. Moderate activity includes some of the actions involved in daily life such as walking or cycling.
- Monitor whether or not this advice encourages people to be more physically active.
- Exercise referral schemes, pedometers and community walking and cycling schemes should only be endorsed to promote physical activity if they are part of a formal research study to determine effectiveness.

### 8.3 Summary of key findings

Predictors for participation and non-participation in physical activity are reported more often as fun, enjoyment and the development and maintenance of social support networks more than perceived health benefits. Along with older groups, children see enjoyment and social interaction with peers as reasons to be physically active, this is much more important than skills development for example. For young children and teenage girls in particular, pressure to conform to social stereotypes is a key motivator and this pressure extends to parental influence about choices for activities. Barriers to participation vary for the different sub populations however there are issues related to safety, culture and access which is particularly significant where efforts are focused in locations comprising large numbers of traditionally sedentary groups and individuals such as traditional environments like leisure centres. Cost is a highly rated factor but this sits alongside child care and other barriers such as not being able to go with a companion and these are factors reflected by stakeholders in Barnet and our work on segmentation.

Current data on effective physical activity interventions are generally the result of short-term studies. Behavioural, physical and clinical outcomes often take much longer to manifest and thus the full impact of the intervention may not be measured within the study follow-up time. Little is known on the sustainability of interventions over time, nor on the cost-effectiveness of physical activity interventions. That said it is apparent that some interventions in some settings are not effective – exercise on referral schemes and some forms of guided walk. There are modifications to both that can increase long term commitment to activity. Improved knowledge and access to specialist input from physical activity expertise in primary care for example are key to increasing activity in people from whom immediate benefits are essence for health.

Studies have shown that across categories, interventions that are multi-component and adapted to the local context are the most successful. Those that are culturally and environmentally appropriate are also far more likely to be implemented and sustained. Furthermore, interventions that use the existing social structures of a community reduce barriers to implementation. Implicit in all successful interventions is the participation of the stakeholders throughout the process. Listening and learning from these target populations ensures that the interventions address their needs.

Finally;

- "Multisectoral policies are needed to promote physical activity."
- "Consistent, coherent, simple and clear messages should be communicated through many channels and in forms appropriate to local culture, age and gender. Simple, direct messages need to be communicated on the quantity and quality of physical activity sufficient to provide sustainable health benefits."
- "School policies and programmes should support the adoption of healthy diets and physical activity."
- "Strategies should be geared to changing social norms and improving community understanding and acceptance of the need to integrate physical activity into everyday life."
- "Routine enquiries as to physical activity, combined with simple information and skill-building to change behaviour, taking a life-course approach, can reach a large part of the population"

## Chapter 9: Recommendations

The needs assessment has been undertaken by considering a range of elements - the health, population and physical activity profile of borough residents, the description of the market in Barnet, the views of stakeholders and a review of the evidence around what are the best ways to motivate people to become more active. All of the elements have come together and provided a view which present a coherent view about what are the most important factors to take into account and in each section the views or evidence gathered serves to endorse the overall perspective.

### Recommendations

These refer to actions which would help to inform further the next steps for the Sport and Physical Activity Review.

#### 1. Strategic Development

The needs assessment has found that although there are some council policies that compliment each other – there are others that do not in terms of promoting physical activity. This is a frustration for those involved in the sector and needs to be rectified.

- **Recommendation**

The development of a sports and physical activity strategic statement, as part of the Health and Well-being Strategy.

Such statement should ensure that provision meets the needs of residents and is an affordable and sustainable approach, balancing competitive sport with stimulating communities and target groups to become more active.

This should follow 'Marmot' approach of Proportionate Universalism to achieve the most gains and benefits.

- **Recommendation**

That there is a clear strategic direction set for physical activity in Barnet utilising the facilities already in place where appropriate but in particular supporting local communities to increase participation through increased support for volunteers, and promoting school sports and school facilities.

#### 2. Local Needs and Promoting Physical Activity

People in Barnet are less active when compared to those in England and London with only 19% of residents taking part in 3x30min sessions of moderate activity per week. This is also the case when Barnet is compared to local boroughs in north central London, only Enfield has lower levels of activity.

In addition to low levels of activity there is a downward trend in contrast to national trends which are rising, though London trends are similarly downward. Chapter 3 has commented on the different sub groups in the population – age, disability, gender, ethnicity, socio-

economic groups and geographical differences and highlighted that there are lower levels in groups who tend to experience greater difficulties with accessing other services and opportunities and there are a number of reasons for this. There are less women than men accessing leisure in Barnet, less non-white groups and less people who live in the more deprived areas, particular along the west side of the borough, but also in the Underhill area. Those groups who are less active in Barnet are also more likely to be suffering from or susceptible to lifestyle disease. Intermediate levels of activity are to be found along the eastern fringes of the borough – Finchley/Woodhouse and Brunswick Park and the highest levels in the central areas, with the exception of Underhill.

The groups who are the most sedentary consist of 48.8% of the population. They are:

- those with life limiting illness or disability,
- older than 55 years,
- residents in lower socio economic groups,
- women
- non white groups

The greatest public health benefit is to get these groups at least minimally active. cancer, diabetes, heart disease, respiratory disease and joint disease all have a relationship with low levels of physical activity.

The evidence and stakeholder conversations also suggest that young people are interested in taking part in physical activity that is not team based, and has an individual focus. There may be less opportunity for this through current structures and this should be addressed to promote more physical activity across schools and young people.

#### ▪ **Recommendation**

To support the Barnet Schools Sports Partnership to provide activities that young people are likely to participate in and choose in addition to competitive sports.

#### ▪ **Recommendation**

That provision recognises those activities which the market segmentation suggests are the most likely to be taken up – swimming, gym and cycling. A planned increase of cycling opportunities in the built environment in Barnet would be key in increasing access.

#### ▪ **Recommendation**

That the roles that can support physical activity and sport within the Council are enlarged to cover the most sedentary populations for whom the most benefit can be gained.

#### ▪ **Recommendation**

A coordinated approach to targeting selective groups and providing a universal message to Barnet residents about the benefits of increasing physical activity and moving from a sedentary lifestyle to a more active one. This should include priority groups and the general population and should take account of the barriers and constraints identified in the needs assessment and in particular through the market segmentation chapter of the needs assessment.

#### ▪ **Recommendation**

A greater involvement of local health and primary care teams to ensure that they are fully informed about local opportunities, understand guidance and what to recommend and have an awareness of the barriers and constraints to becoming more active.

### **3. Provision and Facilities**

The provision of the facilities in Barnet is a key driver for the initiation of the needs assessment. There are several issues which arose from the setting, cost and type of provision that is provided. Barnet has expensive facilities for local clubs to rent, for individuals to use and there are some areas which are poorly served by anything other than private facilities. The type of facilities offered by the key leisure provider does not cover all the range of activities that large segments of the population would like to engage with. Some of these are better suited to community based providers and some might be able to be provided under the auspices of a larger provider. Key to this however is the commitment to the infrastructure to enable residents to access, understand and get to where sport and physical activity is sited.

#### ***Priority groups***

The largest priority group populations are located on the west and south west of the Borough. Key wards include Burnt Oak, Colindale, Childs Hill and East Finchley (to the east). The population between 2012 and 2031 is projected to increase most significantly in the west and central regions of the Borough.

#### ***Accessibility***

In terms of physical access to sport facilities the most deprived area across the majority of facility types is the west part of Edgware. Other areas that have relatively low accessibility levels to a selection of facility types include Burnt Oak and Colindale (west), Childs Hill (south), Hale and Mill Hill (central), High Barnet (north, particularly gyms access) and East Barnet (north east, particularly Synthetic Turf Pitches/STPs).

When considering facility size as well as travel time, as an indicator of overall availability of facilities, priority wards include Edgware, Golders Green, Childs Hill, Garden Suburb and High Barnet (STPs).

#### ***Supply and demand***

There are generally low levels of provision across all facilities in the west with wards such as Colindale with minimal levels of facility share for all activities.

There has been a slight increase in participation rates for swimming, football and tennis but generally all other activities have seen a decline. There are pockets of latent demand, mainly in the south and south east (and small areas of the south west), which supports the Gap Analysis and suggests that these should be areas where capacity and accessibility need to be reviewed as a matter of priority.

There is clearly a need for new sport facility provision across the Borough of Barnet and this need will only increase given the significant population growth projections. At the same time there is the opportunity to refine certain facility mixes and relocated facilities so they best meet the needs (and address the gaps) of the local resident population. The



planning of new facility provision or the rationalisation of existing facilities should balance the areas of priority identified in the Gap Analysis and the levels of undersupply for particular sports identified within the Supply and Demand section.

- **Recommendation**

To consult with leisure providers on the range and scope of activities that can be provided outside of traditional venues

- **Recommendation**

To establish a forum to support the development of community based provision alongside ProActive North London, the Barnet Schools Sports Partnership, Barnet Council (including public health and play support) and private providers and guide on the strategic development of physical activity in Barnet.

- **Recommendation**

To explore the use of school facilities for the provision of community led and community based activities open to residents and address barriers.

- **Recommendation**

To investigate the revision of local provisions the pricing of swimming for concessionary groups.

## 4. Participation and Volunteering

Overall Barnet participation is high in affluent populations but struggling in those groups where a lifestyle change or lifelong habit would be most beneficial to the long term health of the population. In addition the infrastructure of community based organisations is potentially threatened by low levels of volunteers, this suggests that Barnet has an over reliance on private health and fitness clubs most of which attract higher to middle income groups.

- **Recommendation**

To explore ways to increase volunteers through some the sports leadership schemes and support clubs where this is the main need.

## 5. Addressing barriers and constraints

- **Recommendation**

Provision for childcare and family friendly opportunities to encourage parents and families to take part together or to give parents the chance to exercise, particularly in lone households. Active parents often means active children and so the benefits are increased.

- **Recommendation**

Both the stakeholders and the market segmentation identified the cost of physical activity as a barrier to participation. This was supported by the physical activity profile and the evidence in Chapter 7. Concessions should be reviewed to ensure that they are meeting the needs of the potential users.

- **Recommendation**

Older people in particular – but not exclusively – identified not having anyone to go with as a barrier for being active. Schemes to allow buddying or friendship groups to access facilities at reduced rates should be investigated.

- **Recommendation**

To review the ways in which sport and physical activity opportunities are publicised and the means by which people are invited to initiate their involvement in these.

- **Recommendation**

Young mothers, the over 65s, and the middle aged are priority groups for Barnet, they are less likely to be active, more likely to find barriers and are in the groups most likely to benefit from being more active.

- **Recommendation**

To increase the opportunities for every young children to engage in active play through further promotion of free and grassroots based activities

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