Physical activity (inequality) Bristol

Health Needs Analysis

2025

Acknowledgements

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Executive Summary

Physical inactivity is a major contributor to adverse health outcomes, such as cardiovascular disease, mental health conditions, and increased risk of falls. Both nationally and in Bristol, inequalities in participation are evident, shaped by age, ability, ethnicity, gender, and socio-economic status. Nationally, fewer than half of adults aged 70 and over meet recommended activity levels. Inactivity is closely linked to chronic conditions and frailty, with disabled individuals frequently encountering barriers like ableist attitudes and inaccessible environments. The pandemic has led to a decline in children's activity levels, particularly among girls, ethnic minorities, including Black and Asian backgrounds and those from less affluent families. Adults living in deprived areas are less active, and rising living costs exacerbate these disparities. Ethnic minority groups face poorer health outcomes and limited-service access, while women, transgender individuals, and South Asian women experience cultural and social limitations on activity. Effective interventions include enhancing the built environment such as parks and cycling routes and fostering inclusive community initiatives.

Local Challenges in Bristol

Bristol mirrors national patterns. Cardiovascular disease mortality among those under 75 is rising, especially among men in deprived areas, while emergency hospital admissions due to falls in people aged 65 and over are increasing, with women and those in deprived areas most affected. Mental wellbeing is particularly poor among residents in deprived areas, disabled people, and those from mixed or multiple ethnic backgrounds. While 67% of Bristol residents report sufficient regular exercise, this rate falls below 50% for people with no qualifications, disabled individuals, residents in social housing, adults aged 65+, Black/Black British respondents, and full-time carers. Although overall inactivity is declining, disparities between the most and least deprived persist. Two-thirds of inactive adult's report having a disability or long-term health condition, and leisure centre attendance among disabled and older adults remains low.

Children and Young People in Bristol

Children and young people in Bristol face declining physical activity levels, affected by socio-economic status, ethnicity, and gender. Fewer than half meet recommended activity levels, and more children are active for less than 30 minutes per day. Girls and children from Black and Asian backgrounds are particularly impacted. Pupil Voice data shows that gender-diverse pupils, LGBQ+ youth, young carers, and pupils in temporary accommodation have the lowest activity levels, while pupils of mixed heritage are more active. Safety concerns arising from knife crime to traffic limit outdoor play, and cultural shifts have moved activity from unsupervised play to structured, adult-facilitated sessions, which are less accessible for families with limited resources. These trends have long-term implications for health and wellbeing.

Lived Experience and Community Insight

Community insights reveal that inclusive and accessible environments are critical for participation. Disabled people emphasise the need for familiar venues, clear accessibility information, and stable routes, as temporary changes can cause anxiety. Peer recommendations and approachable

instructors help build confidence. Older adults cite the impact of aging, internalised ableism, and the necessity for rest facilities and toilets when being active outdoors. Parents face constraints due to childcare, although some find opportunities to be active with their children. Harassment, especially for women and individuals living with obesity is a significant deterrent. Cultural norms and discrimination, including racism and islamophobia, restrict movement and access to safe spaces, sometimes confining individuals to areas where they feel less likely to experience abuse. Although active travel is seen as vital, poor infrastructure and stigma around activities like cycling in low-income communities reduce uptake.

Priority Areas for Action

Strategic priorities focus on addressing inequalities, improving access to physical activity, and fostering inclusive environments. Three core areas have been identified: Liveability, Accessibility, and Equality. Liveability promotes opportunities to be active outdoors and as part of daily life, advocating for playful movement for children, unstructured opportunities for teenagers, and embedding public health into planning and transport. Accessibility targets support for older adults, disabled people, and those with long-term health conditions through better information, inclusive advertising, staff training, and local opportunities. Equality seeks to empower underrepresented groups by increasing data representation, creating women-only spaces, and ensuring messaging avoids fatphobia and body shaming. Community-led initiatives, infrastructure improvements, and targeted support for vulnerable groups are emphasised.

A Settings-Based Approach

A settings-based approach integrates physical activity into everyday environments such as schools, workplaces, healthcare settings, community spaces, and digital platforms. This ensures interventions are targeted, effective, and responsive to Bristol's diverse population. Embedding physical activity into daily environments supports sustainable behaviour change and equity in access, helping create inclusive and lasting health outcomes.

Conclusion

Tackling physical inactivity in Bristol demands a comprehensive and inclusive strategy. By combining quantitative evidence with lived experience, clear priorities for action emerge, including a settings-based approach to embed physical activity into daily life. These efforts will help reduce inequalities and improve health outcomes, supporting Bristol's ambition to be a more active, inclusive, and equitable city.

Introduction

This report examines and analyses relevant policy, literature and data to identity actions which address inequalities in physical activity locally.

Context

Health Equity

The proportion of physical active adults in Bristol in 2023-24 compared favourably with national figures (75% vs 64%). However, the health benefits of being active are not enjoyed equally across Bristol's populations and this contributes to health inequalities. The term 'health inequalities' along with the objective of 'health equity' recognises the unfair and avoidable differences in health outcomes across different populations and groups within society. These disparities arise from the varying conditions in which people are born, grow, live, work, and age. These conditions significantly impact opportunities for good health and influence mental, physical, and overall wellbeing (Office for Health Improvement and Disparities, 2022). Various factors are believed to contribute to health inequalities, including:

1. **Socio-economic status and deprivation**: Factors like unemployment, low income, living in deprived areas, poor housing, and educational attainment.
2. **Vulnerable or inclusion health groups**: Groups such as vulnerable migrants, Gypsy, Roma, Irish Traveller and Boater communities, people experiencing homelessness, offenders or former offenders, and sex workers.
3. **Protected characteristics under the Equality Act 2010**: These include age, sex, race, sexual orientation, marriage or civil partnership, pregnancy and maternity, gender reassignment, religion or belief, and disability.
4. **Geography**: Characteristics of the place we live, such as population composition, built and natural environment, levels of social connectedness, and specific geographical features like urban, rural, and coastal areas.

These are interconnected and can influence each other in complex ways. This interaction can either benefit or disadvantage individuals or groups, leading to disparities in health outcomes. People often fall into multiple categories, which means they can face several overlapping challenges that impact their health simultaneously (Office for Health Improvement and Disparities, 2022).

International guidelines

The World Health Organisation (WHO) physical activity guidelines offer evidence-based recommendations for various age groups, including children, adolescents, adults, and older adults (World Health Organization , 2020). These guidelines specify the frequency, intensity, and duration of physical activity needed to achieve significant health benefits and reduce health risks. Notably, they also address the impact of sedentary behaviour on health outcomes and provide tailored recommendations for specific subpopulations, such as pregnant and postpartum women, and individuals with chronic conditions.

National guidelines

In 2019, the four UK Chief Medical Officers (CMOs) published evidenced based guidelines regarding the amount and type of physical activity that individuals in the population should be aiming to achieve and these were last updated in 2020 (Department of Health and Social Care, 2020). The recommendations are adapted for different age groups and for those who are pregnant/post-partum, and for disabled adults. Additional guidance for Disabled children and young people was published in 2022 (Department of Health and Social Care, 2022). The guidance highlights that there is no minimum amount of physical activity required to achieve some health benefits "some is good, more is better", and discusses risks concerning sedentary behaviour. Although now 5 years old, these guidelines are widely regarded as an international gold standard.

Physical Activity guidelines for Adults (including older adults and Disabled adults): • At least 150 active minutes per week at moderate intensity OR 75 minutes at vigorous intensity • Build strength on at least 2 days a week • Minimise sedentary time • Improve balance • **Additionally, in pregnancy:** • Stick to 150 minutes of moderate intensity and two muscle strengthening activities per week • Listen to your body and adapt • Don't bump the bump • If inactive, start gradually • If active, keep going	**Physical activity guidelines children** **Under 1 year:** • Aim for at least 30 active minutes across the day **Ages 1-5 years:** • Aim for at least 180 minutes per day for children **Ages 5-18:** • Aim for an average of at least 60 minutes per day across the week **Additionally, for Disabled children:** • For good health benefits, do 20 minutes of physical activity per day • When starting, build up slowly. Ask: can you do this today? • Do bitesize chunks of physical activity throughout the day • Do challenging but manageable strength and balance activities 3 times per week • Small amounts of physical activity are good for you as well

National Strategy

A national strategy for sport and physical activity was published under a previous Government (Department for Culture Media and Sport , 2023). The strategy includes three core priorities:

1. Being unapologetically ambitious in making the nation more active, whether in government or in the sport sector.
2. Playing sports and physical activity more inclusive and welcoming for all so that everyone can have confidence that there is a place for them in sport.
3. Moving towards a more sustainable sector that is more financially resilient and robust.

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS)

This Health Needs Analysis aligns with the strategic priorities of the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS), which emphasises prevention, reducing health inequalities, and promoting healthier communities. Physical activity is recognised within the ICS as a key driver of improved population health, particularly in managing long-term conditions, supporting mental wellbeing, and enabling healthy ageing (ICB, n.d.)

Bristol City Council, One City and WECA

The positive impact that physical activity has across numerous sectors is highlighted by its inclusion in a broad range of local Policies and Strategies. Two key examples include the benefit that an increase in active travel has on air pollution, climate change and sustainability, and the relationship between sport and physical activity participation and crime reduction.

Appendix 1 summarises Bristol City Council, One City and WECA (West of England Combined Authority) policies and strategies that reference physical activity or active travel.

Bristol Active City Network

The Bristol Active City Network (BACN) is a network of individuals and organisation in the Bristol area, collectively working to help reduce physical inactivity inequalities and enable physical activity opportunities. The formation of the BACN is in response to the recognition that a whole system approach is required to increase physical activity within Bristol. A whole system approach explains that individuals and single organisations are not able to provide a solution to a complex problem, and that working together with shared goals will help reduce barriers and create the best opportunities for our population.

"By working collaboratively and cooperatively, as a whole system, we will seek to transform attitudes and behaviours and make it easier for residents to enjoy sport and physical activity and embed it into their everyday lives"

Covid-19

On 23rd March 2020, England entered its first lockdown, leading to the closure of all non-essential businesses, including gyms, outdoor sports amenities, and playgrounds. On 10th May 2020, it was announced that the strict lockdown measures would be eased, allowing unlimited outdoor exercise from 13th May 2020. By 4th July, further public amenities, such as outdoor gyms and playgrounds, were reopened. Finally, on 25th July 2020, indoor gyms and swimming pools were allowed to reopen.

National data and research

Barriers and facilitators to physical activity and associations with health, were explored via scoping national research, literature and data published within the last five years. In the main, this was undertaken via Open Athens, however, Google scholar was utilised for a broader overview. Also considered were publications and data from organisations such as Sport England and other bodies whose work may not be available via academic platforms.

Engagement in physical activity is associated with positive health outcomes (Office for Health Improvement and Disparities, 2022), and a range of cultural, social and historical reasons influence whether someone is active (Cereda, 2023). The factors contributing to health inequalities are interconnected and can influence each other in complex ways. This interaction can either benefit or disadvantage individuals or groups, leading to varied health outcomes. People often fall into multiple categories, which means they may face several overlapping challenges that impact their health simultaneously (Office for Health Improvement and Disparities, 2022).

Health conditions

Inactivity is one of several risk factors for poor health which tend to cluster together and can be remembered through the initialisation ‘SNAP’ (smoking, nutrition, alcohol, physical activity) (Mayhew, 2024). Engaging in physical activity can help prevent and manage various noncommunicable diseases, improve mental health by reducing symptoms of depression and anxiety, and enhance overall well-being (World Health Organization, 2024). Maintaining consistent physical activity or increasing it over time has been linked to lower rates of all-cause and cardiovascular mortality compared to remaining consistently inactive (Yi Yang, 2021).

Exercise is protective against the risk of a fall, something that becomes increasingly harmful as a person ages (Office for Health Improvement & Disparities, 2022). Both muscle weakness and poor balance increase the risk of falling and exercises such as weight training and racquet sports are recommended to reduce this. The severity of injury resulting from a fall is worse for those with osteoporosis and recommended action to prevent this condition also includes weight bearing exercise. People aged 65 and older have the highest risk of falling and around a third of people in this age group, and around half of people aged 80 and over, fall at least once a year. Falling is a cause of distress, pain, injury, loss of confidence, loss of independence and mortality. For health services, falls are high volume and costly. The group-based physical activity programme, REtirement in ACTion (REACT), with strong social and behavioural change elements, are an effective approach to

maintaining good physical function in older adults who are at risk of increasing mobility-related disability (Stathi, 2022)

Specialist strength and balance programmes are available for people at risk of falling.

There is a statistically significant protective effect of objectively measured physical activity on prevalence and incident of depression (Gianfredi, 2020). Higher levels of physical activity are associated with lower odds of major depression and physical activity is also shown to reduce depression severity (Casanova, 2023). Analysis of the 1958 Child Development survey (including follow up data) found physical activity in adolescence to be associated with a reduced likelihood of elevated depressive symptoms in adulthood (Redig, 2022). Physical activity has also been found to be effective in improving the symptoms of anxiety and depression across a wide range of populations (Singh, 2023).

Activity levels

Around 63.7% of the national adult population meet the recommended 150 minutes of activity per week (Sport England, 2024). Men are more likely to be active than women or people who describe their gender in another way. Those from lower socio-economic groups are less likely to be active as are Chinese, Black and Asian people in the UK. Being active is also less common for Disabled adults and activity levels generally decrease with age. Analysis of data from the UCL COVID-19 Social Study, found that between March and August 2020, over 62% of individuals experienced little change, and 9% even increased their physical activity (Bu, 2021). However, nearly 29% saw a reduction in their activity levels during this period.

Older age

Nationally, the lowest proportion of any age group population reaching the recommended amount of activity per week (47%) is reported by adults of 75 and older (Sport England, 2024). An association between a higher number of chronic medical conditions and lower levels of physical activity in older adults (mean age 80.2 years) has been identified (Bevilacqua, 2022). Several motivating factors towards being active have been identified in older adults of 70+ years of age (Meredith, 2023). These include physical activity as part of self-identity as well as enjoyment and fun during exercise. For some older people, regular physical activity is triggered by a chronic illness and used as part of rehabilitation. Where older adults understand that anxiety and depression symptoms can be improved as well as confidence, this can be a motivating factor. However, reduced strength and mobility and impaired hearing and eyesight were amongst the factors which decrease older adults' perception that they can be active. For some, there are increased feelings of frailty as they age and sensations such as becoming breathless through exercise may be off putting. Health symptoms may vary day to day and medications can cause drowsiness which may add to feelings of slowing down as an individual ages. Personal risk and injury may be more of a concern for older adults which can mean they are less likely to want to leave the house in weather conditions such as ice and snow. This was especially true for people who had experienced a fall, although for a few this may prompt regular exercise to improve functionality.

Disabled People

National data suggests that less than half (42%) of Disabled adults are active (Sport England, 2024). An analysis of whether mainstreaming policy leads to inclusive sports practice at community level was undertaken using qualitative methods (Christiaens, 2021). Interviews were conducted with participants from sports organisations, officials and Disabled people. The analysis explored how participants understand inclusion and how this is influenced by ableism. In this study, ableism was found to influence whether Disabled people feel they can participate and identifies three outcomes of inclusion: parallel inclusion, full inclusion, and choice. Additionally, four approaches to achieve these outcomes could be: able-inclusion, barrier removal, creating opportunities, and mutual identity. Despite the intentions behind inclusion policies, their implementation is often influenced by ableist perspectives. This can hinder the expected increase in participation of Disabled individuals. Sports organisations could address this by strategically integrating disability provisions and actively engage with Disabled people to foster genuine inclusion.

Methods of inclusion (Christiaens, 2021)

1. **Parallel Inclusion** – Disabled people participate at the same setting but in separate to non-Disabled people.
2. **Full Inclusion** – Disabled People participate on an equal footing alongside non-Disabled people. Often initiated by a Disabled person themselves.
3. **Inclusive Choice**- Offers a choice of parallel or full inclusion and emphasises sport participation as its priority.

Three narratives have been highlighted in media coverage of the Paralympics: extraordinary normalcy, ableist rehabilitation, and sporting ablenationalism (Pullen, 2021). Narratives around parasport bodies and experiences are shaped by cultural discourses and impact audiences in various ways. These narratives are meaningful within the national and symbolic context of Paralympic sport, evolve with cultural moments and contribute to dominant disability discourses. The representation of Paralympic athletes influences social understandings of Disability, serving as a powerful educational and cultural medium that reflects inclusion, exclusion, and marginalisation.

Narratives identified in media coverage of the Paralympics (Pullen, 2021)

- **Extraordinary normalcy**- a body performing conventional normalcy despite otherness.
- **Ableist rehabilitation**- conceptions and practices that strive to restore the 'normal' life and body, which ableism promotes as key indicators of success.
- **Sporting ablenationalism**- where impairments have been ‘exceeded’ through technological assistance or where the impairment is not noticeable enough to disrupt ableist ideas of normalcy.

Children and Young People

Nationally, Children and young people’s activity levels have remained stable across the 2023-24 academic year (Sport England, 2024). However, Sport England Active Lives data shows that less than

half (47.8%) of children in the country are meeting the Chief Medical Officers' guidelines of taking part in an average of 60 minutes or more of sport and physical activity every day. There are also disparities in physical activity levels among different groups of children and young people. Black and Asian children, those from less affluent families, and girls are less likely to be active compared to their peers.

The UK Chief Medical Officers recommend that all children and young people should do at least an hour of moderate to vigorous intensity physical activity (MVPA) per day. Between 2020 and 2021, lockdowns and restrictions to reduce the spread of COVID-19 affected children's opportunities to be active. Researchers measured the physical activity levels of around 400 children with accelerometers – devices that measure MVPA – at two time points: in 2021 and 2022. This provided an idea of the shorter- and medium-term impact of the lockdowns on child activity levels (Jago, et al., 2023). These data were compared with information measured in the same way in 2017/18, before the pandemic. A year after all COVID-19 restrictions were lifted average child MVPA had recovered, but sedentary time remained high. These changes had the greatest impact on girls and children from lower income households.

In addition, a 'new normal' has emerged in children's physical activity, marked by increased reliance on organised activities and growing demand for school-based provision—demand that many schools are currently struggling to meet (Walker, et al., 2023a). Policies are urgently needed to support all children to be active, with targeted support for girls and children from lower income households (Walker, et al., 2023b).

Adolescents need supportive social and built environments to promote physical activity behaviours such as active travel, play and sport (van Sluijs, 2021). Young people aged 13-18 from socioeconomically deprived areas across the UK described several barriers to physical activity which were relevant before, during and after the COVID-19 pandemic (Alliott, 2024). Before the pandemic, young people described facing limited access to structured physical activity due to poor infrastructure, lack of local sports clubs, and costs. Gendered aspects of sport and school clothing also hindered participation, especially among girls and marginalised groups, due to self-consciousness and gender stereotypes. The COVID-19 pandemic further exacerbated inactivity trends among young people, worsening existing inequities. The absence of routine during lockdowns significantly impacted their physical activity levels and mental health. Young people suggest promoting school-based opportunities, safe and low-cost community facilities, and addressing gender and socioeconomic barriers to ensure inclusivity. Similarly, issues of 'physical activity insecurity' were raised by young people from disadvantaged areas to describe limited or restricted access to physical activity (Dodd- Reynolds.C, 2024). Many of the young people involved in this study described feeling unsafe and/or unwelcome at some indoor facilities and preferred exercise outdoors for reasons often linked to gender and sexuality.

The impact of COVID-19 on the physical activity of 10–11-year-old children and their parents was studied using accelerometer data and interviews with parents, children and school staff (Jago R,

2024). Children's physical activity levels were found to be significantly lower than pre-pandemic levels, with increased sedentary time. Although by 2022, physical activity levels returned to pre-COVID levels, sedentary time remained high. Changes in activity patterns were observed, with children engaging less in active play and more in structured activities like sports clubs. Disparities in activity levels widened, particularly affecting girls and children from low-income families.

Parents highlight how important it is for their disabled children to have social opportunities outside of the school environment where they are often excluded (Coates.J, 2023). In the process of trying to find ways for their child to develop self-esteem and confidence, parents may consider sports even if sporting success is not a goal. However, finding appropriate opportunities is not easy and often involves travel if nothing is available locally. There is a time and financial cost involved for parents of Disabled children which not all are able to provide. For those that can access the opportunities available, benefits were seen to be ‘worth it'.

The nature, purpose and value of special school physical education was explored through qualitative data collection and analysis (Maher, 2020). Participants in this small-scale study, identified Physical Education (PE) in special schools as intended to foster the overall development of students. It emphasises a holistic approach, recognising that PE can address physical, social, and cognitive aspects of a child’s growth. This approach is flexible and responsive to the unique needs of each pupil, rather than strictly adhering to traditional PE practices. By focusing on these diverse dimensions, PE within special schools can support the broader educational goals and curriculum in a way that is tailored to individual student needs. Although mainstream PE often struggles to provide meaningful experiences for Disabled students, Special school PE, frequently serves young people with diverse disabilities and other identity markers, which may sharpen the focus of practitioners on who they teach and how they support them.

PE in special schools, themes identified (Maher, 2020)

1. A broad and balanced curriculum- participants described
2. Needs-based approaches versus normative perceptions of physical education
3. Cross-curricular approaches to (physical) education
4. Physical education as preparation for life outside of school

Deprivation

There are several negative health implications to the cost-of-living crisis in the UK, and these are likely to disproportionately impact people on low-incomes (Broadbent, 2023). Targeting support to these households is likely to protect health most effectively. There are existing and growing inequalities in activity levels based on where someone lives (Sport England, 2024). Just over half (51%) of adults living in the most deprived areas of the country are active, a far lower percentage than in more affluent areas. Increases in the cost of living are amplifying disparities in disposable income and driving inequalities in access to physical activity (Sport England, 2024). The rising cost of running a

facility e.g. increased utility costs, along with cancelled memberships and a decrease in external funding is likely to put pressure on older facilities in communities with lower incomes.

Ethnicity

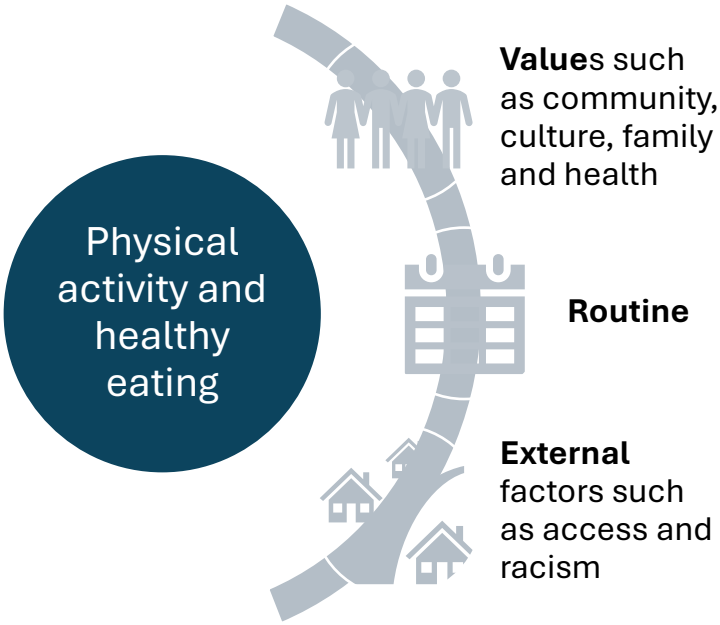
Nationally, adult respondents to Sport England's Active Lives Survey were disproportionately White British (80%) compared to the proportion recorded in the census in 2021 (74%). Only 2% of adult respondents identified as 'Black' which is lower than the national population (4%). Of the 4,166 black respondents nationally, 56% met the 150 active minutes a week recommendation. Along with the similar percentage as for Asian respondents (excluding Chinese), this was the lowest proportion reporting meeting the guidelines for physical activity of respondents from any ethnic group.

People from Black and minority ethnic groups often have worse health outcomes and less access to health services compared to White groups (Robertson, 2021). This situation varies among different ethnic groups and is hard to fully understand due to a lack of good data. Many Black and minority ethnic groups are more affected by poverty, which is a major factor in health. Structural racism in areas like housing, jobs, and the justice system can worsen these inequalities and harm their health.

Studies show that South Asian groups in the UK have higher rates of cardiovascular disease (CVD) and die from it more often compared to White groups (Raleigh.V, 2023). They also tend to develop heart disease at a younger age and have higher rates of stroke. The National Institute for Health and Care Excellence (NICE) recommends lower BMI thresholds for preventive measures in these groups. South Asians also have lower physical activity levels, especially among women. The increased CVD risk is due to a mix of genetic factors, socio-economic conditions, and lifestyle changes after migration. In contrast, Black groups in the UK have a lower risk of heart disease compared to the general population, despite high rates of hypertension and diabetes. However, Black groups have higher rates of hypertension and stroke, and they tend to have strokes at a younger age. Obesity levels are also higher in Black groups, and NICE guidelines recommend lower BMI thresholds for them.

Although there is a lack of research available which identified barriers and facilitators for UK adults from Black, Asian, and minority ethnic backgrounds (Mbabazi, 2022), a study which explored the physical activity and healthy eating behaviours of people of Black, Asian and mixed ethnicities in the UK, focused on the values and external factors influencing these (Gafari, 2024). Values such as culture and family, community and social life, and health are important in driving these behaviours but so too are external factors. External factors such as racism and access issues (including geographical, social, and economic) significantly impact health behaviours. Public Health programs need to align with the values of ethnic minority communities to improve engagement and relevance.

Figure 1. Values and factors influencing physical activity and healthy eating behaviours among UK ethnic minorities. Adapted from Gafari 2024



Women and marginalised genders

Nationally, Sport England Active Lives adult data for 2023/24 shows that 61.4% of female respondents reported that they are active for at least 150 minutes per week compared to 66.3% male respondents (Sport England, 2024). Data also shows that 26.3% of female respondents were likely to report that they are inactive compared to 23.7% of male respondents.

An even lower proportion of Transgender respondents (57.6%) reported they are active for 150 minutes a week and a higher proportion inactive (34.8%) in 2023/24.

For residents that described themselves another way to male or female, the proportion reporting 150 minutes of activity a week and the proportion reporting they are inactive, were similar to that of transgender respondents (59.1% and 33.2%). Amongst Black female respondents and Asian female respondents, the proportions reporting that they are active 150 minutes per week was lower than for White women and the proportion reporting they are inactive was higher.

Although British South Asians have a higher prevalence of overweight and obesity than the wider population, there may be limited opportunities for women from these communities to engage in Physical Activity (Iqbal, 2022). This is partly due to a perceived lack of culturally suitable exercise facilities as well as language barriers and a need to conform to community and family expectations. For example, the use of music may be haram (forbidden) in Islam but is often used in exercise classes and gyms. A lack of women only fitness opportunities has also been identified as a barrier to participation.

Maternity

For women at high risk of developing gestational diabetes, physical activity has been found likely to reduce this risk (Tsironikos, et al., 2023). The physical activity levels of pregnant women with gestational diabetes was explored and levels before and during the COVID-19 pandemic were compared (Hillyard. M, 2021). This identified a decline in activity amongst participant from an average of 4 days of 30 minutes per week before the pandemic to 2.8 days during. Over 60% of participants reported that their physical activity levels decreased during COVID-19. University educated women, those with equipment at home and those with knowledge of how to exercise safely during pregnancy were more likely to meet UK exercise guideline. Women with long term health conditions were less likely to be active. For those whose activity levels did decline, fear of leaving the house was the most stated reason.

Examples of effective interventions and inclusive practice

Unstructured activity outdoors – structured activity outdoors – structured activity indoors.

Built Environment

The built environment impacts health behaviours, and several urban interventions have been found to have a positive effect on physical activity, using pre and post intervention measurements (Zhang, 2022).

Intervention Categories:

1. **Park and Playground Interventions**: Positive effects from park renovations, adding exercise equipment, and new pocket parks.
2. **Walking and Cycling Interventions**: Improvements in cycling environments, walking & cycling environments, and multi-component initiatives for active travel.
3. **Community-Based Interventions**: Enhancing availability & accessibility of destinations showed positive effects.

An emphasis on proximity-based planning, where an urban neighbourhood is planned to ensure residents have access to basic essential services within a 15-min walking or cycling distance have successfully been implemented in cities such as Paris (Moreno, 2021).

Parkrun

Parkrun have a worldwide network of volunteer Ambassadors whose role involves outreach (Quirke.H, 2024). A specific aim is to involve people who are underrepresented at Parkrun events and this is supported through informal conversations at a community level as well as speaking at events. An engagement technique that Ambassadors have found effective is ‘takeover events’ where a parkrun will be run by a local community group and so brings in people from their community. Junior parkrun also helps to engage with children and families with buddy schemes, which can pair children who are regular attenders with a child who is participating for the first time.

Roller Derby

Women's flat track roller derby has been found to provide opportunity for gender inclusive physical activity as well as providing a place that marginalised and alternative identities are accepted and welcomed (Kettley -Linsell, 2023). A liberal approach to gender inclusion has been adopted by the Women's Flat Track Derby Association (WFTDA) which set international standards for the sport. This includes an explicit policy on gender which is inclusive of transgender and intersex women as well as gender expansive participants. Fitness, social interaction and a sense of belonging were found to be motivators for engaging in roller derby. Roller derby is considered a feminist sport and one of only a handful which were established primarily for the participation of women. It can therefore attract those drawn to alternative expressions of femininity.

Bristol Data

Data sources used include:

- Hospital admissions data
- Bristol Quality of Life
- Pupil Voice
- Active Lives (Sport England)
- Walking and Cycling Survey (Sustrans)
- Census 2021

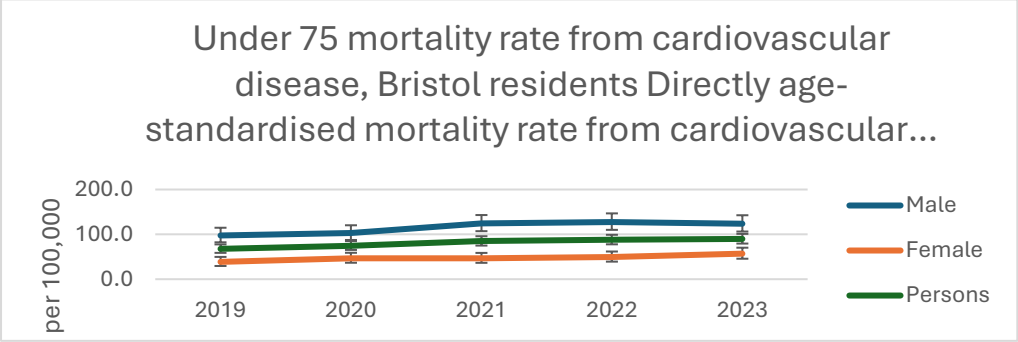
Health

A variety of positive health outcomes are linked to being more physically active. For brevity, this section will consider Bristol data for cardiovascular health/ disease (CVD), risk of falls, and mental health/illness only.

Cardiovascular Disease (CVD)

Although rates of under 75 mortalities from cardiovascular disease (CVD) in Bristol had been dropping over the last 20 years, the rate has been rising again more recently. This is particularly noticeable in CVD mortality rates for men under 75 in Bristol; 98 deaths per 100, 000 of the population in 2019 rising to 127 (per 100,000) in 2022. The most recent data for 2023 shows only a very slight decline in the rate to 124 per 100,000 of the population. The rates for under 75 female mortalities from CVD in Bristol although much lower than for males, have also been rising from 39 per 100,000 of the population in 2019 to 50 (per 100,000) in 2022. Unlike for local males, this continued to rise between 2022 and 2023 to 57 CVD deaths per 100, 000 of the population. Figure 2 is a line graph which shows the rates of CVD mortality per 100, 000 of the population in Bristol for each year 2019-2023 for males, females and all persons. A steady rise in the rate can be observed over the five-year period 2019 – 2022.

Figure 2



Rates of death due to cardiovascular disease (CVD) in residents under 75 years of age in Bristol are higher than the Bristol average amongst people living in the most deprived areas. The Bristol average for 2021-2023 is 87 CVD deaths per 100,000 of the population. Areas with average and below levels of deprivation had a far lower rate of death due to CVD whilst both the more and most deprived areas had higher rates. The three-year average for 2021-23 for CVD deaths in Bristol shows there were 136 deaths per 100, 000 of the population in the most deprived areas compared to under 50 per 100, 000 in the least deprived. Figure 3 shows the CVD mortality rate (per 100,000) for under 75: Bristol residents, 3 years average 2021-2023 by deprivation quintile and a linear relationship between level of deprivation in the area a person lives and the rate of CVD mortality in that area can be observed.

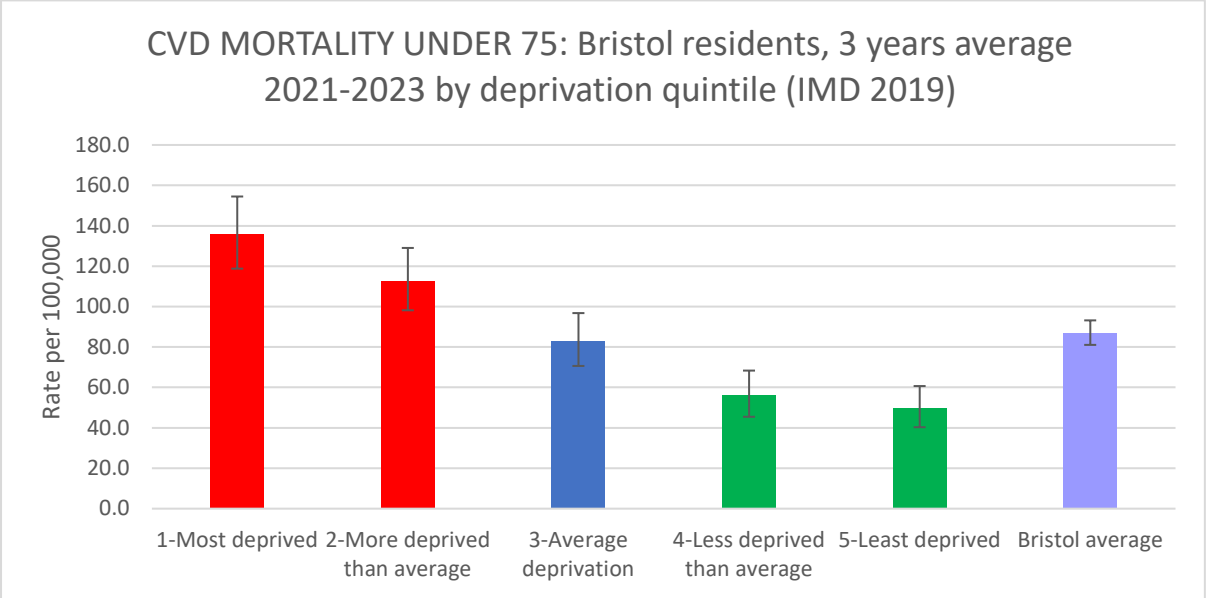


Figure 3

Falls

Rates of emergency hospital admissions due to falls in people aged 65 and over had been rising locally until 2020, when they started to reduce. However, the most recent data (2023/4) shows a slight increase in hospital admissions for falls injuries in persons aged 65 and over, to 2517 people per 100, 000 of the population. Data for gender (male and female only) suggests that Bristol women were more likely to have been admitted to hospital for an injury relating to a fall in the 2019-2024 period than local men. In the most recent year for which data is available (2023-4), 2724 female residents of Bristol per 100,000 of the population were admitted to hospital for an injury from falling. The figure for male residents of Bristol for the same period is 2210 per 100,000. Both these rates rose slightly from the previous year. Figure 4 is a line graph which shows the rate of emergency hospital admissions for falls injuries in persons aged 65 and over per 100,000 for Bristol residents. The rate is given for each year for 2019-2024 for males, females and all persons. A reduction in the rate can be observed for all three groups between 2020/21 to 2022/23 although this rose again in 2023/24.

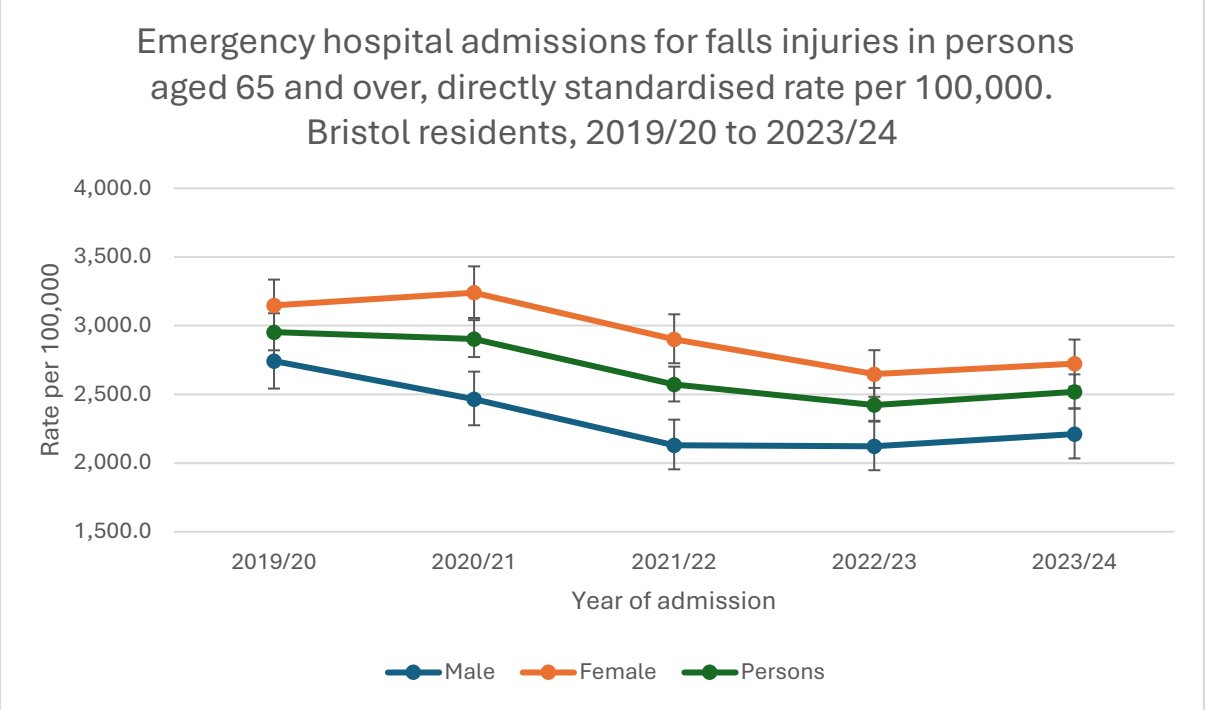


Figure 4

The rate of hospital admissions for injuries relating to a fall for Bristol residents in the year 2023/24 was 2532 per 100,000 of the population. However, a linear association between rates of hospital admissions for falls amongst people over 65 in Bristol and the level of deprivation where they live, was identified. Data for 2023/4 indicates 3077 people per 100, 000 over the age of 65 were admitted to hospital for injuries from a fall who live in the most deprived areas of Bristol, but the rate for those living in the least deprived areas was far lower at 1955 per 100,000 of the population. Figure 5 is a bar graph which shows the rate of hospital admissions 2023/4 for injuries from a fall for Bristol residents by deprivation quintile.

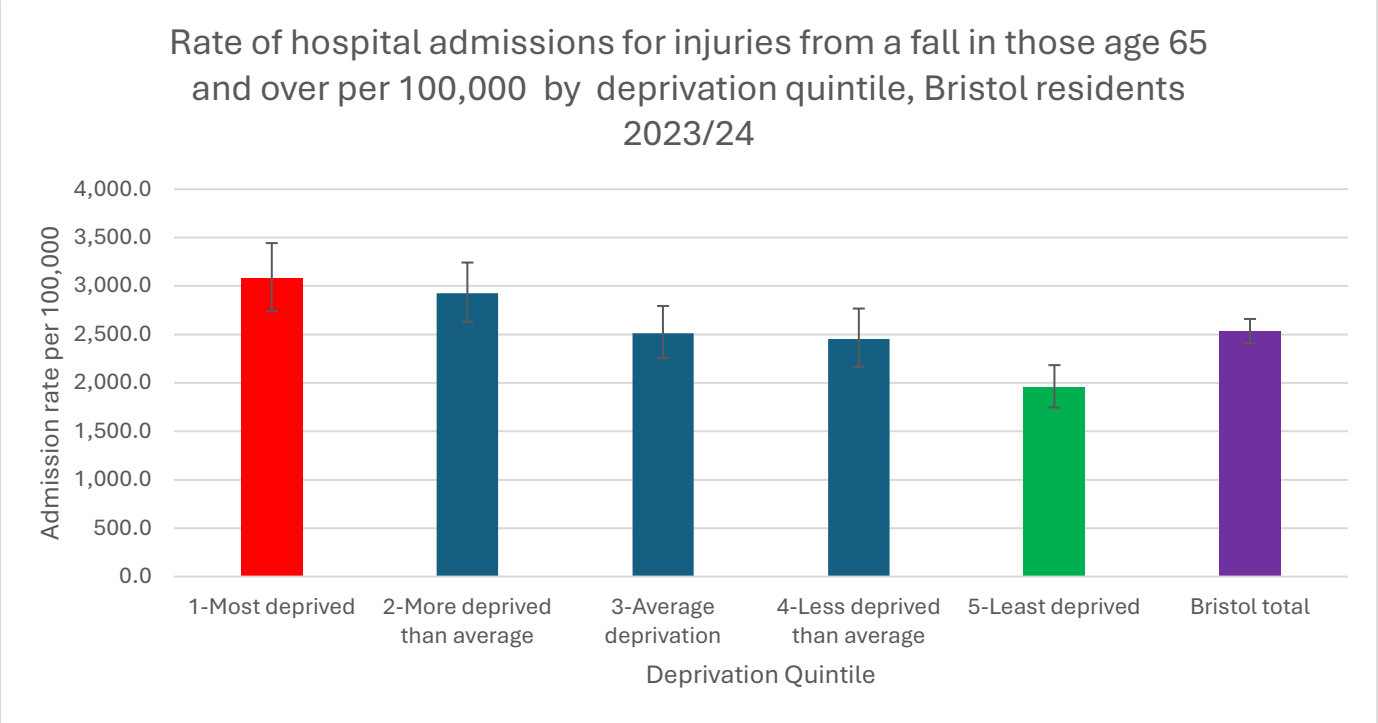


Figure 5

Mental Health

9,479 adult Bristol patients (aged 18) and over had depression recorded on practice disease registers for the first time in the financial year 2023/4, indicating that these are new diagnosis. Quality of life data for Bristol for 2024/25 shows that respondents from the 10% most deprived areas are far more likely to report poor mental wellbeing than those in the 10% least deprived. The Bristol average was 19.9%. However, 24.4% of respondents from the 10% most deprived areas of Bristol reported poor mental wellbeing, compared to just 11.5 % in the 10% least deprived. Poor mental wellbeing was also far more likely amongst respondents in Bristol who are Disabled (42.2%) reporting this. Respondents from Mixed/multiple ethnic groups were also less likely to report poor mental wellbeing.

Physical activity inequality

High quality recent (2022-24) data from over 1000 young adults (30-34) in the Bristol based Children of the 90s study ((Bristol, n.d.)show worryingly low levels of fitness (measured as Low VO_{2peak}). When compared to similar data from Norway, Netherlands, Germany and the USA, our population's fitness levels are about 27% lower on average.

This is particularly troubling firstly because low fitness levels strongly predict poor future health. Secondly, in such long-term studies the healthier individuals often remain part of the study, while the less healthy people often leave the study. Together this means that the actual fitness levels in this age group in Bristol may be worse than what the data shows.

Furthermore, using objectively measured pedometer data, the Children of the 90s study also found that Low fitness was linked to low physical activity: people with the lowest fitness levels in Bristol also did the least amount of moderate to vigorous physical activity (MVPA).

Although we need further research to assess whether this low fitness and activity level is reflecting a UK wide trend over the years or specific to Bristol, it does shows where action is needed.

Bristol needs services that help young adults be more active and improve fitness. This has the potential to lower future health problems in the community and the consequent healthcare needs.

Sport England Active lives survey 2023/4 gained responses from 1010 adults in Bristol, of which 72% reported that they are active (at least 150 minutes per week). This data source also indicates that 19% of local adults are inactive (active for less than 30 minutes a week). 'Quality of life' data for Bristol shows that 67% of the local population who responded, report they engage in 'enough exercise per week'. However, amongst several population groups, less than 50% reported they do enough exercise, including those with no qualifications (32%), Disabled people (42%), respondents renting from a Housing association (47%), respondents renting from the council (37%), respondents of 65 years and older (47%), respondents of Asian/Asian British ethnicity (47%), respondents of Black/Black British ethnicity (61%) and full time carers (44%). Figure 6 shows the percentages in the form of a bar graph.

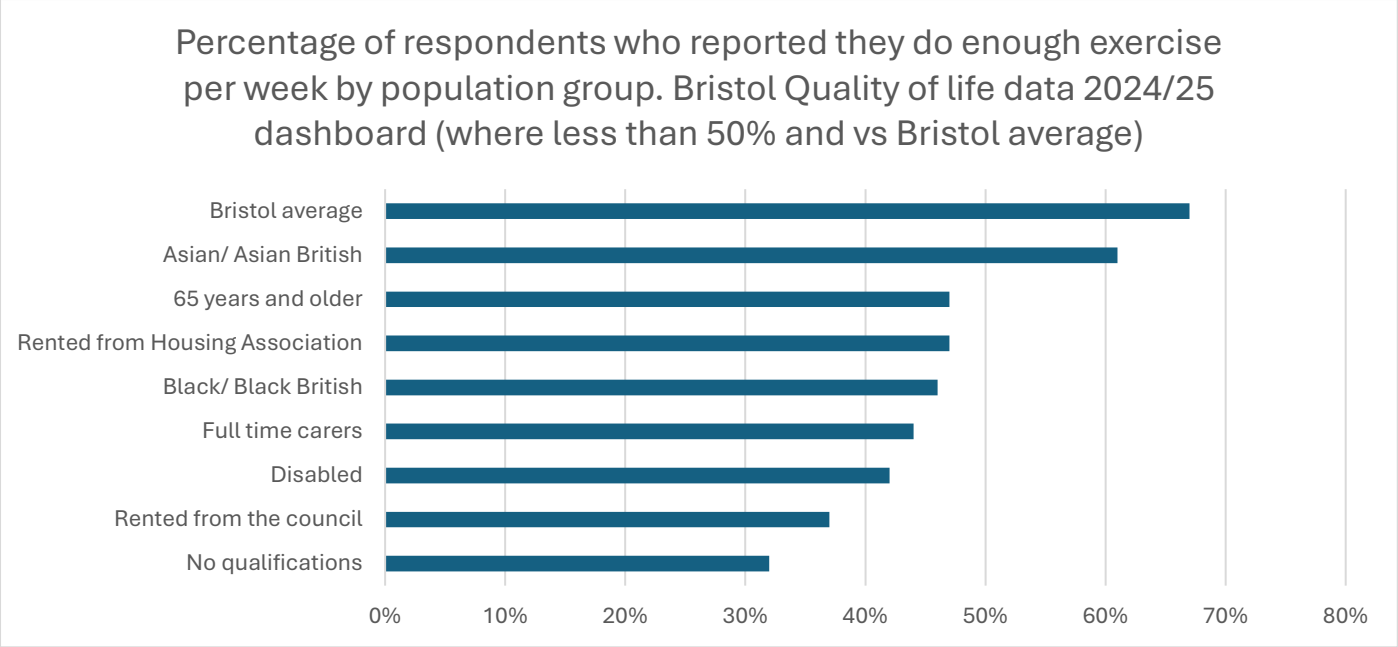


Figure 6

Deprivation

Sport England Active lives data indicates that the percentage of adult respondents who report they are inactive (less than 30 minutes per week) has been falling between 2020 and 2024. However, the inequality gap between those living in the 20% most deprived areas of Bristol and those living in the other 80% of local areas continues. Although this gap narrowed from 18% vs 30% inactive in 2020-21 to 18% vs 25% the following year, it widened again in 2022-23 (14% vs 24%) and then again in 2023-24 (31% - 15%). Figure 7 shows Bristol adults' inactivity trend data as a line graph comparing the percentage of respondents who reported they are inactive in the 20% most deprived areas to that in other areas of the city.

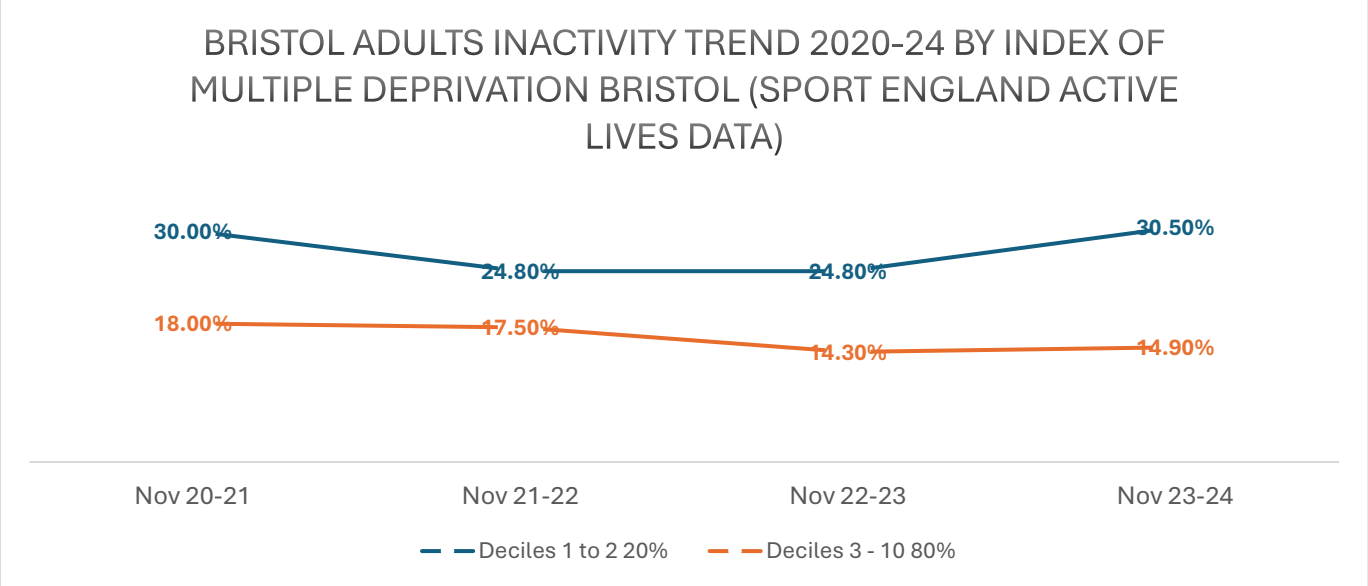


Figure 7

Analysis of data for attendances at Bristol's leisure centres suggest that use of these facilities is lower amongst people living in the 10% most deprived areas. Data from one Bristol leisure operator for 2023/24, showed that 4.2% of attendances were by adults who live in the 10% most deprived areas of the city.

Disabled people

Census 2021 data indicates that more than 81,000 (17%) people in Bristol have long-term physical or mental health conditions or illnesses which limit day-to-day activities (Bristol City Council , 2023). In addition, people who care for others are more likely to be Disabled themselves and this applied for 30% of carers in Bristol. Several other intersections of inequality were identified including that people over the age of 65, those who identify as Lesbian, Gay, Bisexual, plus and people who report they identify with a gender different to that they were assigned at birth were more likely to also be Disabled. The proportion of Disabled people in local areas within Bristol also varies and is associated with living in an area of higher deprivation. Census data indicated that the highest of these is households in Hartcliffe and Withywood ward, where nearly half (46%) reported they include a Disabled person.

Respondents to the Quality-of-Life survey in Bristol (Bristol City Council , 2024) who are Disabled, were far less likely to report they do enough exercise per week compared to the Bristol average. Although 67% of all respondents in Bristol reported they exercise enough, amongst Disabled respondents, this was just 42%. Figure 8 shows the unrounded percentages as a bar graph.

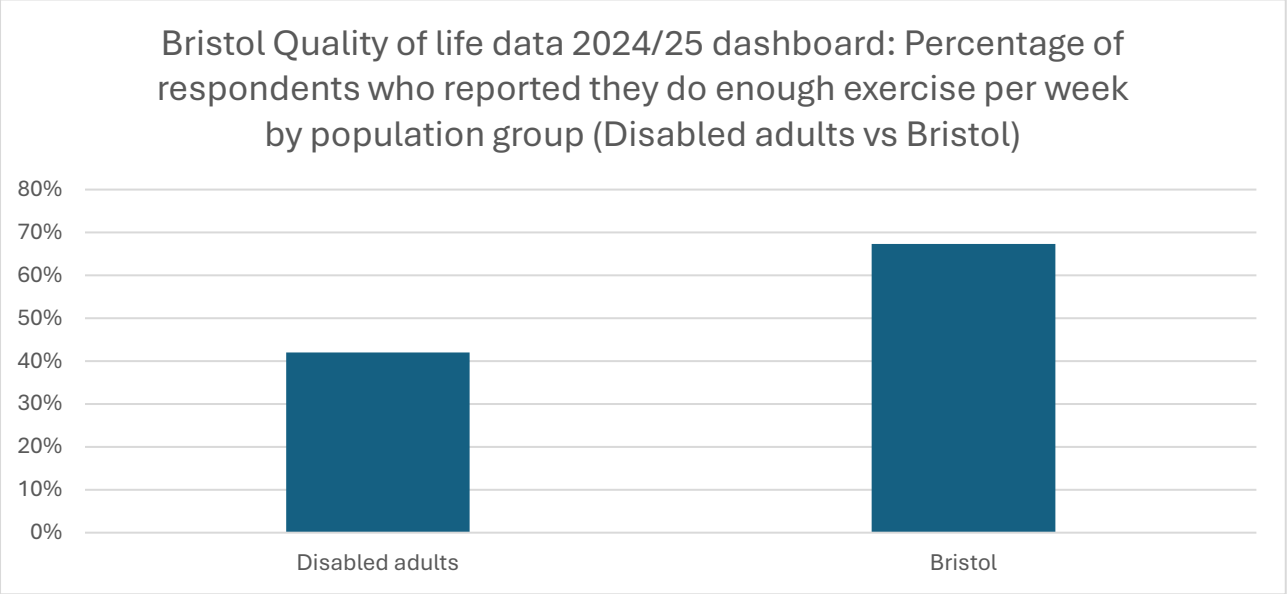


Figure 8

Full time carers who responded to the Quality-of-Life survey were also less likely to report they exercise enough (50%).

Sport England Active Lives data indicates that of adult respondents who reported they were inactive (less than 30 min per week) in 2023-24, two thirds identified they had a disability or long-term health condition. Figure 9 shows is a visual representation of this as a pie chart.

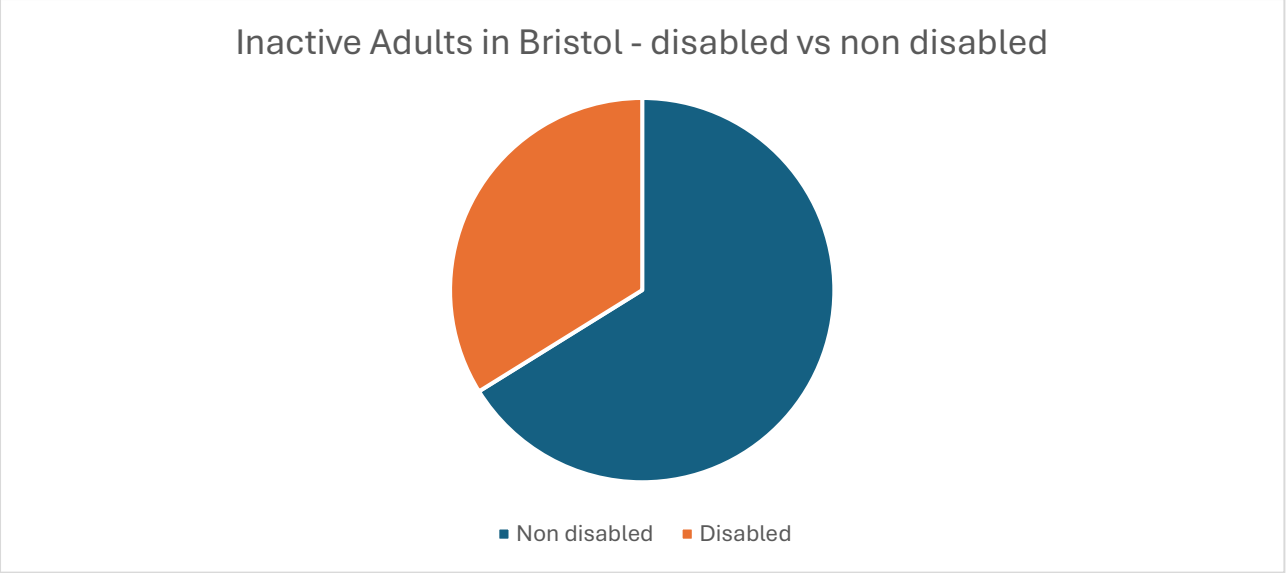


Figure 9

Data for attendances at Leisure Centres in Bristol 2023-4 indicate that less than one percent identified as Disabled customers that year.

Older age

Census 2021 data indicates that there were 60,760 people over 65 in Bristol at that time, around 13% of the local population. The likelihood of having a disability increases with age and of census respondents, 38% of those aged 65+ were Disabled according to the equality act definition compared to 14% for younger people. The proportion of people whose day-to-day activities are limited a lot is especially affected by age. Only 5% of census respondents under the age of 65 reported meeting this criterion whereas 19% of over 65s did. Older people were also more likely to report that they provide unpaid care to someone compared to younger people. 11 % of people over 65 in Bristol in 2021 reported they are a carer compared to 7% of those aged under 65. In 2021, a third (32%) of all people lived in households which included at least one person with long-term physical or mental health conditions or illnesses whose day-to-day activities are limited. For people aged 65 and over, this increases to 47% of people living in a household with at least one disabled person, more than half (54%) of people aged 75 and over and almost two thirds (63%) of people aged 85 and over. General health deteriorates with age. In 2021, 15% of older people in Bristol described their health as ‘bad’ or ‘very bad’ compared to 3.5% of people aged under 65 years. For those aged 75 and over 19% described their health as ‘bad’ or ‘very bad’, whilst a quarter of people aged 85 and over had ‘bad’ or ‘very bad’ health. People over 65 were also less likely to report access to a car (27%) compared to younger adults (19%).

Respondents to the Quality-of-Life survey in Bristol who are 65 and older, were far less likely to report they do enough exercise per week compared to the overall Bristol population. 67% of respondents in Bristol reported they exercise enough but amongst respondents of 65 and older locally, this was just 47%. Figure 10 shows these as unrounded percentages using a bar graph.

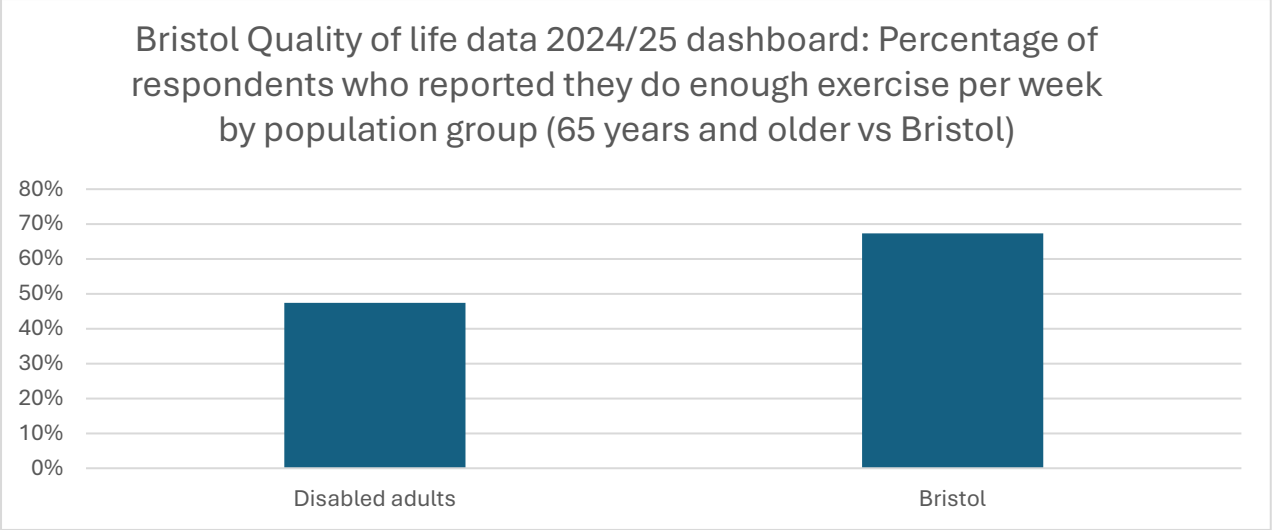


Figure 10

Figure 11 shows the percentage of adult respondents to the Active Lives survey from Bristol who reported they are active at least 150 minutes a week, by ten-year age range, for the one-year period 2023-24. Just 46.8% of respondents aged 75-84 reported they are active at least 150 minutes a week, a far lower percentage than any other age groups and more than 20% lower than those aged 66-74 (70.1%). At the other end of the age range, 79.5% of adults aged 16-24 and 74.5% aged 25-34 reported they were active at least 150 minutes per week. The Active Lives survey reports the percentage of people who reported being active for at least 150 minutes per week declined with age—from 73% of 35–44-year-olds to 71.2% of 45–54-year-olds. Interestingly, activity levels then increased to 75.5% among 55–64-year-olds, before dropping slightly to 70% in the 65–74 age group, and significantly falling to 47% among those aged 75–84.

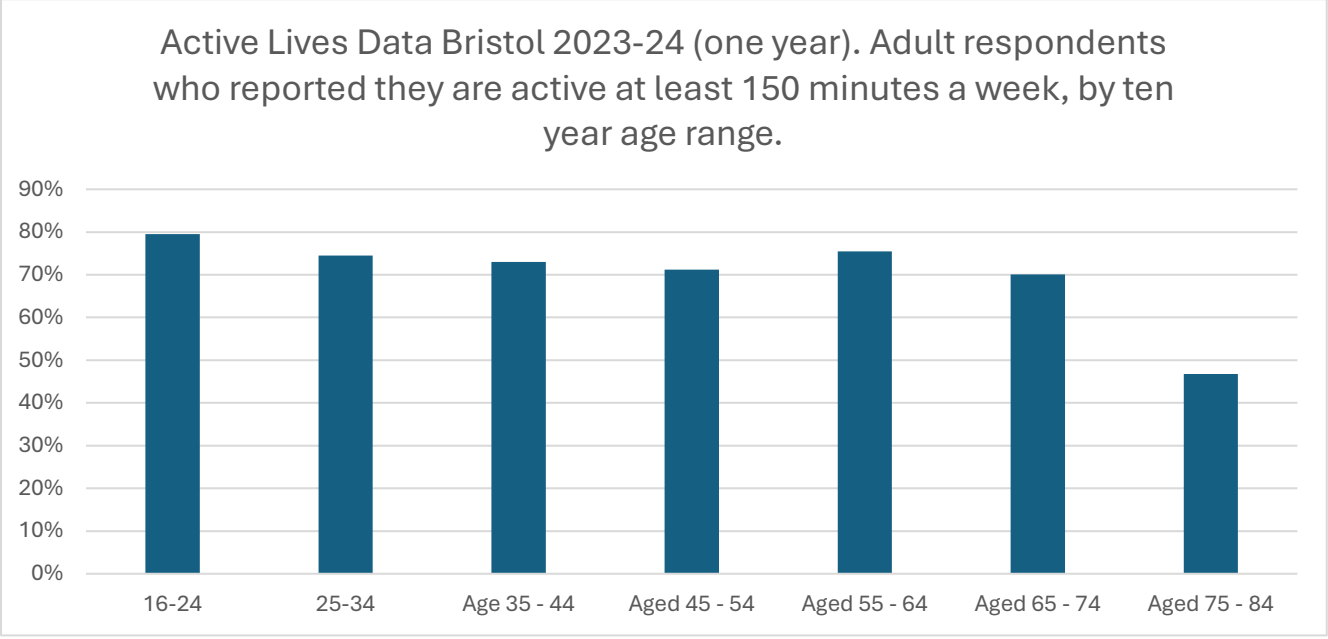


Figure 11

Data for attendances at Leisure Centres by people aged 66 and over varies between different sites. The latest data (2023-4) indicates that between 1% and 5% of attendances were by individuals aged 66 and over suggesting that older residents are much less likely to use their local facility than younger adults.

Asian/Asian British

According to Census 2021, two of the largest minority ethnic groups in Bristol at that time were Pakistani 9,103 (2%) and Indian 8,371 (2%). People who identified as 'Asian or Asian British Bangladeshi' in the census locally also reported poorer health than might be expected since this group is relatively young. 6% of respondents to the census from these ethnic groups reported bad or very bad health -compared to 5% for the general population.

Respondents to the Quality-of-Life survey in Bristol of Asian/Asian British ethnicity were far less likely to report they do enough exercise per week compared to the overall Bristol population. Although overall 67% of respondents in Bristol reported they exercise enough, amongst respondents of Asian/Asian British ethnicity locally, this was just 61%.

Black/ Black British

According to Census 2021 data, the largest minority ethnic group in Bristol at that time was Somali 9,167 (2%). The other large 'Black or Black British African' identity was Nigerian with 1,229 people (0.3%). The Somali population in Bristol reported better general health than the population. Of those who identified as Somali in the census in Bristol, 69% reported having 'Very good health' compared with 51% of the total Bristol population; this is likely because of the younger age profile of this group. Fewer residents who identified as Somali reported being Disabled (8%), compared with Bristol overall (17%). 8% of 'Black or Black British Caribbean' respondents reported their health was bad or very bad compared to 5% for the general population in Bristol. Somali people were more likely to identify as a 'Single family lone parent household' (31%), than in Bristol overall (12%)

Less than half (46%) of respondents to the Quality-of-Life survey in Bristol who identified as Black/Black British, reported they do enough exercise per week, compared to 67% in the overall Bristol population.

Although Active Lives data from Sport England is a generally a useful data source, only 166 of the 1010 adults in Bristol responded to Sport England's Active lives survey 2023/24 were from BME communities, a sample too small to draw any meaningful conclusions regarding activity levels

Women

Census 2021 indicated that of the Bristol population, 50.4% identify as female and 49.6% male. Respondents to the Quality-of-Life survey in Bristol who are female, were slightly less likely to report they do enough exercise per week compared to the overall Bristol population. 71.9% of respondents in Bristol reported they exercise enough but amongst respondents who are female, this was slightly lower at 71.4%. For male respondents the proportion was slightly higher than average (71.7%).

Data available via the online walking and cycling index from Sustrans, indicates that nearly two thirds (64%) of the 607 female respondents from Bristol in 2023 reported they never cycle compared to 53% of all respondents. Of the 547 male respondents, well under half (42%) of indicated they never cycle. This data is shown as a bar graph in Figure 12.

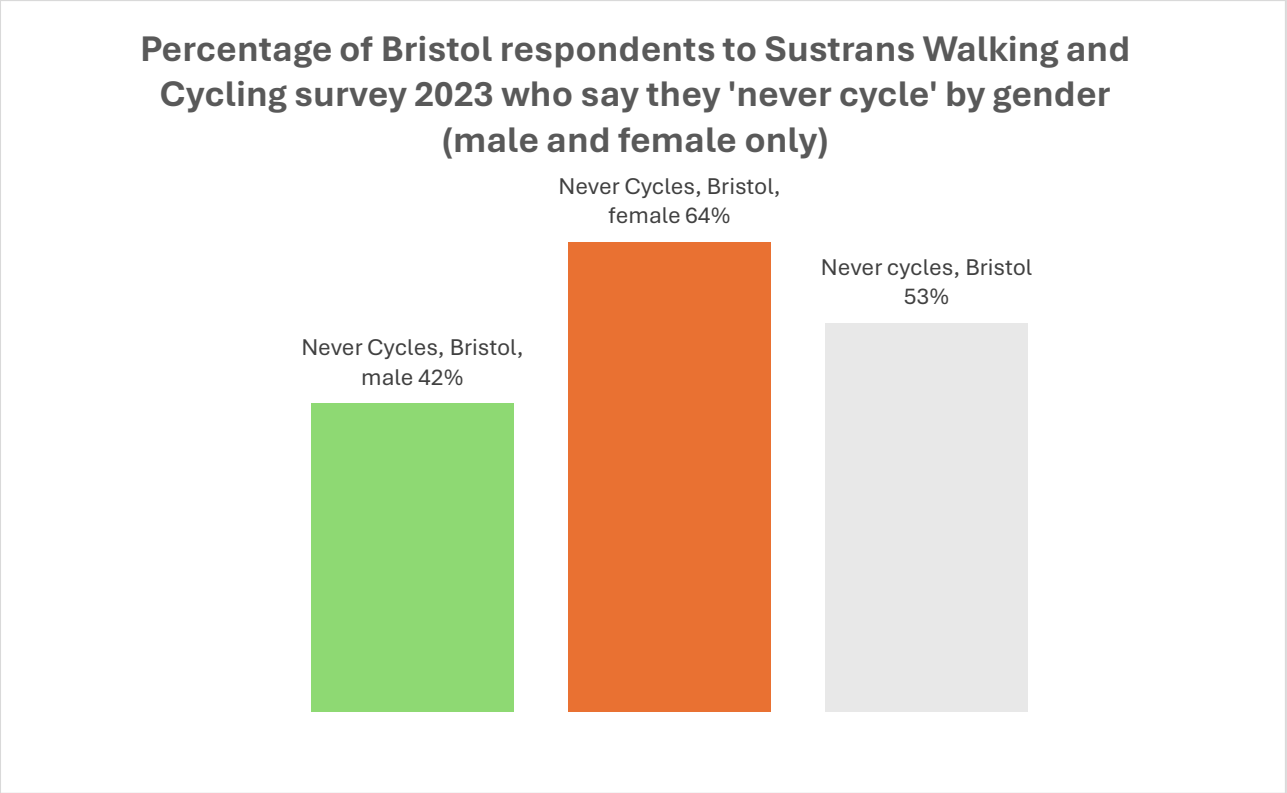


Figure 12

Attendances by women at Leisure centre varied across sites and providers in Bristol in 2023/4. One provider reported that 57% of attendances at their leisure centres in 2023/4 were by women. Another provider indicated that 31-46% of their attendances in 2024 were by women and girls.

Data for the period 2023/4 and 2024/5shows 1937 attendances for maternity free swimming.

Children and Young people

Active lives data shows that 47% of Bristol's children and young people who responded, reported that they met the Chief Medical Officer's (CMO's) recommendation of 60 minutes of activity in the academic year 2023-4, similar to the national figure. Just under a quarter (24%) reported they are active 30-59 minutes per day and a higher percentage (29%) that they are active less than 30 minutes per day. This data is shown as unrounded percentages in a bar graph in Figure 13.

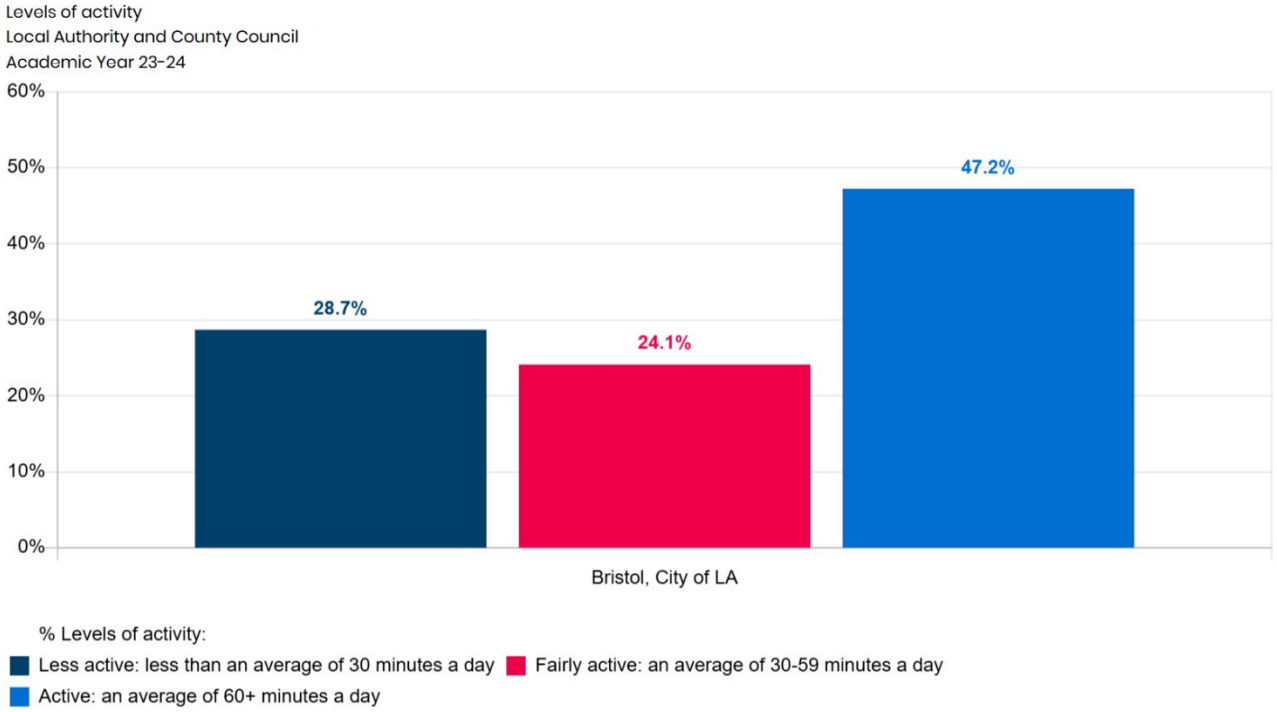


Figure 13

The same data source indicated that the proportion of children and young people in Bristol who are active less than 30 minutes a day has been rising over the last three academic years. During the same period, the proportion of children who reported they exercise 60 minutes or more a day has been falling. Figure 14 shows the unrounded percentage data trend for Bristol children's reported activity levels from 2021 to 2024. In the academic year 2021-2, 55% of children who responded to the survey indicated that they are active 60 minutes or more a day but this fell to 47% the following year and stayed at that level in 2023-4. In 2021-22, around 19% of respondents reported levels of activity lower than 30 minutes a day but this percentage rose to 23% the following year and rose again to 29% in 2023-4.

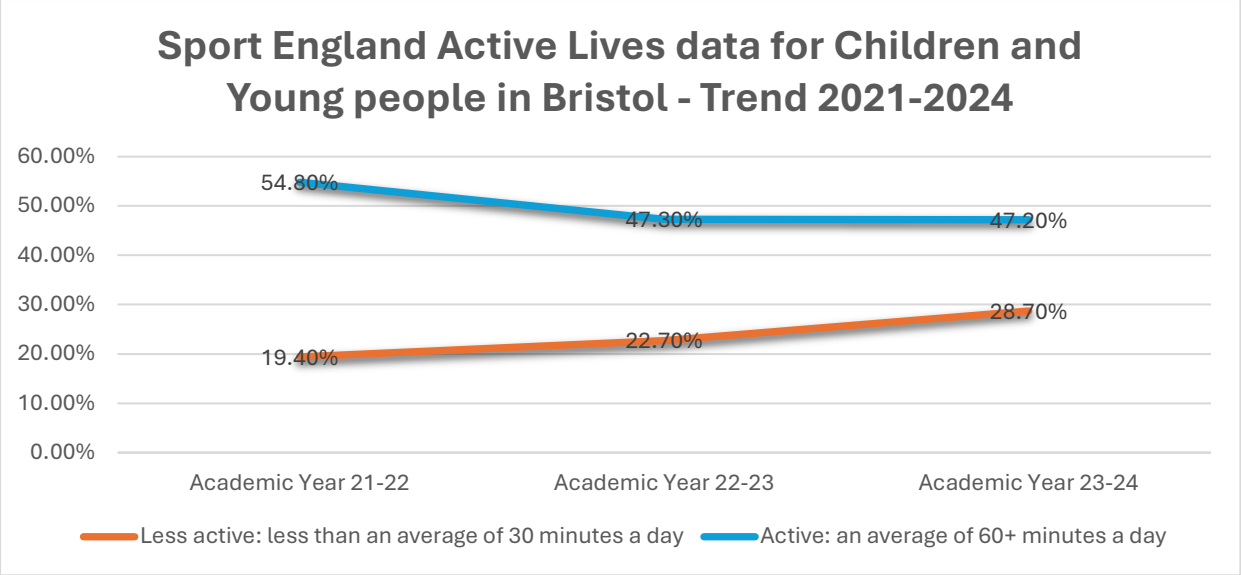


Figure 14

Children's swimming capability

Figure 15 shows a line graph using unrounded percentages for swimming capability of children in Bristol by gender (male and female only) and academic year. This indicates a dip in the proportion of respondents who identified as a 'girl' who could swim 25 metres unaided in 2022-23 to just 40%. In the more recent data (2023-24) the proportion of 'girl' respondents who reported they can swim unaided for 25m appears to have recovered back to that of the year before (66%). The proportion of 'boy' respondents who reported they could swim 25 metres unaided has been dropping steadily from 71% in 2021-2022 down to 60% in 2022-23. The reason for these fluctuations is unclear.

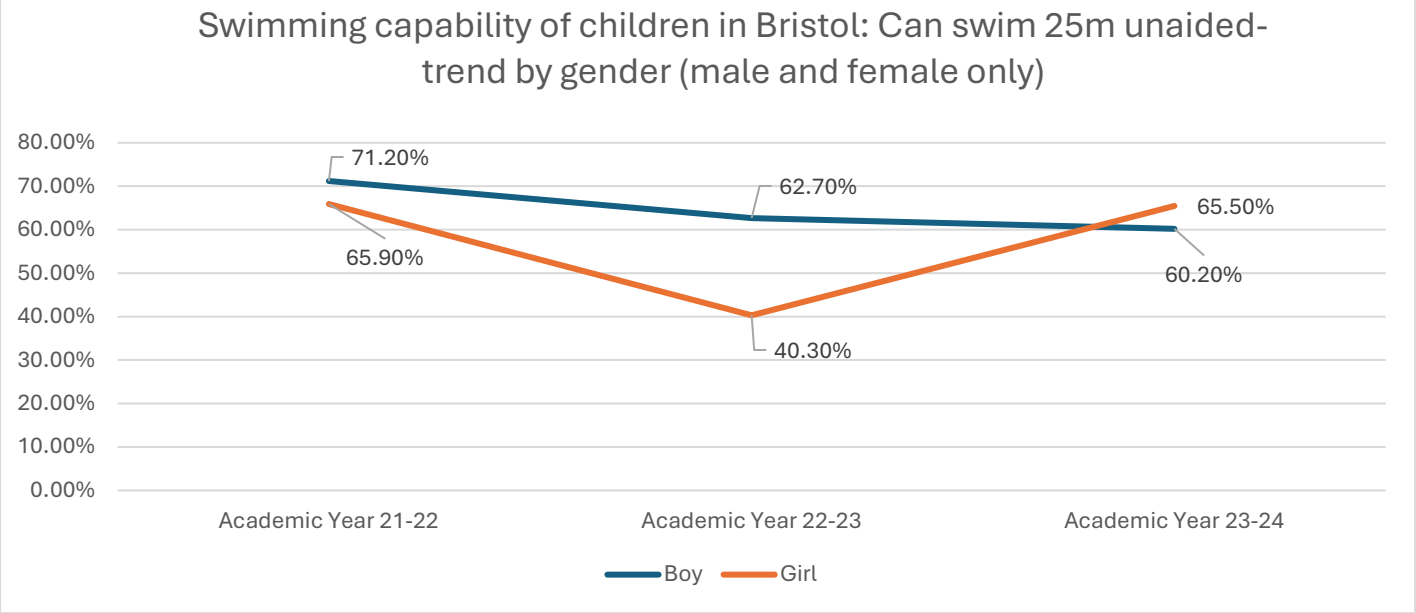


Figure 15

An additional local data source with a high number of respondents is the Bristol Pupil Voice Survey which is commissioned and facilitated by Bristol Healthy Schools, within the Public Health team at

Bristol City Council. The survey was first commissioned in Bristol in 2008 and all schools in Bristol are given the opportunity for their pupils to complete it. In 2024 an estimated 22% of all schools participated with an around 14% of all year 4, 6, 8 and 10 pupils involved. Participating schools are self-selecting and overall the gender and ethnicity characteristics of the responding cohort were reasonably similar to what we know of the population of the city. It is possible that the results include some overrepresentation of pupil responses in secondary schools with a higher average level of pupil deprivation which should be borne in mind when interpreting findings. Children not in education, employment or training (NEET) are likely not to be represented, due to absence from the school settings where the survey takes place. Nevertheless, findings from the survey provide reasonable indicative measures of physical activity for the focus year groups and help to add some detail on the variation in physical activity participation amongst local children and young people.

2462 responses to the Pupil Voice survey were logged which indicate a pupil's level of physical activity. Of these, 1494 responses were from primary school children and 968 from secondary school pupils. 1208 responses were from female pupils, 1151 from males and 53 from gender diverse pupils (the last category is available for secondary school pupils only).

Overall, 76% of respondents reported that they had been **active enough to breathe harder and faster or feel hot and sweaty for at least half an hour on three or more days in the previous week** (note that this is different measure to the CMO's recommendation).

Response trends were analysed for the last three years of data available (2019, 2022 and 2024). When viewing all age groups, there was a slight dip in the proportion of respondents meeting the described activity level in 2022 which rose back up in 2024. However, for children in year 4 in 2024, the proportion fell to well below that of 2019 and 2022. This year group includes children who were 8-9 years of age in 2024 and born 2015-2016. A possible explanation for the lower activity level reported by this age group could be that more children in Bristol who were aged 4-5 years old at the start of the COVID-19 pandemic in 2020 had their activity levels negitively impacted by the UK lockdown measures than older children.

Figure 16 consists of two line graphs which show the percentage of Pupil Voice respondents who reported they met the described activity level each year, by age group. Whilst a rise in the percentage of pupils in Year's 6, 8 and 10 is observed between 2022 and 2024 (most noticeably in secondary school children), there is a drop for respondents in year 4 for the same period, to below 70%.

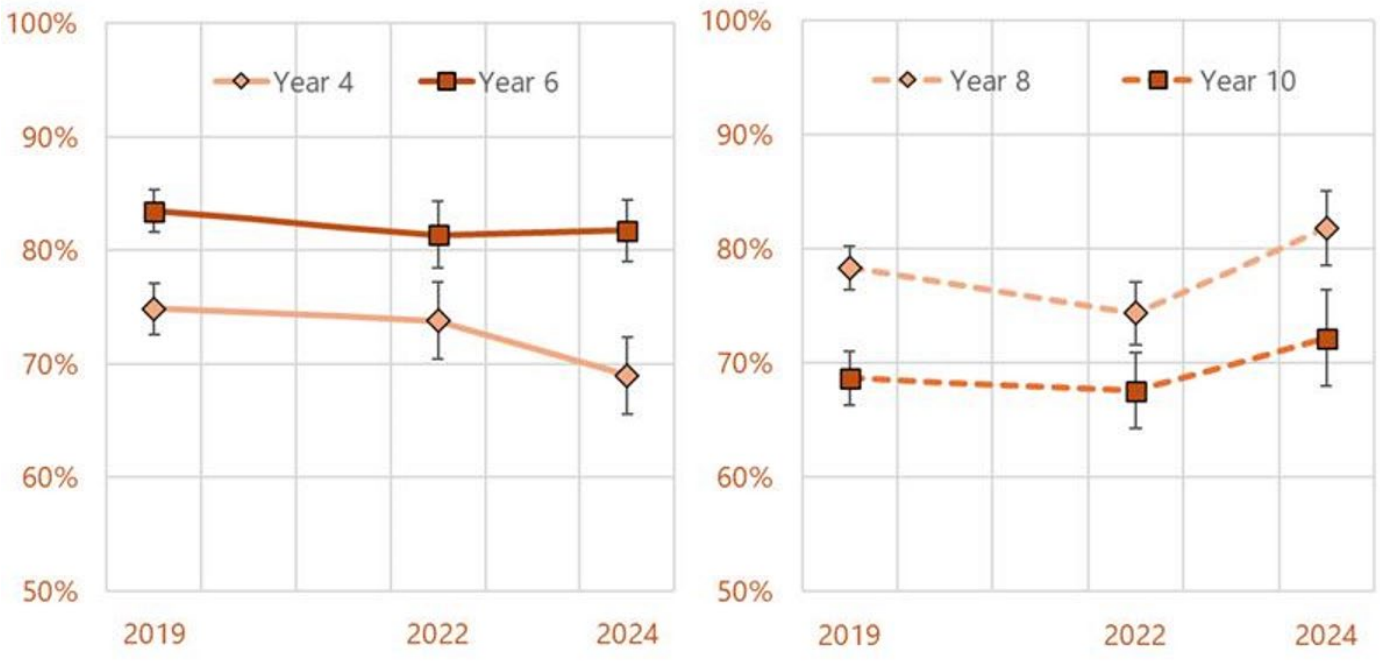


Figure 16 Percentage of respondents to Bristol's Pupil Voice Survey who reported that they had been active enough to breathe harder and faster or feel hot and sweaty for at least half an hour on three or more days in the previous week for each years 2019, 2022 and 2024, by age group.

Considering Pupil Voice Survey data for 2024 only, there were statistically significant gender differences with 80% of male respondents saying they had been "active enough to breathe harder and faster or feel hot and sweaty for at least half an hour on three or more days in the previous week" compared to 74% of female respondents. Although based on responses from just 53 pupils, the lowest proportion of any single group to report meeting the described activity level were gender diverse respondents. Only 64% of this group reported being active enough to breathe harder and faster or feel hot and sweaty for at least half an hour on three or more days in the previous week. There were also differences in proportions by pupil's ethnicity. A significantly higher proportion of pupils who identified as mixed ethnic heritage met the activity level (85%). Black British pupils were slightly less likely to report the level of activity described (71%) as were White Minority ethnic respondents (72%).

Other children and young people with lower proportions of respondents reporting meeting the described activity level were:

- Looked after children (65%)
- Children from single parents households (67%)
- Pupils in temporary accommodation (69%)
- LGBQ+ (secondary school pupils only) (70%)
- Young Carers (70%)
- Pupils with Special Educational Needs or Learning difficulties (70%)
- Pupils with a family or household member in prison (71%)

- Pupils in receipt of free school meals (72%)

Pupils from some equality groups had the same or higher proportions of respondents than average, who reported they met the described activity level. These were:

- Pupils with a long-standing illness (83%)
- Neurodivergent pupils (79%)
- Disabled pupils (76%)

Figures 17 shows Pupil Voice data for each of these equality groups in the form of a bar graph.

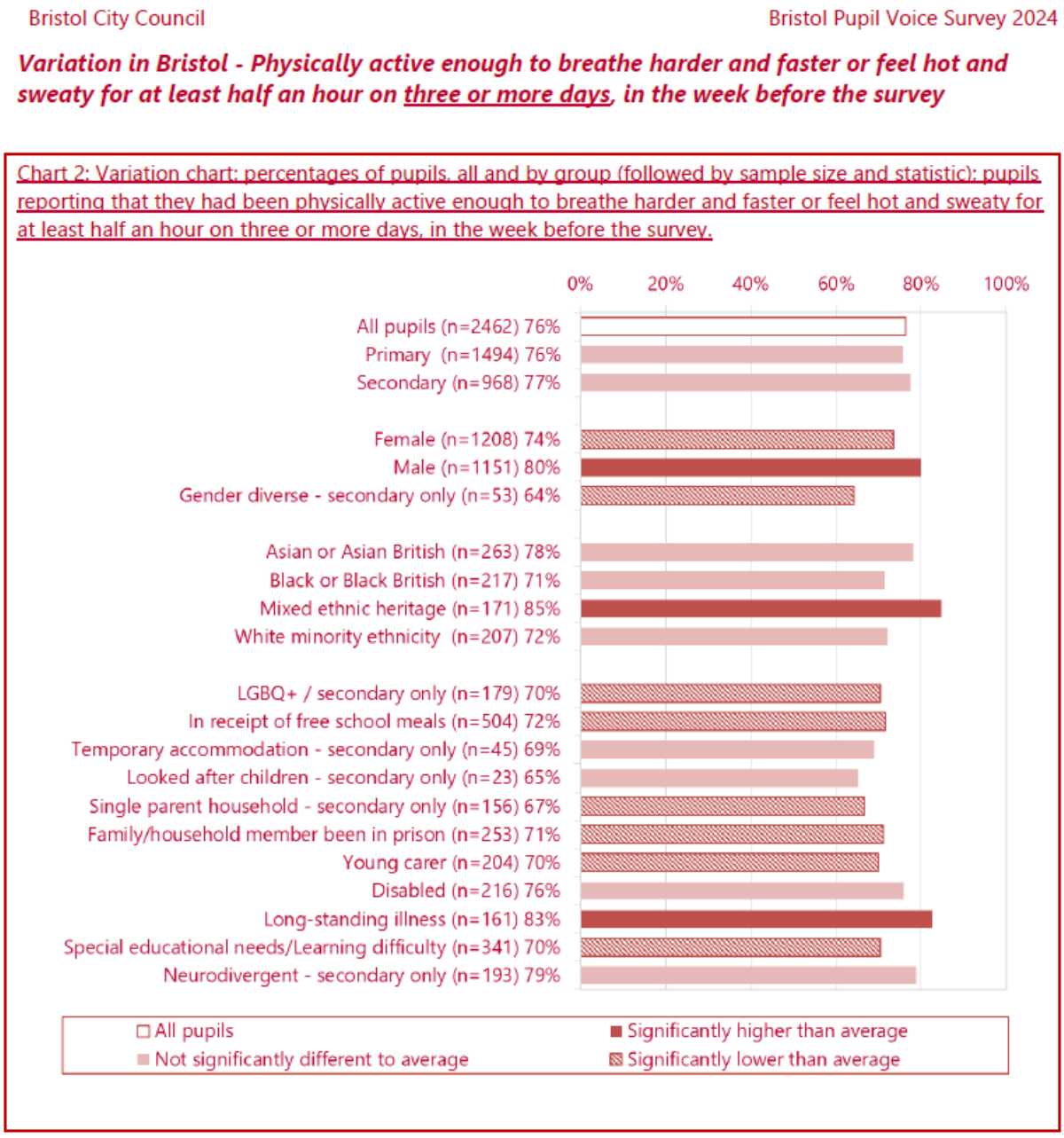


Figure 17

Data available for leisure centre attendances for children from the most deprived areas of the city varied between facilities and accounted for roughly 9 to 35 % of those recorded for under 16s in 2023/4.

Local Voice

Time and resource restrictions prevented community engagement with the preparation of this report. However, relevant qualitative data were gathered via the perspectives of five local professionals.Each professional is a Bristol resident and has professional and/or lived expertise of one or more of the population groups identified as less active. Participants were interviewed by the author during February to March 2025 using a topic guide, adapted from that used in previous research (Goyder. E, 2014). Interviews were conducted online and each lasted for approximately 60 minutes. A systematic approach was used for thematic analysis using a well-recognised six-stage, non- linear framework via colour coding and sorting cells in a spreadsheet.

1. Become familiar with the data
2. Generate initial codes
3. Search for themes
4. Review themes
5. Define themes
6. Write-up

(Braun, 2006) (Bree R, 2016).

Table 1, Interview participants

Participant	Job description/area of work	Further information
1	Community development worker	Bristol resident, Disabled, Black British, she/ her, parent
2	Representative of a Walking, Wheeling and Cycling Charity	Bristol resident, Mixed race, Born in the US, she/her, parent
3	Representative of an older people's organisation	Bristol resident, over 60, white British, he/him, parent
4	Strategic City Transport department	Black African Caribbean, migrant, Bristol resident, he/him, parent
5	Campaigning for children's rights in the built environment	Lifelong Bristol resident, White British, she/her, parent

The following pages detail the themes identified along with relevant quotes from interview participants.

Access Needs

One of the participants is Disabled and was able to identify several access needs, both for themselves and others. Access needs were also highlighted by other participants.

Facilities local to where a Disabled adult lives can help them access the activities there independently. For example, a visually impaired person in Bristol ideally needs physical activity opportunities within walking distance of where they live.

“Particularly now in wintertime when it gets dark a bit earlier, it's harder for me to navigate around the big City of Bristol. I really like having places that are local to me and that are easy to get to.”

Participant 1

Similarly, Disabled children could benefit from the opportunity to be active via ‘doorstep play’. An example of how this benefited one Disabled child was highlighted along with the potential of this approach.

“This opportunity to just play in the space immediately outside her house was crucial for her because she'd found it difficult going to other spaces. She could be outside and play with other children. I think there's huge potential for Disabled children to benefit from having more doorstep play.”

Participant 5

Changes to the local environment, especially those which a Disabled person has not been informed of in advance such as the closure of pavements or building work, can cause anxiety. An individual may have a carefully planned walking or wheeling route which they know to be accessible and cannot be sure the temporary layout will accommodate their needs.

“Today, I have this level of anxiety because I'm going down roads where they're doing lots of building work. I'm walking then I noticed that there's flashing lights in front of me. I feel like I can't carry on going down straight. Is there a pavement on the other side? There isn't usually a pavement on the other side. But I wonder if there is now.”

Participant 1

As well as local walking and wheeling routes, the importance of familiarity with a venue where an activity takes place can also instil confidence in its accessibility. Along with this, it is important for the fitness instructor or coach to be approachable. Disabled people also support each other through recommending accessible venues and sessions.

“Knowing that the venue was going to be accessible for me, then also that understanding that when I'm in the class I'm able to discuss with the leader. A lot of Disabled people that I know are creatures of habit. We like to go to places that we know are going to be accessible for us. Recommendations are useful as well”

Participant 1

Along with recommendation from other Disabled people, motivation to attend a new session may be supported through explicitly advertising details of the class and how different people can be accommodated.

“The wording around how inclusive and accessible a class might be is going to motivate me to go and feel a bit less anxious as well.”

Participant 1

Older Age

One of the participants was over the age of 65 and works with older people in Bristol. They related their own feelings of slowing down as they age and the increased likelihood of medical conditions.

“I'm sort of slowing down, legs are a bit stiff and stuff, touch of gout, that’s the most painful thing. As you get older, obviously you're gonna have health challenges it's about how you deal with those.”

Participant 3

Attitudes to older age and internalised ageism along with negative messages about aging were highlighted as impacting activity levels.

“Internalised ageism as well. Older people take that on board with them. Old age is seen as a negative thing.”

Participant 3

The importance of having a sense of purpose to help motivate someone to get out and be active was raised.

“Without that (sense of purpose), I'd probably be sat home watching ‘homes under the hammer’ on a Thursday afternoon.”

Participant 3

Without a sense of purpose or support systems in place, isolation can negatively impact older people’s health related behaviours. A specific example was given which helps to illustrate this.

“He's 65 and basically stuck at home all day. He's drinking and there's a spiral. He talks about doing stuff, but he's not in the position to do it; the drink has taken over”

Participant 3

Empowerment models can help engage older people themselves and could help create appropriate exercise opportunities.

“We use the social empowerment model of age. So, ensuring people aren't passive recipients. I want older people to be around the table and be involved in decision making”

Participant 3

In the built environment, the importance of opportunities to stop and rest and the need for toilets to be available so that older people can get outdoors independently was raised.

“The importance of benches. more spaces for people to stop and rest for elderly people and others. Toilets are also very important”

Participant 2

Activities which support healthy aging can be started at a younger age. This was considered by one participant who was under 65 themselves.

“I'm thinking about training for my old lady body.... bones will be more dense so that I won't get osteoporosis... be able to enjoy life and movement”

Participant 2

Attitudes, beliefs and social norms

A wide variety of attitudes, beliefs and social norms were highlighted at an individual and community level which are believed to impact local physical activity levels.

Amongst communities who already experience lower social standing, there is an increased risk of further stigma through engaging in forms of exercise with perceived links to criminal behaviour.

“All the people you know within your circle that do cycle... might have just been the drug dealer or this person committing antisocial behaviour”

Participant 4

The expense, both real and perceived, of engaging in physical activity may make it feel impossible for local people on low incomes.

“It's a bit more challenging for people, just surviving in some cases because of the cost of living. It's not cheap to join the gym.”

Participant 3

In addition to financial cost itself, people living day to day in survival mode may not have the available energy to consider behaviour change.

“...just trying to survive... doesn't allow them to make those sort of shifts”

Participant 4

The word ‘sport’ itself is off putting for some who may relate more to engaging in activities which are non competitive and built around social relationships.

“When I hear the word ‘sport’, I have a little bit of an allergic reaction. I think being active just sounds a lot more appealing. I'm just going for a bike ride with my friends.”

Participant 2

An example of how local activities may be diversifying and becoming more appealing to people who are not ‘sporty’ was given.

“ I think Park Run is a really great example and when I led couch to 5K groups, we always graduated at a park run, which is a really nice way to leave people with a way of staying active in a noncompetitive environment. That (parkrun at Eastville park) has become more inclusive over the years. A lot of people who aren't necessarily, you know, runners. It does feel like it's become more diverse. “

Participant 2

Families and children

All five participants are raising or have raised children in Bristol and one was from an organisation which campaigns for children’s rights within the built environment.

The historical context and changes in the type of activity children previously engaged with was considered. The cultural norms and how acceptable it was and is for children to play outside without adult supervision appears to have changed. Although previously it may have been equally acceptable across communities for children to be active outdoors, the current culture focuses more on planned activities which must be facilitated by parents (or other adult caregivers). The concept of ‘safety’ and social stigma towards parents who allow their children to be outdoors without supervision was also explored.

“When I was a child growing up in Bristol in the 70s, I think I felt very free to be outside. We would have a certain amount of freedom to be out and about around the neighbourhood. I remember playing under the fly over and it was like our own space. The number of children made it feel safe and we could navigate risks and get to those spaces independently.”

Participant 5

“It was like a universal offer that children had regardless of background. Just being outside, having freedom to be in your community, to be physically active in the environment..”

Participant 5

“Parents have become worried about being judged for allowing their children that freedom. There's the term 'feral', isn't there?”

Participant 5

Safety concerns for children such as knife crime can sometimes be emphasised by schools. It was acknowledged that not all parents feel it is safe for their children to walk to places on their own although the type of safety considerations may vary.

“I had an e-mail from my child's school about a knife crime over half term.... yeah, there's not very many places I think for young people that are designed for young people that are safe.”

Participant 2

“From talking to quite a few parents, they think it's unsafe, them playing without you there or walking around to meet friends. So, then they're not going anywhere.”

Participant 4

“My main concern was the fear that they would be run over. It's very, very rare for children to be snatched off the streets. it's far more common for them to be hit by a car.”

Participant 5

Despite a widespread culture which prioritises safety concerns, participants who did allow their children some freedom did so because of the positive impact on their activity levels.

“My older one, most of her physical activity is active travel. I wanted her to walk around and be active. Like walking to go to her friends, taking the bus to places and then having to walk from town. She isn't into any organised sports.”

Participant 4

Because of these safety concerns, parents who have the financial and time availability may feel pressure to drive children to activities.

“Kind of sports, mums you've got to drive to other places to watch people run around tracks.”

Participant 2

However, some families find ways of accessing physical activity without a car.

“I started driving because when I had my second child I got a car because I felt that, oh, you can't get anywhere. Then the car broke down and I started cycling more. I realised that not having the car meant they (the children) will start taking the bus and spend less time inside.”

Participant 4

“My child finds that (sport) motivational, that is something that my child derives joy from. We usually cycle there, but some of the other kids because it's early evening, their parents are driving through, rush hour traffic for an hour. That journey in the car would probably break me”

Participant 2

The impact of the pandemic was highlighted and how this may have had a negative impact on children’s activity levels.

“We pushed kids onto their phones, on to tablets on the things more because was the only way of doing it at the time. Because of that 18-month period. she then didn't take back up most of the activity stuff”

Participant 4

As with adults, any financial costs associated with an activity will restrict access by children and young people from low-income families.

“I used to do a lot of work with the youth service and kids would come and you'd send them to the youth centre, and they’d be active playing football or table tennis and doing that sort of thing. I know a lot of young people from low-income communities, that was their only opportunity to be active. If they have to pay, that automatically becomes a barrier.”

Participant 4

The intrinsic motivation that children have to be active was expressed by more than one participant. A suggestion was made that rather than a focus on why children are not active and encouraging children to be more active, barriers could be removed to allow their natural urge to move is to be realised. The issue of older children not feeling welcome or having anywhere to go was also highlighted.

“Children are naturally physically active. They have this intrinsic urge and instinct to play and if you create the right environment and the conditions for them to do that, it will just happen naturally.”

Participant 5

“My son is very active and that's made me think of being more active too”

Participant 1

“The focus should be like, what's stopping children from just getting outside their front door and playing?”

Participant 5

“Once kids are in secondary school, it does feel like they're not really welcomed anywhere.”

Participant 2

Being a parent may prevent or reduce exercise levels in the adult due to childcare responsibilities, especially when children are young. However, there may also be opportunities to be active together.

“I was doing a lot of parenting and I just thought I can't...do the football stuff anymore”

Participant 3

“When my child was younger because we could be active in that space literally on the doorstep.”

Participant 2

“I guess having him as particularly, like he's very active boy has made me start thinking more about increasing my physical activity with him.”

Participant 1

“Did a bit of boxing sparring with my son”

Participant 3

“My little boy thinks he can run faster than his dad. He can't. But he thinks he can. It's cute. And then they do a bit of climbing together as well.”

Participant 1

The gendered nature of children and young people’s activities was raised and how important it is to consider the needs of girls in planning.

“I did like being active as a kid and I got really into skateboarding as a teenager, which brought me a lot of joy and there weren't very many girls that did it. I think that girls really need to be considered. What kind of spaces girls want and young people in general should have some way of influencing the design of spaces.”

Participant 2

Gender

Harassment of women was raised and how this may make it harder for them to feel like they can get outdoors and be active.

“It still seems acceptable to give women and girls a hard time when they're out exercising. It does make that threshold of getting out difficult. It shouldn't be that difficult. It doesn't happen to men that I know in the same way ”

Participant 2

Gender harassment towards women living with obesity in Bristol was described, including physical abuse.

“Women living with obesity say that they've experienced a lot of harassment in public space, whether it's verbal or physically having things thrown at them”

Participant 2

Relaying the perspective of a female colleague, it was explained that her embarrassment would prevent her cycling. In her community growing up in Kenya, cycling as children was acceptable for all genders. However, it no longer felt appropriate to her to cycle as an adult, despite working as part of a team in Bristol who promote active travel.

“as a female, as a professional adult, it is embarrassing to be seen on a bike”

Participant 4

Perhaps for reasons such as harassment and embarrassment, some prefer women only exercise opportunities.

"I will generally seek out women only spaces."

Participant 1

"Going to the gym with other women makes it easier"

Participant 2

Examples of work in Bristol to support women to exercise were also highlighted.

"Cycling sisters, in Easton... do cycle training and so on, Stepping sisters, trying to promote walking"

Participant 4

For men, there were thought to be benefits of men walking with other people, especially if this gave the opportunity to talk.

"Men.... like they're walking side by side. They're more likely to open up than doing a face-to-face discussion, where people find out a bit kind of pressurised."

Participant 3

Mental Health

The mental health benefits of being active were acknowledged.

"So mentally that's quite nice because I walk across the park every day"

Participant 3

"Like it really does help my mental health."

Participant 1

However, anxiety can make it harder or even prevents someone from participating.

"Hardest bit for me is actually leaving the house. It's the mental struggle is sometimes the thing that will stop me. It has stopped me. That's the thing that I have to overcome to be able to engage in an activity."

Participant 1

Discrimination

Three participants are people of colour living in Bristol. Discrimination, and racism were raised as having a negative impact on physical activity participation in Bristol due to not feeling safe.

"I think for a lot of people, particularly people from black and brown communities, there are issues around feeling safe."

Participant 1

Specific examples were given of experiences and how these create a barriers to participation. Although non-Muslim themselves, Islamophobic sentiment may impact feelings of safety, given the potential racist undercurrent. In this example, the lack of safety was compounded by being in an enclosed space and reliant on the other person to return home safely.

"There was a running club for Disabled people, and I was going. I used to get picked up and taken there by another lady and her partner. She made a comment once; she was talking to another guy in the car. She was talking about Muslim people and then she said to him, oh, you know, they're not like us. It just felt very uncomfortable. And then I didn't go back to that group again. I didn't feel like that was a safe space for me."

Participant 1

Intersectional harassment in Bristol was also described.

"There has been intersectional harassment as well that, you know, because of their ethnicity. So if they're visibly Muslim, for example, and a woman that they receive harassment along those lines as well."

Participant 2

Participation may feel restricted to certain areas of Bristol where racism is less likely. This is further compounded by racism specifically directed at parents who have non white children with them.

"She particularly feels more unsafe when she's with her children, because people have commented on her creating more brown people. There's a boundary at Fishponds but also a boundary of going out with her children and enjoying that family time together. Whether that's on a bike path or in a green space, in a park or something like that."

Participant 1

A further example was described by a participant of how racism impacts children's activity levels.

"We've heard about racism and racist attacks being another factor for parents feeling scared about letting their children be outside"

Participant 5

When leading others in exercise sessions, a participant described how they address discriminatory comments.

“If people do say something to the group from outside the group, then I will confront them indicating that that kind of behaviour is not acceptable. Just because you might come from a different background doesn't mean that you have any less right to use the public space.”

Participant 2

Active Travel and the built environment

All five participants use active travel such as cycling or walking in Bristol and some are also involved in the sector in their professional role.

Active travel (walking, wheeling and cycling to get to places) was highlighted as making an important contribution to population and individual activity levels.

“It means you're building in physical activity, into day-to-day lives”

Participant 4

“So walking to work…then I also walk to meetings and things. That's my physical activity.”

Participant 3

For some, the fact that this was moving to get somewhere was an important motivator.

“When I walk generally, I'm walking for a reason. I'm walking to go to work, I’m walking to take my son to childcare. “

Participant 1

“I'm not going to wander about, you know, I want to walk. If I can walk from my house to town or whatever. You know, something like that.”

Participant 3

There were examples given where roads have been temporarily or permanently closed leading to an increase in physical activity.

“Liveable neighbourhood close off access to some roads, it means that people start walking. Kids start scootering to school. Kids start cycling. It changes the whole environment.”

Participant 4

Conversely, the lack of good local active travel routes for walking and cycling and the built environment may prevent people from being active.

“Sometimes the physical environment is not welcoming”

Participant 2

Discussion

Inactivity is a known risk factor for poor health, while regular physical activity offers protective benefits. This relationship was examined using Bristol health data focusing on cardiovascular health, falls, and mental health—areas that could all benefit from increased physical activity among those most at risk. Although around two-thirds to three-quarters of the local population report meeting recommended activity levels, in some groups fewer than half do so. The populations least likely to be active in Bristol also tend to have higher risks of poor health and lower life expectancy.

Research had also identified an association between lower levels of physical activity in older adults and a higher number of chronic medical conditions. Exercise is protective against the risk of a fall; something that becomes increasingly harmful as a person ages. Falls are a leading cause of injury, loss of independence, and hospitalisation among older adults, particularly those with conditions like osteoporosis, where injuries can be more severe. Weight-bearing exercise is recommended to prevent osteoporosis and reduce fall risk. In Bristol, older adults can benefit from well-evidenced programmes such as REtirement in ACTion (REACT), which support safe, structured physical activity and social connection. Despite these opportunities, older people in Bristol are far less likely to report meeting recommended activity levels compared to the general population. Leisure Centre attendance data also shows a disproportionately low number of users aged 66 and over. Barriers to activity include poor eyesight and hearing, frailty, fear of injury, medication side effects, and internalised ageism—all of which were echoed by interview participants. These insights highlight the need for inclusive, empowering programmes that address both physical and psychological barriers. Providing rest stops, accessible toilets, and positive messaging around ageing can help older adults feel more confident and independent outdoors.

Falls prevention programmes like REACT are not only effective but essential to support healthy ageing. They include exercise, education and social activities, helping to tackle loneliness and promote behaviour change. The strong evidence base makes REACT a valuable model for falls prevention and healthy ageing particularly in community settings. Starting these interventions earlier in life can build resilience and reduce future risk.

Policies intended to support inclusive practice for Disabled people although well-meaning, may be implemented in ways influenced by ableist perspectives resulting in a lower increase in participation than anticipated. Narratives from media coverage of the Paralympics such as extraordinary normalcy, ableist rehabilitation and sporting able nationalism may do little to promote physical activity at population level. There are more than 81,000 people in Bristol who have long-term physical or mental health conditions or illnesses which limit their day-to-day activities and people who care for others are more likely to be Disabled themselves. People over the age of 65, those who identify as LGB+ and people who report they identify with a gender different to that they were assigned at birth were more likely to also be Disabled. The proportion of Disabled people in local areas is associated with living in an area of higher deprivation. Local Disabled people were far less likely to report they do enough exercise per week compared to the Bristol average and full-time carers were also less likely to exercise enough. Of adults in Bristol who reported they were inactive, two thirds identified they had a

disability or long-term health condition and a far lower proportion of users of Leisure centres identify as Disabled. Interview participants explained several access needs, both for themselves and others such as the importance of facilities being very near to where an individual lives. Doorstep play opportunities were also thought to have potential to support Disabled children's physical activity. The closure of pavements and other temporary alterations can cause anxiety for Disabled people who may have a carefully planned accessible route. Familiarity with a venue and the local area can instil confidence in its accessibility for Disabled individuals. Fitness instructors can support inclusivity by being approachable and Disabled people can also support each other through recommending accessible venues and sessions. For Disabled people, motivation to attend a new session may be supported through explicitly advertising details of the class and adjustments which can be made.

Less than half of local children have been found to meet the recommended levels of activity and children from less affluent families, Black children, Asian children and girls have been found to be even less active than their peers. Children's physical activity levels were found to be significantly lower than pre-pandemic levels, with increased sedentary time. There is a need to address 'physical activity insecurity' for young people through supportive social and physical environments and include structured and unstructured opportunities. Inclusive opportunities for Disabled children are less common and harder to get to and provision in special schools can support activity levels. A dip in the activity levels of local children born 2015-2016 suggest that this age group may have been particularly negatively impacted by COVID-19 pandemic restrictions. The potential negative impact on children's activity levels in Bristol was also highlighted though interviews. Although historically, children have been active in Bristol through unsupervised outdoor play the acceptability of this appears to have changed. Safety concerns for children such as knife crime and risks from drivers of motor vehicles may prevent parents from allowing them to play outside. The current culture which focuses more on planned activities for children must be facilitated by adult caregivers and requires time and money which not all families have. Although children are thought to be intrinsically motivated to be active, barriers may prevent this and in addition, older children may not feel welcome in public spaces. Being a parent may prevent or reduce exercise levels in the adult due to childcare responsibilities but can present opportunities to be active together.

People from Black and minority ethnic groups often have worse health outcomes and less access to health services compared to White groups. South Asian groups in the UK have higher rates of cardiovascular disease (CVD) and die from it more often compared to White groups. British South Asians have a higher prevalence of overweight and obesity than the wider population. Black groups have higher rates of hypertension and stroke, tend to have strokes at a younger age and higher obesity levels are also higher. External factors such as racism and access issues (including geographical, social, and economic) significantly impact health behaviour however, the sample size for any non-white ethnic group in respondents from Bristol to the Active Lives survey is too small to draw any meaningful conclusions regarding activity levels locally. Interview participants described discrimination and racism, islamophobia and intersectional harassment in Bristol and the negative impact on physical activity participation. Individuals who are targets for racism may feel restricted to

certain areas of Bristol where abuse is less likely. Racist abuse directed at parents who have non white children with them further restricts activity opportunity for families. The fear of racism may also impact children's activity levels whereby parents consider this an additional safety concern.

There are existing and growing inequalities based on where someone lives and adults living in the most deprived areas of Bristol report lower activity levels. Increases in the cost of living are amplifying disparities in disposable income and access to paid physical activity opportunities is impacted. The rising cost of running a facility along with cancelled memberships and a decrease in external funding is likely to put pressure on older facilities in more deprived communities. Data for Leisure centres by suggest very low levels of attendance by adults who live in the most deprived areas of the city. Several groups at higher risk of poverty and deprivation were also less likely to report that they are active enough each week via the Quality-of-Life Survey. This includes residents with no qualifications and those living in social housing. Active lives data indicates that inequality gap between those living in the most and least deprived areas continues. Interview participants explained that people living in 'survival mode' may not have the available energy to consider behaviour change and this is compounded by the prohibitive cost (or perceived cost) of engaging in physical activity.

Nationally, and locally, adult data shows that women are slightly less likely to report that they are active for at least 150 minutes per week compared to men. Locally, nearly two thirds of women report that they never cycle in contrast to figures for local men, amongst whom only 42% report they never cycle. An even lower proportion of Transgender individuals than women report they are active nationally. Amongst Black women and Asian women, the proportions reporting that they are active is lower than for White women nationally. There may be limited opportunities for women from Asian communities to by active due to a perceived lack of culturally suitable exercise facilities as well as language barriers and a need to conform to community and family expectations. A lack of women only fitness opportunities has also been identified as a barrier to participation. Interview participants also identified that some local women prefer women only exercise opportunities. In pregnancy, physical activity has been found to reduce the risk of developing gestational diabetes in higher risk individuals. A decline in activity amongst pregnant women with gestational diabetes has been identified from before to during the COVID-19 pandemic. Over 60% of reported that physical activity levels decreased during although University educated women, those with equipment at home and those with knowledge of how to exercise safely during pregnancy were more likely to meet UK exercise guideline. Women with long term health conditions were less likely to be active. For those whose activity levels did decline, fear of leaving the house was the most stated reason. In Bristol, interview participants identified harassment of women makes it harder to be active. Harassment towards women living with obesity in Bristol was described, including physical abuse. The gendered nature of children and young people's activities was also raised and how important it is to consider the needs of girls in planning. For men, there were thought to be benefits walking together to give them time to talk. More generally, the mental health benefits of being active were acknowledged although anxiety can make it harder for some.

Active travel and the built environment were identified as a theme through literature, data and by participants. Communities who experience lower status may feel that the social sanctions

associated with engaging in cycling as an activity are not worth the risk. Active travel (walking, wheeling and cycling to get to places) was highlighted as making an important contribution to population and individual activity levels. Examples where roads have been temporarily or permanently closed have led to an increase in physical activity and conversely, the lack of good local active travel routes for walking and cycling can prevent people from being active. Some activities such as cycling may be seen as acceptable for girls as children as part of play, but not for adult women.

Areas for action

The ICS's place-based and prevention-focused approach provides a strong foundation for advancing the three intersecting areas for action identified through this report—Liveability, Accessibility, and Equality—through targeted interventions across key settings. . This is shown as Venn diagram in figure 18.

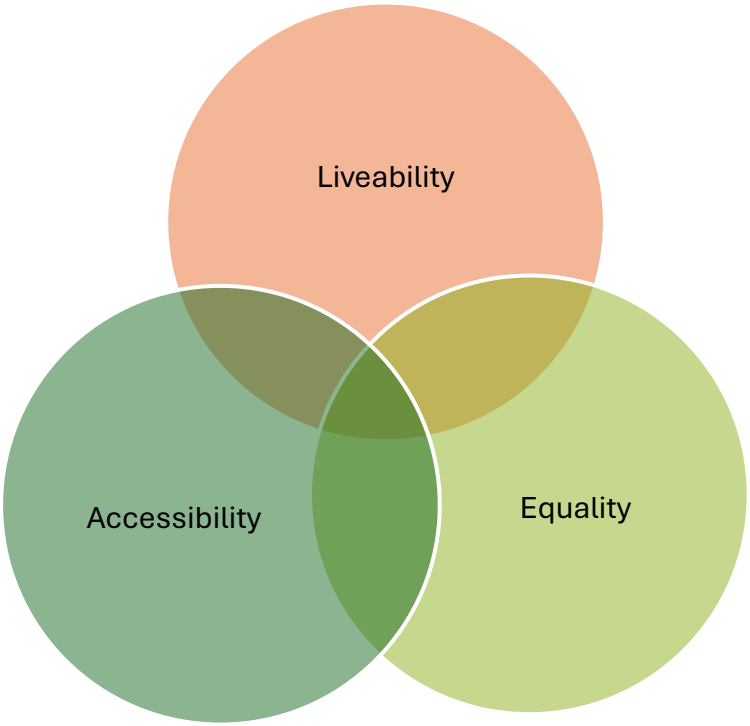


Figure 18

1. Liveability

Actions which improve opportunities to be active outdoors, where resident live and as part of everyday life, such as:

- Advocate for children's playful movement and active travel in the public realm.
- Ensure unstructured exercise opportunities are available for teenagers in Bristol.
- Promote a Public Health approach in planning and transport projects.
- Promote walking, wheeling, cycling and outdoor play as low/no-cost activities.

- Incentivise and improve access to leisure centres and sports facilities via walking, wheeling, cycling and public transport.
- Disincentivise and reduce access to leisure centres and sports facilities via private motorised transport.
- Provide for the needs of women, girls and other marginalised genders within the public realm.

2. Accessibility

Actions which improve accessibility to physical activity opportunities for older adults, Disabled people and people with long term medical conditions, such as:

- Provide easily accessible maps and information about toilets and outdoor seating areas.
- Include information about adaptations available for exercise sessions in advertising.
- Provide Disabled people in Bristol with platforms and forums to recommend exercise opportunities to each other.
- Provide training opportunities for relevant staff at facilities to improve the accessibility of exercise sessions.
- Promote the benefits of exercise for prevention and management of mental health/illness, reduced falls risk and reduced incidence of cardiovascular disease.
- Identify and promote exercise opportunities within a15-minute walk of where people live to support exercise for Disabled people and older adults.
- Promote 'Planning for an active older age' to residents aged under 65.

3. Equality

Actions aimed at improving physical activity levels amongst specific groups, such as:

- Use community empowerment models to improve access to physical activity for groups who are currently less active.
- Identify opportunities to support Sport England's data collection via the Active Lives Survey to increase responses from Black and Asian adults in Bristol.
- Ensure that the needs of women and girls within less active communities e.g. Black women, Disabled women are considered and provide more women only opportunities.
- Promote opportunities for men to walk together to improve social connections.
- Map opportunities for pregnant women and produce easily accessible resources for maternity professionals
- Ensure that actions to improve healthy lifestyles do not negatively impact overweight and obese people in Bristol (avoid fatphobia and body shaming).

Settings

Settings play a foundational role in shaping opportunities for physical activity across the three intersecting areas for action: Liveability, Accessibility, and Equality. Whether in schools, workplaces, healthcare environments, community spaces, or digital platforms, settings determine how easily and equitably individuals can engage in movement as part of daily life. By embedding physical activity into

the places where people live, learn, work, and interact, we can create environments that support active lifestyles, reduce barriers for marginalised groups, and promote inclusive, sustainable health outcomes.

This approach aligns with Bristol's Belonging Strategy for Children and Young People, which emphasises the importance of creating inclusive environments where all children feel supported and able to thrive. Schools and early years settings are particularly vital in promoting active travel, outdoor play, and positive attitudes toward movement from a young age—laying the foundation for lifelong health and wellbeing.

Recognising the influence of settings ensures that interventions are not only targeted and effective, but also responsive to the diverse needs of Bristol's population.

To translate these principles into meaningful change, it is essential to consider how each area for action -Liveability, Accessibility, and Equality, can be advanced through targeted interventions within specific settings.

The following outline how different environments, from community spaces to healthcare and digital platforms, can be leveraged to address the unique challenges and opportunities within each area. By mapping relevant settings to each area for action, we can ensure that strategies are both context sensitive and impactful, supporting a more active and equitable Bristol for all.

Liveability

Focus: Making environments conducive to everyday physical activity.

Relevant Settings:

- Community settings: Parks, green spaces, active travel routes.
- Planning and transport: Built environment and infrastructure.
- Schools and early years: Promoting active travel and outdoor play.

How to incorporate:

- Highlight how community design (e.g. walkable neighbourhoods, safe cycling routes) supports playful movement and active travel.
- Emphasise the role of schools and public spaces in offering low-cost, unstructured opportunities for children and teens.
- Link transport and planning policy to physical activity by advocating for infrastructure that supports walking, wheeling, and cycling.

Accessibility

Focus: Ensuring physical activity is reachable and usable by all, especially older adults, Disabled people, and those with long-term conditions.

Relevant Settings:

- Healthcare settings: Exercise referral, mental health support.
- Leisure centres and sports facilities: Adaptations and staff training.
- Digital/home settings: Online resources and remote access.

How to incorporate:

- Promote inclusive design in leisure centres and outdoor spaces (e.g. seating, toilets, signage).
- Use healthcare settings to raise awareness of the benefits of physical activity for managing conditions.
- Encourage digital platforms to provide accessible information and peer support networks.

Equality

Focus: Addressing disparities in physical activity participation across different population groups.

Relevant Settings:

- Community settings: Empowerment models, peer-led initiatives.
- Workplaces: Gender-sensitive programmes and social walking groups.
- Healthcare and maternity services: Tailored resources and support.

How to incorporate:

- Use community settings to co-design programmes with underrepresented groups (e.g. Black women, Disabled women).
- Ensure workplace and healthcare settings offer culturally appropriate and gender-sensitive opportunities.
- Support data collection and mapping to identify gaps and target interventions effectively.

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Appendix 1 Bristol City Council, One City and WECA (West of England Combined Authority) policies and strategies that reference physical activity or active travel.

Corporate level policies	BCC Corporate strategy (2022 to 2027)
	BCC business Plan 2024-2025
	One City Plan 2023 – A plan for Bristol to 2050
Climate	BCC mayor's Climate Emergency Action Plan 2019
	One City Ecological Emergency strategy
	Joint Green Infrastructure Strategy
	Keeping Bristol Cool Framework
	One City Climate Strategy
	Health and Wellbeing strategy

Health, wellbeing, sport and physical activity	Playing Pitch Strategy
	Sport and Physical Activity Strategy 2020-2025
	Thrive Bristol
	A strategic plan for healthy weight in Bristol
	A Sport and Active Recreation Facility Strategy for Bristol 2020 - 2025
Transport	A Safe Systems Approach to Road Safety in Bristol
	Home to School Travel: Travel Support Policy (16-25)
	Bristol City Council Home to School (5-16) Travel Support Policy
	Joint Local Transport Plan 4 2020-2036
	Bristol temple quarter enterprise zone: Sustainable urban mobility plan
	Bristol Transport Strategy
	West of England Local Cycling and Walking Infrastructure Plan 2020-2036
	Cycle parking
	Designing for walking, Designing for cycling
Planning	Bristol central area plan
	Bristol City Council Corporate Property Strategy
	Bristol Local Flood Risk Management Policy
	Bristol development framework, core strategy
	Project 1000, Housing Plan
	Regeneration Plans
	Bristol Avon Flood Strategy
	Bristol temple quarter: A vision for the future
	Planning a healthier Bristol – assessing the health impacts of developments
Crime	Bristol Safer Options Approach 2020-2030
Other	BCC Corporate Parenting strategy 2023-2029

	Bristol Cultural Strategy
	Designing a New Social Reality
	Employment, Skills and Learning Plan
	Bristol global city – international strategy
	Parks and Green Spaces Strategy
	The Integrated education and capital strategy
	Bristol Belonging Strategy
	Social Value Policy
	Healthy and Sustainable Procurement Policy
	Bristol City Council Ethical and Equitable Investment Policy