Natural England Research Report NERR041

Who took part in Walking for Health?

An analysis of walker demographics April 2008 to March 2010

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Project details

This report explores the demographic data of participants in Walking for Health (WfH) between April 2008 and March 2010.

A summary of the findings covered by this report, as well as Natural England's views on this research, can be found within Natural England Research Information Note RIN041 – Who took part in Walking for Health?

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Summary

This Research Report examines the demographics of participants in Natural England's Walking for Health (WfH) programme between April 2008 and March 2010. The report is based primarily on the data of around 50,000 participants held on the WfH Database, but also draws on other related research.

The purpose of this report is to provide a clear and detailed picture of who took part in WfH, in order to inform the delivery of future led walk interventions aimed at tackling health and physical activity issues. It also provides evidence on the demographic impact of the first year of the WfH expansion programme.

The report explores the following:

- Topline demographic information
- An analysis of the main demographics:
  - Age band
  - Gender
  - Disability
  - Ethnicity
  - Health factors
  - Deprivation
- Regional differences
- A comparison before and after the start of the WfH Expansion Programme
- A discussion in the context of other related research.

The findings show that participants were primarily white, non–disabled females in their early 60s. Participants' ethnicity was largely representative of the older age groups taking part, but those with a disability or from deprived areas were under–represented. Regionally there were small variations in the gender and age profile of walkers, with bigger differences in other demographics. There was minimal change in the profile of walkers during the first year of the WfH expansion programme. The report concludes that although the profile of WfH participants was well established, there is certainly scope for widening the audience of future interventions.

The findings in this report will be useful to those involved in delivering led walk interventions in identifying and addressing inequalities, and in better understanding the nature of who takes part and the factors that affect this.

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1 Introduction

Walking for Health

1.1 The Walking for Health (WfH) programme was the largest led walk intervention of its time and one of the largest public health interventions for physical activity in the UK. It aimed to encourage people to take regular short walks in their local communities, in order to increase their levels of physical activity, improve their health, and connect them with their local environment.

1.2 Initially set up in 2000 by the Countryside Agency, ownership of WfH transferred in 2006 to Natural England, the newly–formed amalgamation of the Countryside Agency, English Nature and the Rural Development Service.

1.3 WfH was delivered at local level by organisations such as Local Authorities, Primary Care Trusts and voluntary agencies. Natural England provided a full package of support in the development of these schemes, including staff help and advice, training for walk leaders, insurance and accreditation to walk schemes, free promotional resources, and a monitoring and evaluation programme.

1.4 From April 2009 Natural England – working in partnership with the Department of Health (DH) – embarked on a three–year expansion programme for WfH which aimed to increase participation fourfold. This period of work is referenced throughout this report as the 'expansion programme'.

Monitoring and evaluation of Walking for Health

1.5 In 2008 two key tools were introduced that underpinned WfH's monitoring and evaluation framework: the Outdoor Health Questionnaire (OHQ) and the WfH Database. The OHQ collected data about individual walkers, with schemes that adopted it requesting all new and existing walkers complete one. The database stored data from OHQs which, when combined with information from walk registers (also stored on the database), showed the 'walk history' of participants.

1.6 The Database generated detailed demographic reports of participants which could be used in a number of ways at national, regional and local level; for example to monitor and evaluate the impact of walk schemes, to inform delivery, and to report back to funders and stakeholders.

Research need

1.7 The need for this research was identified by the Natural England Evidence team delivering the WfH Evaluation programme. Its purpose is to provide a clear and detailed picture of who took part in Walking for Health, in order to inform delivery and develop the understanding of people working on WfH and similar interventions. It provides robust, high quality findings on the demographic 'impact' of Walking for Health that can be shared with Walking for Health funders and stakeholders.

1.8 This report also includes a comparison of walker demographics before and during the expansion programme detailed in 1.4, providing evidence of the impact this first year had on the overall demographic profile of walkers, and with specific regard to its target audience.

2 Methodology

Sample

2.1 This study looks at the OHQ data of around 50,000 participants (all 16+) who were active between April 2008 and March 2010, as stored on the WfH Database. Because the Database was 'live', the exact total depended on the day on which data was retrieved. The total at the start of the study was 49,737. The total by the end of the study was 50,882; ie 1,145 new participants were recorded during the time it took to carry out this study.

2.2 These participants came from a total of almost 45,000 recorded walk registers, from nearly 3,500 recurring walks across over 400 walk schemes.

Confidentiality and ethics

2.3 All findings in this report are anonymised. All participants whose data was held on the database gave their consent for it to be so. The Database itself was fully compliant with the Data Protection Act and had built–in security features and documented internal processes for its use.

Notes on accuracy

2.4 The database was introduced in June 2008 (though users could retrospectively add walk registers from before this time). We estimate that it held the data of around half of all WfH participants active from April 2008 to March 2010. It can therefore be considered a reliable and accurate sample of the entire walker population; albeit still a sample and one which is naturally up–weighted in the second year due to the higher number of schemes using it.

2.5 Non–responses are not included in the analysis of figures from the database; ie figures relate to those who gave an answer only. (Though there is a slight exception to this, detailed in 2.6.) The highest non–response rate (7.5%) related to participants not giving a postcode that could be cross–referenced with the Indices of Multiple Deprivation (IMD). Non–response rates in other areas were considerably lower and are not considered to affect the accuracy of the figures presented here.

2.6 With regard to the questions around Health Screening, Diagnosed Medical Condition, and Recommendation from a Doctor or Health Professional to attend the scheme: data – or rather the lack of it – from incomplete OHQs may have skewed figures somewhat as a non–response to the questions would be recorded the same as a negative response.

3 Topline figures

3.1 The ‘typical’ walker was a white, non–disabled female aged in her early 60s, from an area within the second least deprived IMD quintile.

3.2 The demographic breakdown of WfH participants is shown in Tables 1a–f.

Table 1a Demographic breakdown of WfH participants – gender

Gender	Percentage
Male	27.5
Female	72.5

Table 1b Demographic breakdown of WfH participants – age band

Age Band	Percentage
16–24	3.1
25–34	6.1
35–44	7.4
45–54	10.7
55–64	31.9
65–74	31.3
75–84	8.7
85+	0.8

Table 1c Demographic breakdown of WfH participants – ethnicity

Ethnicity	Percentage
White[1]	94.8
Non–White[2]	5.2

Table 1d Demographic breakdown of WfH participants – disability

Disability	Percentage
Disabled[3]	10.3
Non–disabled	89.7

Table 1e Demographic breakdown of WfH participants – health/medical conditions

Health/Medical Conditions	Percentage
One or more of the listed Health Screening Conditions[4]	16
One or more of the listed Diagnosed Medical Conditions[5]	31.6

Table 1f Demographic breakdown of WfH participants – residential address

Residential Address by IMD[6]	Percentage
IMD 0–20%	10.6
IMD 20%–40%	15.4
IMD 40%–60%	21.8
IMD 60%–80%	25.3
IMD 80%–100%	26.8

Base: ~50,000 WfH participants active between 1/4/08 and 31/3/10.

[1] White British, White Irish, White Other or Traveller / Roma / Irish Traveller.

[2] Any other ethnic group not classified as White.

[3] Defined as a long–standing (ie: for more than 12 months and likely to continue) illness or disability that affects or limits the person's day to day activities.

[4] The screening conditions listed were: heart condition, chest pain when doing physical activity, losing balance due to dizziness or losing consciousness, chest pain when not doing physical activity and bone or joint problem that a change in physical activity could make worse.

[5] The medical conditions listed were: heart disease, high blood pressure, COPD (Emphysema and Chronic Bronchitis), Diabetes and Asthma.

[6] IMD = Indices of Multiple Deprivation, a method of ranking the relative deprivation of the geographical areas where people live. 0–20% is the most deprived; 80–100% is the least deprived.

4 Analysis by demographic

Gender

4.1 Female participants outnumbered male participants by around 2.5 to 1, the profile being 72.5% female and 27.5% male. There has evidently been very little change in this respect over a number of years, as Dawson and others (2006) found a very similar picture, with a female share of 71.2%.

4.2 Comparing the profile of female and male participants:

- Female participants were on average slightly younger. Just under 4 in 10 (38.3%) were aged 65 or over, compared to nearly 1 in 2 male participants (47.6%). The median age was 60 (female) and 64 (male).
- Female participants were more likely to be from a Non–White background (5.3% F / 4.8% M).
- Male participants were more likely to be disabled (12.1% M / 9.6% F).
- Male participants were more likely to have one of the listed health screening (19.8% M / 14.5% F) or diagnosed medical conditions (36.8% M / 29.7% F).
- Male participants were 50% more likely to have been referred by their GP or health professional (9.1% M / 6.0% F).
- Male participants were more likely to be from the 20% most deprived areas (11.2% M / 10.4% F).

Age band[1]

4.3 Over 7 in 10 participants (72.7%) were aged 55 or over, with 4 in 10 participants (40.8%) aged 65 or over.

Table 2 Age profile of WfH participants

Age Band	16–24	25–34	35–44	45–54	55–64	65–74	75–84	85+
%	3.1%	6.1%	7.4%	10.7%	31.9%	31.3%	8.7%	0.8%

4.4 Although a relatively elderly profile at first glance, this is somewhat younger than that reported by Dawson and others (2006), which found that well over half of walkers (56.6%) were aged 65 or over, including 14% aged 75 or over. We can speculate as to the reasons for this shift, for example that the growth of the WfH scheme over the intervening years has helped widen its appeal to younger age groups.

Ethnicity

4.5 19 in 20 (94.8%) participants were of White ethnicity, with 1 in 20 (5.2%) of Non–White ethnicity. This compares with a split of 93.8% and 6.2% as reported by Dawson and others (2006). Although on the surface this suggests a missed opportunity when compared to the 9.1% of the

[1] Participants were asked for their age band rather than their date of birth in order to achieve a higher response rate, and because the data itself is less sensitive. These figures therefore provide the age band of participants when they completed the OHQ, not necessarily their current age band.

English population that are of Non–White ethnicity as reported in the 2001 Census, this is in fact representative when taking into account the older age profile of WfH.

4.6 Of those of White ethnicity, the vast majority (96.9%) were White British.

4.7 Of those of Non–White ethnicity, the most common was Indian (37%), followed by Pakistani (11%), Other (11%), Caribbean (9%) and Chinese (9%).

Table 3 Ethnic profile of WfH participants

Ethnic Group				%	
White	White British			91.9%	94.8%
	White Irish			1.2%	
	White Other			1.7%	
	Traveller / Roma / Irish Traveller			0.0%	
Non–White	Mixed	White and Black Caribbean	0.1%	0.5%	5.2%
		White and Black African	0.1%		
		White and Black Asian	0.1%		
		Other	0.2%		
	Asian or Asian British	Indian	1.9%	2.8%	
		Pakistani	0.6%		
		Bangladeshi	0.1%		
		Other	0.2%		
	Black or Black British	African	0.3%	0.9%	
		Caribbean	0.5%		
		Other	0.1%		
	Total Chinese			0.4%	
	Total Other			0.6%	

Disability[2]

4.8 1 in 10 participants (10.3%) had a disability or long–standing illness. This compares with around 1 in 6 (17.3%) of the UK population as reported by the 2001 Census (ONS[3], 2001), though this figure is expectedly higher amongst older age groups, putting WfH's share as a significant under–

[2] Participants who stated they had a disability were asked to give brief details, with the intention of categorising their disability by type (physical, sensory, learning etc). In practice, due to the wide range of responses and the difficulty of matching them to disability type, these data are not reliable enough for inclusion in this report.

[3] Office for National Statistics

representation. Dawson and others (2006) reported 7% of walkers were registered as disabled (rather than the self–reported rate presented here, which may explain the difference).

Health and medical conditions

4.9 1 in 6 participants had one or more of the listed health screening conditions[4]. The most common was Heart Condition, cited by 1 in 12 of all participants.

Table 4 Percentage of WfH participants with a health screening condition

Health screening condition	%
Heart Condition	8.0%
Bone or joint problem that a change in physical activity could make worse	6.3%
Losing balance due to dizziness or losing consciousness	3.8%
Chest pain when doing physical activity	1.4%
Chest pain when not doing physical activity	1.1%
One or more of the above	**16.0%**

4.10 3 in 10 participants had been diagnosed with one or more of the listed medical conditions[5], with the most common being high blood pressure, cited by 1 in 5 of all participants. These figures suggest that the 'health' draw of WfH had some success, notwithstanding the higher occurrence of such conditions amongst older age groups.

Table 5 Percentage of WfH participants with a diagnosed medical condition

Diagnosed medical condition	%
High blood pressure	21.1%
Asthma	7.4%
Heart disease	5.6%
Diabetes	5.4%
COPD (Emphysema and Chronic Bronchitis)	1.4%
One or more of the above	**31.6%**

4.11 As noted in 4.2, males were more likely than females to have one of the health screening conditions or diagnosed medical conditions. This correlates with the findings from the MENE[6] survey (Natural England, 2010) that reported that men were more likely than women to be motivated by health benefits when visiting the natural environment. This is encouraging given Reynolds' (2005) finding that 'many schemes report that many men do not see walking as

[4] These are standard conditions asked of those about to undertake physical activity, as a way of screening for those who should be advised to seek medical advice prior to doing so.

[5] These conditions were chosen for inclusion on the OHQ as they were identified as being among the most likely to benefit from physical activity.

[6] Monitor of Engagement with the Natural Environment

'exercise' and therefore are put off joining for health reasons', and suggests that this observation may have changed.

4.12 Dawson and others (2006) reported that 20.6% of walkers had problems with health that hampered or discouraged walking and that 17.6% classed their own health status as fair / poor; but these measures are too dissimilar to those used here for any direct comparison.

4.13 Around 1 in 14 (6.9%) participants stated that their doctor or health professional recommended they come on the walk scheme, though this figure may be higher as we don't know the rate of non–response (see 2.3). By comparison, Reynolds (2005) reported that around 10% of walkers joined on recommendation from their GP.

Deprivation

4.14 1 in 10 participants (10.6%) lived in one of the 20% most deprived areas, with 1 in 4 (26%) living in the 40% most deprived. More than half (52.5%) lived in the 40% least deprived.

Table 6 Profile of WfH participants by residential IMD classification

	Most deprived				Least deprived
Deprivation quintile	**0–20%**	**20–40%**	**40–60%**	**60–80%**	**80–100%**
%	10.6%	15.4%	21.8%	25.3%	26.9%

4.15 If deprivation were no barrier to participation in WfH then we would expect roughly 20% of participants to have lived within each IMD quintile, since the population[7] distribution in each is very even (Rose, 2010). This is not the case, and the distribution instead suggests that WfH appealed more, or was more accessible, to those from less deprived areas. This agrees with Dawson and others (2006), who reported that participants were relatively well educated and affluent.

[7] Mid 2005 estimates (excluding prisoners)

5 Regional differences

Notes on tables in this section:

a) The following abbreviations are used in the tables in this section:

E = East

EM = East Midlands

L = London

NE = North East

NW = North West

SE = South East

SW = South West

WM = West Midlands

YH = Yorkshire and the Humber

b) The highest regional values in each table appear in bold, and the lowest in bold italics.

Gender

5.1 The gender profile of WfH participants was very similar across all regions, with a difference of less than five percentage points between the largest male share (the North West, 30%) and the smallest (Yorkshire and the Humber, 25.3%).

Table 7 Gender profile of WfH participants by region

Region	Female	Male
E	71.2%	28.8%
EM	71.3%	28.7%
L	72.7%	27.3%
NE	74.0%	26.0%
NW	***70.0%***	**30.0%**
SE	73.8%	26.2%
SW	72.2%	27.7%
WM	72.1%	27.9%
YH	**74.7%**	***25.3%***
Total	72.5%	27.5%

Age band

5.2 The South West (44.6%), East (44.4%) and Yorkshire and the Humber (44.0%) had the largest share of walkers aged 65 or over. The North West had the youngest profile with the largest share of walkers in every age band under 55, and the smallest share aged 65 or over (34.8%).

Table 8 Age profile of WfH participants by region

Region	16–24	25–34	35–44	45–54	55–64	65–74	75–84	85+
E	***1.4%***	***3.2%***	***5.3%***	9.3%	**36.3%**	**35.5%**	8.3%	0.6%
EM	2.9%	8.4%	8.3%	10.9%	34.3%	28.7%	***6.2%***	***0.3%***
L	2.0%	4.3%	7.9%	11.7%	31.6%	32.8%	8.7%	1.0%
NE	4.2%	6.8%	7.4%	9.3%	32.0%	32.4%	7.2%	0.6%
NW	**4.6%**	**9.5%**	**10.8%**	**12.9%**	***27.4%***	***27.5%***	6.8%	0.5%
SE	3.7%	6.0%	6.8%	11.2%	30.4%	30.6%	9.9%	**1.3%**
SW	1.8%	5.4%	5.7%	***8.8%***	33.6%	33.3%	10.2%	1.1%
WM	3.5%	6.2%	8.9%	11.7%	30.2%	30.5%	8.3%	0.8%
YH	3.0%	4.7%	6.6%	10.2%	31.5%	32.0%	**11.0%**	0.9%
Total	3.1%	6.1%	7.4%	10.7%	31.9%	31.3%	8.7%	0.8%

Ethnicity

5.3 London had the largest share of walkers from a Non–White background (19.4%), followed by the West Midlands (8.3%). The North East (2.1%) and South West (2.9%) had the smallest.

5.4 However, assigning an index to each region based on comparison with the 2001 Census (Natural England / BTCV[8], 2007) as in Table 9, shows the South West (1.25) had the highest Non–White share relative to the local population, followed by North East, North West and Yorkshire and the Humber (all 0.87). The East (0.64) and London (0.67) had the lowest.

[8] Formerly stood for British Trust for Conservation Volunteers

Table 9 Non–White profile of WfH participants compared with 2001 Census profile of English population (16+)

Region	Non–White %		Index A/B
	WfH (A)	Census (B)	
E	3.1%	4.9%	***0.64***
EM	4.5%	6.5%	0.70
L	**19.4%**	**28.9%**	0.67
NE	***2.1%***	2.4%	0.87
NW	4.9%	5.6%	0.87
SE	4.0%	4.9%	0.82
SW	2.9%	***2.3%***	**1.25**
WM	8.3%	11.3%	0.74
YH	5.7%	6.5%	0.87
Total	5.2%	9.1%	0.58

Note: the national (total) index is not an average of all regions.

Disability

5.5 Yorkshire and the Humber had the largest share of participants with a disability or life–limiting illness (12.3%) while London had the smallest (8.1%).

5.6 Assigning an index to each region based on comparison with the 2001 Census (ONS, 2001) shows that the South West had the highest share relative to the local population, while the North West had the lowest. However, all are significantly under–represented, and even more so when considering the higher rates of disability and long–term illness in the older age groups.

Table 10 Percentage of WfH participants with a disability compared to the total population

Region	Disabled %		Index A/B
	WfH (A)	Census (B)	
E	10.0%	15.6%	0.64
EM	9.0%	17.8%	0.51
L	***8.1%***	15.1%	0.54
NE	11.4%	**22.1%**	0.51
NW	9.8%	20.1%	***0.49***
SE	9.6%	***14.8%***	0.65
SW	11.6%	17.4%	**0.67**
WM	10.4%	18.3%	0.57
YH	**12.3%**	18.9%	0.65
Total	10.3%	17.3%	0.59

Note: the national (total) index is not an average of all regions.

Health and medical conditions

5.7 The West Midlands (18.1%) and South West (17.7%) had the highest prevalence of participants with at least one of the health screening conditions, whilst the South East (14.0%) and London (14.6%) had the lowest.

5.8 The East (34.8%) and West Midlands (32.7%) had the lowest prevalence of participants with at least one of the diagnosed medical conditions, whilst the North West (27.9%) and London (29.4%) had the lowest.

5.9 London (9.6%) and the North West (9.1%) had the highest prevalence of walkers recommended to take part by their doctors or health professionals. The South East (5.4%) and the East (5.8%) had the lowest.

Table 11 Percentage of WfH participants with one or more health or medical conditions, or recommended to take part by their doctor or health professional

Region	One or more health screening conditions	One or more diagnosed medical conditions	Recommended by doctor or health professional
E	15.5%	**34.8%**	5.8%
EM	15.1%	31.0%	7.8%
L	14.6%	29.4%	**9.6%**
NE	16.9%	31.5%	8.3%
NW	15.4%	***27.9%***	9.1%
SE	***14.0%***	31.5%	***5.4%***
SW	17.7%	32.1%	6.8%
WM	**18.1%**	32.7%	6.7%
YH	16.7%	31.4%	6.2%
Total	16.0%	31.6%	6.9%

Deprivation

5.10 The North West had the highest share of walkers from the 20% most deprived areas (31.0%), while the East had the lowest (2.2%).

5.11 This relationship also holds when assigning an index to each region based on comparison with the percentage of the overall population[9] living in the 20% most deprived areas, with the North West still the highest (0.98) and the East still the lowest (0.36). In other words, the North West had the strongest representation relative to the regional population, while the East had the weakest.

[9] Mid 2005 estimate (excluding prisoners)

Table 12 Percentage of WfH participants in the 20% most deprived areas compared with the English population

Region	% living in 20% most deprived areas		Index A/B
	WfH (A)	Population (B)	
E	***2.2%***	6.2%	***0.36***
EM	11.1%	16.6%	0.67
L	16.0%	28.5%	0.56
NE	21.1%	**33.7%**	0.63
NW	**31.0%**	31.8%	**0.98**
SE	3.5%	***5.9%***	0.60
SW	4.5%	9.2%	0.49
WM	10.3%	27.4%	0.38
YH	15.3%	27.2%	0.56
Total	10.6%	19.9%	0.53

Note: the national (total) index is not an average of all regions.

6 WfH expansion programme

Introduction

6.1 The WfH expansion programme (detailed in 1.4) started in April 2009, and was the first time WfH had a stated target audience [targets prior to this related to the number of participants only]. This new target audience was defined as:

- 'Key sedentary groups where there is a particularly strong health benefit to be gained from walking'; which included
- 'over 65s; those with diagnosed ill health issues (mental and physical); families including mothers and toddlers [aged] 1–5 (weight management and emotional well–being); and hard to reach groups (particularly black and ethnic minorities)'.

6.2 This section provides a comparison of walker demographics before and during the expansion programme. Specifically it looks at the data of walkers active in the year before the expansion programme started, and at the data of walkers active in the first year of the expansion programme. Notwithstanding the time it took for the expansion programme to become fully operational, this provides evidence of the impact this first year had on the overall demographic profile of walkers, and in hitting its target audience.

6.3 The following terms are used in this section:

Year 0 — This refers to the year before the expansion programme started (1st April 2008 to 31st March 2009), and is based on the data of around 19,000 participants who were active over this period.

Year 1 — This refers to the first year of the expansion programme (1st April 2009 to 31st March 2010), and is based on the data of around 44,000[10] participants who were active over this period.

As noted in 2.4 the sample is naturally higher in Year 1 due to the higher number of walk schemes using the database by that point (441, compared to 277 in Year 0). However the regional distribution of schemes is very similar in both years, meaning we can be confident the two years are comparable.

Topline figures

6.4 The demographic profiles of walkers in Year 0 and Year 1 are shown in Table 13, along with the changes observed.

[10] Base is subject to the same slight increase over the course of this report as detailed in 2.1

Table 13 Summary of demographic profiles of WfH in Year 0 and Year 1

Demographic		Year 0	Year 1	Change
Gender	Female	72.4%	72.4%	None
	Male	26.6%	26.6%	None
Age band	16–24	2.7%	2.9%	+0.2
	25–34	5.0%	5.7%	+0.7
	35–44	6.0%	7.0%	+1.0
	45–54	9.2%	10.4%	+1.2
	55–64	32.8%	32.5%	–0.3
	65–74	33.9%	32.0%	–1.9
	75–84	9.5%	8.7%	–0.8
	85+	0.9%	0.9%	None
Ethnicity	White	95.1%	95.0%	–0.1
	Non–White	4.9%	5.0%	+0.1
Disability	Disabled	10.0%	10.2%	+0.2
	Non–Disabled	90.0%	89.8%	–0.2
Health / Medical Conditions	One or more of the listed Health Screening Conditions	16.3%	15.9%	–0.4
	One or more of the listed Diagnosed Medical Conditions	32.2%	32.0%	–0.2
Residential address by IMD	IMD 0–20%	8.9%	10.4%	+1.5
	IMD 20–40%	14.7%	15.2%	+0.5
	IMD 40–60%	22.7%	21.7%	–1.0
	IMD 60–80%	26.5%	25.3%	–1.2
	IMD 80–100%	27.3%	27.4%	–0.1

Gender

6.5 Nationally the gender split was the same in Year 0 and Year 1 (72.4% female and 22.6% male in both years). Regionally there were no significant changes, with the biggest being West Midlands (female share increased from 69.8% to 72.4%), Yorkshire and the Humber (decrease from 75.3% to 73.8%) and London (increase from 71.6% to 72.9%).

Age band

6.6 Nationally the age profile of walkers became somewhat younger in Year 1, with a decrease of nearly three percentage points in the share of participants aged 65 or over, and a similar increase

in the share aged under 55. The North West and Yorkshire and the Humber experienced the biggest such changes, with the share of those aged 65 or over falling from 46.1% to 33.8% in the former, and from 51.7% to 44.8% in the latter. There were relatively modest changes in the other regions.

6.7 This shift towards a slightly younger profile may be an indication of success in targeting 'families including mothers and toddlers [aged] 1–5'. However since this is the only relevant data available on this target group we cannot be certain.

Ethnicity

6.8 Nationally there was a small increase in the share of Non–White participants, from 4.9% to 5.0%. Of the regions, the North East (1.0% to 2.1%) and North West (3.4% to 5.0%) had the biggest relative increases.

Disability

6.9 Nationally there was a small increase from 10.0% to 10.2% in the share of walkers with a disability or long–standing illness. The biggest regional changes were London (decrease from 9.6% to 7.3%), the North East (increase from 9.2% to 11.3%) and the North West (decrease from 12.9% to 9.1%).

Health and medical conditions

6.10 The share of walkers with one or more of the health screening conditions fell slightly from 16.3% to 15.9%.

6.11 The share of walkers with one or more of the diagnosed medical conditions fell slightly from 32.2% to 32.0%.

6.12 The share of walkers who were recommended to attend by their doctor or health professional fell slightly from 6.9% to 6.8%.

Deprivation

6.13 The share of walkers from the 20% most deprived areas increased from 8.9% to 10.4%. The North West experienced the biggest increase (22.3% to 32.0%) while the North East experienced the biggest decrease (24.6% to 19.9%).

Conclusion

6.14 The demographic changes from Year 0 to Year 1 were generally rather minor, with even the biggest relative changes (age and deprivation) doing little to offset the overall profile of participants.

6.15 The expansion programme's success in hitting its target groups in this first year is debatable, with increases in some target groups (Non–White walkers and those from deprived areas) countered by decreases in others (walkers aged 65 or more and those with a diagnosed medical condition).

6.16 It seems likely therefore that any marketing used during the first year of the expansion programme did not succeed in attracting any new markets, but rather consolidated the appeal to existing ones. It can be argued that the expansion programme took some time to really hit its stride, in which case a further study might focus on data from the second year of the expansion programme, April 2010 to March 2011, to examine any changes to the profile of walkers over this period.

7 WfH in context – A discussion

Introduction

7.1 This section discusses WfH in the context of other related research. It is divided into two sub–sections: the first looks at research into demographic participation rates in walking; the second looks at studies providing insight into the characteristics and types of people that often take part in walking.

Participation in Walking

Measure of Engagement with the Natural Environment

7.2 Natural England's Monitor of Engagement with the Natural Environment (MENE) survey collected information on people's use and enjoyment of the natural environment. The findings referenced here (2010) are from the first year's fieldwork, carried out between March 2009 and February 2010.

7.3 MENE featured the following question in relation to respondents' visits to the natural environment over the 12 months prior to survey: 'Which of these activities, if any, did you undertake?'. One category of response was 'walking, not with a dog (including short walks, rambling, and hill walking)'. This has clear relevance to WfH, ie people visiting the natural environment for the purpose of taking a walk.

7.4 Response rates to this category are presented in Table 14, and suggest that the prevalence of walking in the natural environment was relatively consistent across demographic groups. The overall response rate is 26%; the low is 22% (socio–economic group C2DE), and there are only three groups with a response rate above 30% (Retired at 33%, 65+ at 34%, and BME (Non–White) at 39%).

Table 14 Percentage by demographic that had visited the natural environment and taken part in 'walking, not with a dog (including short walks, rambling, and hill walking)' in the 12 months prior to survey

Demographic group	%
Female	26%
Male	26%
16–24	24%
25–44	23%
45–64	25%
65+	34%
White	25%
BME (Non–White)	39%
Disabled	26%
Non–Disabled	26%

Table continued...

Demographic group	%
IMD Top 10%	22%
IMD 11–89	26%
IMD Bottom 10%	28%
ABC1	29%
C2DE	22%
Working FT/PT	23%
Retired	33%
Still in education	29%
Unemployed	23%
Overall	26%

7.5 From the response rates in Table 14 we can make the following observations:

1) Participation amongst females and males was very even, a characteristic not shared by WfH.
2) Participation rates were higher amongst those aged 65 or more and those who were retired, something common to WfH.
3) Participation rates were lower amongst those who were unemployed, in the C2DE group, or from a top 10% deprived area. Given that areas of higher deprivation generally have a higher density of those who are unemployed or from a lower socio–economic group, then there is a clear correlation with WfH.
4) Participation rates were – perhaps surprisingly – the same for disabled and non–disabled people. Had WfH shared this equality of access, we would expect its share of disabled participants to be considerably higher than that reported in 4.7.
5) Participation rates were – again, rather surprisingly – higher for those from a BME (Non–White) background than those from a White background. Had WfH shared this characteristic, we would expect its share of Non–White participants to be more strongly represented than is reported in 4.4.

Active People Survey

7.6 Sport England's Active People Survey (APS) collected information on people's participation in sport and physical activity over the four weeks prior to survey. The results presented here are from the third complete year of the survey (APS 3, 2010), which took place between mid–October 2008 and the same point in 2009.

7.7 APS 3 asked a number of inter–related questions around walking, allowing the answers to be categorised into a number of different responses. The most relevant to WfH is: 'At least one recreational walk lasting 30 minutes at moderate intensity'.

7.8 Response rates to this are presented in Table 15. The overall response rate is 21.92%, but across the demographic groups there is a much wider range of participation rates than for MENE.

Table 15 Percentage by demographic that had done 'at least one recreational walk lasting 30 minutes at moderate intensity' in the four weeks prior to survey.

Demographic group	%
Female	21.45%
Male	22.42%
16–24	21.42%
25–34	26.70%
35–44	27.14%
45–54	26.26%
55–64	21.80%
65–74	14.10%
75–84	6.27%
85+	2.34%
White	22.92%
Non–White	13.34%
Disabled	9.62%
Non–Disabled	24.15%
A	27.97%
B	21.53%
C1	21.76%
C2DE	16.38%
Working	26.62%
Retired	11.95%
Student	22.17%
Unemployed	18.76%
Overall	21.92%

7.9 Again, we can make some general observations from the response rates in Table 15:

1) Participation by gender was again very even, similar to MENE but not to WfH.
2) By age band, participation dropped considerably after 55, something which goes against the findings from MENE and WfH.
3) Participation was lower amongst Non–White groups, different to WFH's equal representation, and in direct opposition to MENE.
4) Participation was considerably lower amongst disabled people than non–disabled people. Again, this agrees with WfH but not MENE.
5) Participation was lower amongst the lower socio–economic groups, and those who are unemployed, agreeing with both WfH and MENE.
6) Participation was very low amongst those who were retired, going against the findings from MENE and WfH.

Conclusion

7.10 Although the definition of walking measured by MENE and APS was very different, we can still draw some useful conclusions. With MENE and WfH both showing high participation amongst older age groups, but APS showing one much lower, this may suggest that appreciation of the natural environment – a characteristic detailed later in this section – is a strong factor in influencing older age groups to participate in walking. The MENE participation rates of the Non–White and Disabled groups meanwhile, suggest that demand for walking in the natural environment is considerably broader and more diverse than was catered for by WfH, and this should be explored by future interventions.

Characteristics of walkers

DEFRA segmentation study

7.11 DEFRA's 2009 segmentation study built on MENE and was based around the question: '*What aspects of people's lives, experiences and attitudes influence their engagement with the natural environment?*'. The output of the study was a set of eight segments: ie groups of people who share similar attitudes, behaviours and demographic characteristics.

7.12 The segment with the closest overlap with the profile of WfH participants is:

- **Mature Explorers:** Male and female; aged 55+; married or separated, divorced or widowed. 3% are from a Non–White ethnic group; 3 in 10 have a disability; 1 in 3 is within the AB social class with the rest in C1C2. They see themselves as 'outdoors people' and view time spent in the natural environment as an essential part of the day/week. Their main drivers are mental and physical health, strong personal interest, and appreciation for the natural environment. Some are facing increasing physical limits though this is not yet perceived as a barrier (DEFRA, 2010).

Sport England market segmentation

7.13 Sport England's nineteen sporting segments were developed in 2007 to help delivery partners understand attitudes to sport and motivations for taking (or not taking) part. It combined data from APS, the DCMS's Taking Part survey, and the Mosaic tool from Experian.

7.14 Although focused more on sport than physical activity, there are two segments with a clear overlap with the profile of WfH participants:

- **'Roger and Joy' – Early Retirement Couples:** 'Roger' and 'Joy' are mainly aged 56–65, married, and near the end of their careers – either retired or approaching retirement. When their time coincides they often go for a walk together, and they might typically read magazines including Gardeners' World and Country Walking.
- **'Ralph and Phyllis' – Comfortable Retired Couples:** 'Ralph' and 'Phyllis' are mainly aged 66+, married or single, and retired. They are more active than others in their age range and amongst other activities love to go for long walks together. They are proud that they're still active, enjoying life, and can just about keep up with the grandchildren (Sport England, 2010).

Research into lapsed WfH walkers

7.15 As part of the WfH evaluation programme, Natural England commissioned a piece of research in 2010 looking at walkers whose participation in WfH had lapsed (defined as not having taken part in a WfH walk for six months or more). Although primarily looking at the barriers and motivators of participation and the physical activity habits of participants, it also includes useful information on the characteristics of walkers.

7.16 The findings relevant to this report are detailed below, and come from an in–depth interview conducted with 20 lapsed participants who could be considered broadly representative of the larger profile of participants:

1) Respondents were mostly retired.
2) The majority of respondents described an active lifestyle (walking, gardening and swimming were commonly cited).
3) The primary motivation for respondents in deciding to go on a WfH walk was health reasons.
4) The majority said they expected the other walkers to be like themselves, by which they usually meant older people who are retired and want to look after their health.
5) Many respondents were active citizens, being part of organisations like the Women's Institute, or volunteering.
6) A large number of respondents said that the natural environment was important to them and they had had a large degree of interaction with it over the course of their lives (Natural England, 2010).

Conclusion

7.17 The similarities between the lapsed walker study and the segmentation studies seem to offer quite a fitting encapsulation of the market WfH appealed to, that is: older, retired, health conscious individuals, with an existing appreciation for the outdoors. These characteristics are of course indicative rather than absolute, but nevertheless offer interesting insight.

8 Conclusions

8.1 The participants in Walking for Health over the two years April 2008 to March 2010 were primarily female, white, non–disabled, and averaging around 60 years of age. Male participants (22.5%) were of a similar demographic make–up, albeit a few years older and more likely to have a disability or health / medical condition.

8.2 4 in 10 participants were aged 65 or over, 1 in 20 was from a Non–White ethnic background, and 1 in 10 had a disability. 1 in 10 came from a top 20% deprived areas, 1 in 6 had one of the listed health screening conditions, and 3 in 10 had one of the listed diagnosed medical conditions.

8.3 The share of walkers from hard–to–reach groups – specifically Non–White, Disabled and those from the most deprived 20% – was in each case around half what it is for the population as a whole. In the case of ethnicity this was characteristic of WfH's older age profile, but for disability this was quite the opposite, with a much lower rate than would be expected.

8.4 Regionally there were only small variations in the gender and age profile of walkers, but more pronounced differences in ethnicity, disability and deprivation, both compared to one another, and relative to the regional population.

8.5 When looking at each of the two years in isolation there is little change in the demographic profile of walkers, suggesting that the first year of the expansion programme had negligible impact in increasing the share of walkers from its target groups.

8.6 Other research suggests that:

- WfH appeals more strongly to females than general recreational walking.
- WfH participants were generally health conscious and had an existing appreciation of the natural environment.
- An appreciation of the natural environment may have a positive effect on attracting those from older age bands who are less inclined to take part in general recreational walking.
- The appeal of walking in the natural environment is strong amongst those with a disability and those from a Non–White background, but was not reflected in the profile of WfH participants.

9 Implications for delivery

9.1 WfH appealed to a distinct and well established market, and in the period April 2008 to March 2010 succeeded in consolidating this market rather than reaching out into new ones. It can be argued that the market was so well established that it became somewhat self–perpetuating and continued to attract 'more of the same' rather than appealing to new groups. However this report demonstrates that the profile of participants was certainly not as broad or diverse as it could have been, and future interventions should consider carefully how to pitch themselves in order to develop an image which appeals to all target audiences.

9.2 The demand amongst Non–White and Disabled groups to walk in the natural environment – as demonstrated by MENE – was not reflected in WfH and was a missed opportunity. Reynolds (2005) stated that 'ethnic minority participation was greater where defined as a priority from the outset', and this is a good starting place for future interventions in considering how they can capitalise on such demand.

9.3 Another missed opportunity of WfH was in attracting those from the most deprived areas. A 2010 CABE[11] report stated that 'people living in deprived urban areas view green space as a key service...one of the essentials in making a neighbourhood liveable', and future interventions should seek to take advantage of this positive viewpoint and work harder to engage those living in deprived areas.

9.4 Although accounting for less than 1 in 4 WfH participants, males were more likely than females to have one of the diagnosed medical conditions. With MENE finding that men were more likely than women to be motivated by health benefits when visiting the natural environment, future interventions should take note of such findings and look at how they can balance attendance across their target groups whilst still achieving the biggest health outcomes for participants.

9.5 Other research suggests that the type of person participating in WfH would often be health–conscious and with an existing appreciation for the natural environment. Indeed, Reynolds (2005) reported the danger that health walks could attract significant numbers of people who are 'keen walkers', which in turn could risk alienating less fit participants. Future interventions should therefore look for ways to attract those who are less health–conscious (who are at the greatest risk) and those who are less in–tune with the natural environment (who therefore have the most to gain from developing this association).

9.6 WfH had considerable appeal to those aged over 65; no surprise given that the majority of walks took place during the daytime. Future interventions must find a way to schedule walks around (or as part of) normal work hours, if they are to appeal to a broader proportion of their target groups.

9.7 Future interventions should ensure they have the means to monitor progress against all target groups prior to starting delivery.

[11] Commission for Architecture and the Built Environment

10 Further research

10.1 Further research could investigate the motivations for taking part in WfH of different demographics, which would provide helpful context alongside the figures in this report. For example WfH clearly had a greater appeal and / or accessibility to women than men, and while retirement age is one possible explanation it is unlikely to be the only one, and further research could examine the different gender motivators. Such research could also extend to an analysis of the WfH brand and its appeal to different demographics.

10.2 An analysis of the second year of the WfH expansion programme would offer more robust evidence of its impact in hitting its stated target groups.

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Appendix 1 Outdoor health questionnaire

This form will contain sensitive or personal data once completed – it should be handled and stored securely

Outdoor Health Questionnaire

1. **Name of scheme**

2. **Name of walk**

3. **Your name**

4. **Title (Mr, Ms, etc)**

Your Contact Details

5. **Address**

6. **County**

7. **Postcode**

8. **Tel No.**

9. **E-mail**

10. **Are you happy to be contacted** by your scheme (e.g. about forthcoming events)?
☐ Yes If yes, what is your preferred method:
☐ phone ☐ email ☐ post
☐ No – please do not contact me

Health Screening

11. **For most people, physical activity** does not pose a hazard. The questions below have been designed to identify the small number of people for whom it would be wise to have medical advice before starting:
a. **Has a doctor** ever said you have a heart condition? ☐ Yes ☐ No
b. **Do you feel pain in your chest** when you do physical activity? ☐ Yes ☐ No
c. **Do you ever lose balance** because of dizziness or ever lose consciousness? ☐ Yes ☐ No
d. **In the past month have you had pain** in your chest when you were **NOT** doing physical activity? ☐Yes ☐ No
e. **Do you have a bone or joint** problem that could be made worse by a change in your physical activity? ☐ Yes ☐ No

If you answered yes to any of the Health Screening questions, you must seek medical advice before participating in a walk.

Health Declaration

I understand that if I have answered yes to any of the previous Health Screening questions, I must seek medical advice before attending a walking programme. I agree to tell the walk leaders if there is a change in my medical condition.
I understand that this information will be shared with other walk leaders and that I walk at my own risk.
Signed

Date

To make the case for funding and to help us to monitor the effectiveness of walks for your walking schemes, please help us by answering the following questions:

12. **Have you been diagnosed** by your doctor or health professional with any of the following medical conditions?

☐ Heart disease
☐ High blood pressure
☐ COPD (Emphysema and chronic bronchitis)
☐ Diabetes
☐ Asthma
Please advise the walk leader if you have any other conditions you feel they might need to know of.

13. **Do you have a long-standing** (for more than 12 months and likely to continue) illness or disability which affects (or limits) your day to day activities?
☐ No ☐ Prefer not to say ☐ Yes
If **Yes**, please tick all that apply:
☐ Physical disability ☐ Sensory disability
☐ Learning disability ☐ Learning difficulties
☐ Mental Health issues
☐ Long-term or life limiting illness
☐ Other ☐ Prefer not to say

This form will contain sensitive or personal data once completed – it should be handled and stored securely

Outdoor Health Questionnaire

14. **Are you a trained** walk leader?
☐ Yes ☐ No

15. **Have you been recommended by your doctor** or a health professional to come on this scheme?
☐ Yes ☐ No

16. **In the past week, on how many days** have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate?

This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job. Please tick one box:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

17. **Age**:
☐ 16-24 ☐ 25-34 ☐ 35-44
☐ 45-54 ☐ 55-64 ☐ 65-74
☐ 75-84 ☐ 85+

18. **Gender**: ☐ Male ☐ Female

19. **Ethnicity**:
☐ White British ☐ White Irish
☐ White Other ☐ Chinese
☐ Traveller/Roma/Irish Traveller
☐ Mixed/White and Black Caribbean
☐ Mixed White and Black African
☐ Mixed/ White and Black Asian
☐ Mixed/ Other
☐ Asian or Asian British/Indian
☐ Asian or Asian British/ Pakistani
☐ Asian or Asian British/ Bangladeshi
☐ Asian or Asian British/ Other
☐ Black or Black British/ African
☐ Black or Black British / Caribbean
☐ Black or Black British /Other
☐ Other
☐ Not disclosed

20. **Please tell us how you found out** about this scheme *(please tick any that apply):*
☐ GP/ Health professional referral
☐ Library
☐ Walking Group
☐ Poster/advertisement
☐ Leisure centre
☐ Residents' Association
☐ Health trainer referral
☐ Millets/Blacks ☐ Tesco ☐ M&S
☐ VisitWoods
☐ Told about it by someone (not covered above)
☐ Other – please state

21. **Are you happy to be contacted to** help us evaluate health walks?
☐ Yes ☐ No

Thank you for completing this questionnaire

Using and Sharing Your Information

Natural England will hold your information in accordance with the Data Protection Act 1998. It will be entered onto a secure database managed by BTCV (formerly known as British Trust for Conservation volunteers) on our behalf, after which this form will be shredded or if needed stored securely by your walk scheme. Permission to access the database is strictly controlled and monitored by Natural England. The information you have given may only be viewed by those who need to do so and you will only be contacted in accordance with your wishes.

Your information is used to evaluate the impact of Walking for Health on people's physical activity levels for the Department of Health, and to measure Walking for Health's impact on other health and environmental outcomes. It will be used to influence and support further funding bids for local and national schemes, and for academic institutions studying and furthering our understanding of the roles walking and the natural environment play in our health and wellbeing.

Signed

Date

Natural England works for people, places and nature to conserve and enhance biodiversity, landscapes and wildlife in rural, urban, coastal and marine areas.

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