More People, More Active, More Often

Active Communities
A Strategy For Rother

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Acknowledgements

We would like to thank LSP partners and other local organisations for their significant contribution, leadership and on-going input into creating the Active Communities programme in Rother. Thanks also to the East Sussex Public Health Directorate for their specialist health improvement knowledge and advice and for funding the Active and Healthy Communities Specialist post, as part of its Active Rother grant to Rother District Council in 2010. This post has made a significant contribution to developing our approach.

Introduction

Rother District Council has successfully managed the development of the Active Rother programme since 2008. Discussions within Rother between the District Council, the Primary Care Trust and other Local Strategic Partnership (LSP) partners reviewed this work and looked at how it could be developed further, to ensure opportunities to maximise its impact were addressed. Key factors influencing this work included:

- A need to ensure maximum benefit is achieved from previous investment (Play Pathfinder, Active Rother, Sports Facility Improvement, Open Spaces) by enabling increased use of facilities and participation
- A desire to respond to the needs identified by communities through Local Action Planning (LAP) and other processes, although recognising that it is not feasible to effectively respond to all sectors and that priorities would need to be agreed based on the evidence of effectiveness
- An aspiration to support community stakeholders to develop their capacity and stimulate volunteering.

In 2011 it was agreed that there would be a greater focus on contributing to the development of a strategic framework and delivery plan for a programme titled ‘Active Communities’. The focus was to continue to be on ‘physical activity’, but with an ambition of building capacity and capability across all sectors. This combined with the resources available within Rother District Council (Sports, Leisure, Culture and Amenities) would provide leadership to enable greater value to be gained from existing multi-agency resources and community assets.

Through the LSP, it was recognised that this work would require strong collaboration across the partnership itself and with other organisations such as Hastings Borough Council, Age UK, The Conservation Volunteers, Freedom Leisure and the County Sports Partnership (Active Sussex) in order for it to be effective. The outcome is that following a review of its work, the LSP has recognised Active Communities as one of its 3 priority areas for action.
Purpose

The purpose of this strategy is to enable partners to work effectively together and combine efforts by:

- Providing a reference point for all relevant organisations to draw upon when developing strategic and operational approaches to health and wellbeing with a specific focus on physical activity
- Strengthening coordination, capacity and commitment between organisations, community groups and agencies responsible for the decisions and delivery that will encourage more people to become more physically active more often
- Maximising the impact of current investment, funding and resources available for physical activity.

The framework draws upon the findings of a Gap Analysis report produced in early 2012. This looked at Rother in the form of an evidence base review. This review considered the following two issues:

1. The evidence of need, based on a health and deprivation profile
2. How well current local strategy, services and programmes reflect the evidence set out in national strategy and interventions guidance, regarding increasing physical activity participation and reducing health inequalities.

The key findings from this report are reflected in the recommended actions to be addressed within the life of this strategy through an annual Delivery Plan. See page 17.

It aims to inform and energise communities and local partnerships to reflect on current work and identify effective and appropriate future opportunities for action. Here is a specific focus on work to maximise the use of existing resources and community assets and enable and encourage members of the community that do not currently engage in physical activity.

Our Strategic Aims

The aims of the Active Communities programme reflect the aspirations of the LSP, the health and deprivation profile of Rother and the evidence base review. They are as follows:

1. To reach out to local communities, especially disadvantaged groups, in order to influence behaviour and increase physical activity participation, thereby contributing to reducing health inequalities
2. To facilitate in partnership, the increased provision of flexible, attractive, sustainable and affordable opportunities for people to develop and engage in physical activity
3. To widen the appeal of greater participation by raising the profile of physical activity and its benefits throughout the community.
What Do We Mean By Physical Activity?

Physical activity includes all forms of activity such as everyday walking or cycling to get from A to B, active play, active recreation, (such as working out in the gym), work activity, dancing, gardening or families playing together, as well as organised and competitive sport. Sport, active recreation and everyday activity are all interlinked. The diagram on this page sets out this description and gives examples of the different types of activity and the scope and aspirations set out in this strategy.

Facilities such as leisure centres and community venues provide important locations for sport and other physical activity opportunities. Maximising potential for use and delivering activities that local residents want to participate in will be a role for all those involved in delivering this strategy.

Open and green spaces are maybe less recognised as places where people can be active and lead healthier lifestyles. These spaces can offer opportunities to walk, cycle and connect with the surrounding countryside. Therefore encouraging use and ensuring a coordinated approach to access will be part of the work delivered. Recognition of the health and well-being benefits of increasing access to open and green spaces, and the contribution this can make to reducing health inequalities is also set out within the Environment Strategy for East Sussex.

Source: Start Active, Stay Active, DH, 2011
The Evidence Base for the Active Communities Programme

Guidelines published by the Department of Health (England) in 2011 Start Active, Stay Active and the Government’s public health strategy Healthy Lives, Healthy People, both emphasise the importance of physical activity for people of all ages. It draws on the evidence for the health benefits people can achieve by taking regular physical activity throughout their lives. This guidance is reflected in a range of other national strategy and policy documents that not only highlight the health, economic and social benefits of a physically active population but also set out how such an outcome can contribute to reducing health inequalities. In addition, the National Institute for Clinical Excellence (NICE) produces evidence based guidance on a wide range of public health issues, including physical activity, and sets out a range of interventions across different population and age groups.

In addition there is evidence that shows the contribution the natural environment can play in enhancing health and wellbeing. The promotion and use of outdoor green space be effective in encouraging physical activity participation, and can contribute to addressing a range of health and social problems that include mental ill-health, anti-social behaviour, and health inequalities.

This evidence base has contributed to the development of this strategy and should be used to support the design, development and evaluation of the Delivery Plan. Appendix 1 provides a list of the evidence base documents that informed the development of the strategy.
The Benefits of a Physically Active Population

Start Active, Stay Active, emphasises how physical activity can bring about major health benefits. The new guidelines indicate that the benefits of physical activity and health continue throughout people’s lives (or life-course) and the gains that can be achieved if more people become more active from early years (under 5’s) to older adult age (65+ years). The benefits of different types of physical activity are also different at key life stages.

Even doing as little as 15 minutes physical activity a day is associated with some protection against chronic diseases (including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health and musculoskeletal conditions).

There is also a clear relationship between the amount of physical activity people do when comparing the most active with the least active when looking at deaths from all causes (all cause-mortality).

These benefits can deliver cost savings for health and social care services and extend further to improved productivity in the workplace, reduced congestion and pollution through active travel and the healthy development of children and young people. Other benefits include:

- contributing to improved health and well-being and increased life expectancy
- improving quality of life
- managing stress
- supports weight management
- reducing costs of using active travel options
- reducing 'carbon footprint'
- acquisition of social skills (leadership, teamwork, co-operation)
- reduction of anti-social and criminal behaviour
- opportunities to spend time with family and friends
- opportunities to meet new friends
- improving capacity for concentration and learning
- increasing personal confidence and self-esteem
- maintaining independence in later life.
The Recommended Guidelines on Physical Activity

The guidelines differ across the age groups because people have different needs at different ages and stages of development. For example, as soon as they can walk, pre-school children need unstructured, active and energetic play to allow them to develop their fundamental movement skills and master their physical environment. They also need to be active for several hours a day in order to achieve this. By the time children start school, however, they are developmentally ready to benefit from more intensive activity, over shorter periods, so a daily minimum of 60 minutes of moderate intensity activity is recommended.

The guidelines outline the amount, duration, frequency and type of physical activity required across different age groups, or life-course to achieve general health benefits. The guidelines recommend that everyone should aim to participate in an appropriate level of activity for their age. Other features highlighted in the new guidance include:

• More emphasis on the role of vigorous intensity activity and muscle strengthening
• An emphasis on daily activity with weekly target of 150 minutes in bouts of 10 minutes or more; offering more flexibility for busy lives
• The importance of reducing sedentary behaviour i.e. long periods of inactivity.

For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of travelling by car, bus or train. However, a larger quantity of activity at higher intensity (such as playing sport) can bring further benefits, and this might be the aspiration for many people.

The Delivery Plan will reflect the life course approach. A summary of the guidelines for each age group is set out in appendix 2.
The Cost of Physical Inactivity

Physical inactivity has a cost to it, which it is important to quantify when considering the case for action and investment. The economic burden of inactive lifestyles results from the additional health and social care costs for the treatment of long-term conditions and associated acute events such as heart attacks, strokes, falls and fractures, as well as the costs arising from the loss of functional capacity. Inactivity also leads to costs to the wider economy from sickness absence and premature death of productive individuals, costs to the individuals themselves, and the costs of lost productivity of their carers. This can impact on the wider economy, affecting areas such as industrial competitiveness, transport and the environment.

The Department of Health commissioned the British Heart Foundation Health Promotion Research Group at Oxford University to prepare estimates of the primary and secondary care costs across England. The figures for Rother present a clear case for action showing that the cost is significantly higher than both the South East Region and overall England estimates. The figures are as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Cost</th>
<th>Cost per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>£2,044,854</td>
<td>£2,357,587</td>
</tr>
<tr>
<td>South East England</td>
<td>£116,373,522</td>
<td>£1,396,829</td>
</tr>
<tr>
<td>England</td>
<td>£764,661,960</td>
<td>£1,531,401</td>
</tr>
</tbody>
</table>

Source: Be Active, Be Healthy: A Plan for Getting the Nation Moving. Department of Health. 2000
Physical Activity Participation

There are a number of national surveys that give us an understanding of local participation levels. Wherever it is available, Rother data is expressed as an overall figure and the figure for the most significant wards depending on the indicator. However it is important to note that in some cases the ward level data is modelled and should therefore be treated with caution.

(a) Adults

The Active People Survey (APS) is the national survey for sport and recreation. In terms of this strategy and its aims, a key indicator within the survey is adult participation in sport and active recreation. It includes recreational walking and cycling (but excludes walking and cycling for transport). The table below show the data for from the 2011 survey and compares it with the first survey in 2006.

The percentage of the adult (age 16 and over) population who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week)

<table>
<thead>
<tr>
<th>Area</th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>19.8%</td>
<td>21.9%</td>
<td>+2.1%</td>
</tr>
<tr>
<td>Lowest wards:</td>
<td></td>
<td>No ward data available.</td>
<td></td>
</tr>
<tr>
<td>Old Town</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sidney</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sackville</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rye</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Michaels</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Sussex</td>
<td>21.6%</td>
<td>21.3%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Overall</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other relevant findings from the 2011 data are:

- 50% in Rother have not taken part in one 30 minute session. East Sussex figure is 48.5%
- 14% of adults aged 55+. East Sussex figure is 13.2%

The survey also measures the proportion of the adult population that:
- volunteer in sport on a weekly basis
- club membership
- involvement in organised sport/competition
- receipt of tuition or coaching
- overall satisfaction with levels of sporting provision in the local community.

When measuring the impact of action to support increases in physical activity participation, these indicators will also be important. The data for these indicators from the 2006 and 2011 surveys is set out in Appendix 5.

Adult obesity is another indicator that can be closely related to physical activity participation. Little or no participation is seen as a risk factor for an individual being overweight or obese. However when considering data relating to this issue, there is also a need to be aware of the contribution of diet, types of food consumed and overall calorie intake.

Prevalence of obesity, persons aged 16 years and over

<table>
<thead>
<tr>
<th>Area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>Overall = 22%</td>
</tr>
<tr>
<td>Highest wards:</td>
<td>Rye 25%</td>
</tr>
<tr>
<td></td>
<td>Sidely 25%</td>
</tr>
<tr>
<td></td>
<td>St Michaels 25%</td>
</tr>
<tr>
<td></td>
<td>Eastern Rother 24%</td>
</tr>
<tr>
<td></td>
<td>Marsham 24%</td>
</tr>
<tr>
<td></td>
<td>Brede Valley 24%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: Joint Strategic Needs Assessment, NHS East Sussex/East Sussex County Council, November 2011
(b) Children and Young People

There are several datasets that provide us with some understanding of levels of physical activity participation amongst children and young people.

**Participation in high quality PE and school sport (years 1-3 pupils) 2009/10**

<table>
<thead>
<tr>
<th>Area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>60%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>47%</td>
</tr>
</tbody>
</table>

*Source: Health Profiles, Rother, 2011*

**Exercise levels and modes of travel to school: Year 10 students**

<table>
<thead>
<tr>
<th>Area</th>
<th>%Boys (Exercise 5 or more times in previous week)</th>
<th>% Girls (Exercise 5 or more times in previous week)</th>
<th>% Students Travel by car</th>
<th>% Students Travel by walking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>37%</td>
<td>19%</td>
<td>30%</td>
<td>36%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>40%</td>
<td>20%</td>
<td>29%</td>
<td>47%</td>
</tr>
</tbody>
</table>

*Source: Health Related Behaviour Survey, 2007*

**Overweight and Obese (of those measured) Reception year (4-5 years) and year 6 (approx. 11 years) school age children**

<table>
<thead>
<tr>
<th>Area</th>
<th>% Overweight and obese Year R (previous week)</th>
<th>% Overweight and obese Year 6 (previous week)</th>
<th>% Obese Year R</th>
<th>% Obese Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>Overall = 18% <em>Highest 4 wards:</em> Sidley 26%</td>
<td>Overall = 31% <em>Highest 4 wards:</em> Ticehurst and Etchingham 38%</td>
<td>Overall = 8% <em>Highest 4 wards:</em> Old Town 18%</td>
<td>Overall = 31% <em>Highest 4 wards:</em> Eastern Rother 27%</td>
</tr>
<tr>
<td></td>
<td>Rother Levels 25% Old Town 24% Western Rother 23%</td>
<td>Old Town 36% Eastern Rother 23% Rother Levels 35%</td>
<td>Rye 26%</td>
<td>Rye 26%</td>
</tr>
</tbody>
</table>

| East Sussex | 21%                                           | 30%                                           | 8%                       | 16%                         |

*Source: Joint Strategic Needs Assessment, NHS East Sussex/East Sussex County Council, November 2011*
Increasing Participation and Reducing Health Inequalities

In order to achieve its strategic aims, the Active Communities programme needs to prioritise its work and target it effectively, taking account of the findings of the evidence base review. Therefore the following factors will influence the direction of the project and should be reflected in the actions set out in the Delivery Plan.

(a) Addressing barriers to physical activity participation

A number of specific barriers are identified within the evidence base that can prevent people from participating in physical activity. These are:

- Time constraints
- Motivation
- Availability
- Affordability
- Accessibility
- Low on confidence
- Special needs
- People to go with.

(b) Priority Population Groups

There are clear and significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability and these need to be addressed at all life stages. The barriers set out above are especially relevant to addressing these inequalities within the following population groups:

- People living in low-income households - which are associated with low levels of participation
- Older adults - who experience a notable decline in activity after the age of 55
- Women - 70% of whom are not doing enough physical activity to benefit their health
- Black and ethnic minority groups - in particular women from South Asian countries such as Bangladesh and Pakistan
- Young adults - in particular girls, who are more likely to reduce their activity levels as they move from childhood to adolescence
- People with disabilities - ranging from physical and neurological to sensory impairments and learning disabilities.

(c) Priority Geographical Areas

The Indices of Multiple Deprivation (IMD) measure relative levels of deprivation in small areas of England called Lower Super Output Areas (LSOAs). There are seven distinct domains that make up the overall measure and these are Income, Employment, Health and Disability, Education Skills and Training, Barriers to Housing and Services, Living Environment and Crime. The latest overall IMD figures (2010) shows the 4 LSOAs that are ranked as worst performing, with 11 others being areas of concern.

<table>
<thead>
<tr>
<th>Lower Super Output Area (LSOA)</th>
<th>IMD Status 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Sidley 007E</td>
<td>Worst 5% nationally</td>
</tr>
<tr>
<td>Bexhill Sidley 007D</td>
<td>Worst 10% nationally</td>
</tr>
<tr>
<td>Bexhill Central 011C</td>
<td>Worst 20% nationally</td>
</tr>
<tr>
<td>Rye 004E</td>
<td></td>
</tr>
<tr>
<td>Eastern Rother 002A</td>
<td>Area of concern</td>
</tr>
<tr>
<td>Bexhill Central 011B</td>
<td></td>
</tr>
<tr>
<td>Bexhill Sidley 007F</td>
<td></td>
</tr>
<tr>
<td>Bexhill Central 011A</td>
<td></td>
</tr>
<tr>
<td>Bexhill St Michaels 007A</td>
<td></td>
</tr>
<tr>
<td>Bexhill Old Town 007A</td>
<td></td>
</tr>
<tr>
<td>Bexhill St Michaels 008D</td>
<td></td>
</tr>
<tr>
<td>Bexhill Sidley 009G</td>
<td></td>
</tr>
<tr>
<td>Bexhill Sackville 008B</td>
<td></td>
</tr>
<tr>
<td>Brede Valley 005B</td>
<td></td>
</tr>
<tr>
<td>Bexhill St Michaels 008E</td>
<td></td>
</tr>
</tbody>
</table>

Source: Indices of Multiple Deprivation Profiles 2010. DCLG 2011
Circulatory diseases, cancers and respiratory diseases are the top three causes of the life-expectancy gap between the most deprived and least deprived in Rother. The need to target low income and vulnerable groups in encouraging physical activity should be prioritised due to the higher levels of these diseases in these groups, limiting long term conditions and the impact on early mortality or life expectancy. The table below shows the local authority wards within Rother District that have a life expectancy below the overall East Sussex figure.

<table>
<thead>
<tr>
<th>Local Authority Ward</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother = 81.8 years</td>
<td></td>
</tr>
<tr>
<td>East Sussex = 82 years</td>
<td></td>
</tr>
<tr>
<td>Bexhill Sidley</td>
<td>78.6</td>
</tr>
<tr>
<td>Bexhill St Michaels</td>
<td>78.6</td>
</tr>
<tr>
<td>Ewhurst and Sedlescombe</td>
<td>78.5</td>
</tr>
<tr>
<td>Darwell</td>
<td>79.9</td>
</tr>
<tr>
<td>Bexhill Sackville</td>
<td>80.0</td>
</tr>
<tr>
<td>Bexhill Central</td>
<td>80.1</td>
</tr>
<tr>
<td>Crowhurst</td>
<td>80.6</td>
</tr>
<tr>
<td>Bexhill Old Town</td>
<td>80.9</td>
</tr>
</tbody>
</table>

(d) Addressing the wider determinants of health and well-being

The Active Communities Programme will have a specific focus on increasing physical activity participation. However attention will also be on how other determinants that can affect health can be addressed. These factors can all impact on individuals and communities ability to adopt and maintain a healthy lifestyle and are commonly expressed as the wider determinants of health and well-being. There is an obvious link here with the IMD figures set out earlier, with the determinants relating closely to the seven domains that make up the overall IMD score.

Source: Joint Strategic Needs Assessment, NHS East Sussex/East Sussex County Council, November 2011
Targeting Our Work

Deprivation is both a cause and a consequence of issues which impact on health and the ability of individuals and communities to be physically active. This strategy has presented a number of key pieces of evidence relating the prevalence of deprivation and health inequalities in Rother along with what we know about current levels of physical activity participation. The conclusion is that if the Active Communities programme is going to achieve its strategic aims of impacting on the most disadvantaged communities, then action should be targeted on the population groups, wards and LSOAs indicated, with a focus on the barriers that can reduce ability to participate in physical activity.

It is recognised however that many partner organisations have a statutory requirement to provide services that are universally available and promoted to all the population within the District. Therefore a Proportionate Universalism approach, as outlined in the Marmot Review will be applied to the Delivery Plan, i.e. actions that are universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Social Marketing

The government social marketing strategy for public health Changing behaviour, improving outcomes, identifies that despite people placing a high value on health and wanting to live healthy lifestyles, the majority of the adult population has at least one of the major lifestyle risks (such as not being physically active) that can lead to poor health, increased cost to society and lives cut short. Changing these behaviours is extremely challenging, often requiring not just individual motivation but sustained support from friends, family and society. Social marketing borrows concepts and techniques from commercial sector marketing, such as insight generation and customer segmentation and applies them to problems such as lifestyle behaviour.

Sport England have produced a report on market segmentation. It aims to provide an insight into the behaviours, barriers and motivations to taking part in physical activity amongst existing participants and those we wish to see involved in a more active lifestyle. The overall report is broken down into 19 different market segments and the data allows us to identify the dominant segments for Rother and draw some conclusions on key issues when it comes to increasing participation.

The ageing population in the District means the area is dominated by residents aged 65 years and over. The overall Rother profile identifies 3 dominant segments and they are:

• Retired couples enjoying a comfortable lifestyle such as ‘Ralph and Phyllis’ make up 10.5% of the population, almost 7% more than the national average. Ralph and Phyllis are the most active in their peer group, enjoying a range of individual activities such as swimming, fishing, golf and bowling
• Retired single people or widowers living in sheltered accommodation ‘Elsie and Arnold’ make up 9.9% of the population. They are likely to be doing less activity than 12 months ago, mainly due to health or injury and enjoy activities such as keep fit classes, swimming and bowling
• Males looking to settle down such as ‘Tim’ make up 9.8% of the population and are the other dominant profile in the district but reside in the northern, more rural areas. Tim is an active type that takes part on a regular basis in activities such as cycling, gym, athletics and football.
There are however younger/middle age and early retirement segments who are interested in a variety of more active leisure pursuits and who are likely to have families. These profiles appear if we look more closely at specific geographical areas within Rother. Taking the latest IMD figures for Rother set out earlier, we are able to map the dominant profiles for each of the LSOAs identified as strategic priorities.

<table>
<thead>
<tr>
<th>Lower Super Output Area (LSOA)</th>
<th>IMD Status 2010</th>
<th>Dominant Market Segmentation Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexhill Sidley 007E</td>
<td>Worst 5% nationally</td>
<td>10 – Paula</td>
</tr>
<tr>
<td>Bexhill Sidley 007D</td>
<td>Worst 10% nationally</td>
<td>9 – Kev</td>
</tr>
<tr>
<td>Bexhill Central 011C</td>
<td>Worst 20% nationally</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Rye 004E</td>
<td>Worst 20% nationally</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Eastern Rother 002A</td>
<td>Area of concern</td>
<td>17 – Ralph and Phyllis</td>
</tr>
<tr>
<td>Bexhill Central 011B</td>
<td>Area of concern</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Bexhill Sidley 007F</td>
<td>Area of concern</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Bexhill Central 011A</td>
<td>Area of concern</td>
<td>11 – Phillip</td>
</tr>
<tr>
<td>Bexhill St Michaels 007C</td>
<td>Area of concern</td>
<td>10 – Paula</td>
</tr>
<tr>
<td>Bexhill Old Town 007A</td>
<td>Area of concern</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Bexhill St Michaels 008D</td>
<td>Area of concern</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Bexhill Sidley 009G</td>
<td>Area of concern</td>
<td>13 – Roger and Joy</td>
</tr>
<tr>
<td>Bexhill Sackville 008B</td>
<td>Area of concern</td>
<td>19 – Elsie and Arnold</td>
</tr>
<tr>
<td>Brede Valley 005B</td>
<td>Area of concern</td>
<td>17 – Ralph and Phyllis</td>
</tr>
<tr>
<td>Bexhill St Michaels 006E</td>
<td>Area of concern</td>
<td>17 – Ralph and Phyllis</td>
</tr>
</tbody>
</table>

Source for market segmentation profiles: Sport England

The overall Rother profile points towards the need to provide a range of flexible facilities to cater for a broad range of interests. Transport accessibility, price and childcare provision are other considerations in encouraging participation by these groups. Detailed information on each of the dominant profiles is available as part of the Sport England data at http://segments.sportengland.org/pdf/summarySheet.pdf

Locally, an example of social marketing in action can be found in work commissioned by Active Sussex. The research focused on the attitudes, motivations and barriers of women aged 25-38 throughout Sussex, currently engaging in less than 3 x 30 minutes of physical activity per week. The overall aim was to understand the life stages, triggers and motivations of inactive women and gain insight into what might help them to become more active. Information on the recommendations resulting from this work is set out in appendix 6.

Social marketing, including the use of market segmentation profiles, will be used to inform the service provision and communication work that the Active Communities programme is going deliver, if it is to impact on those areas most in need.
Measuring and Evaluating Progress

Measuring and evaluating the impact of the Active Communities programme is essential in order to determine whether the strategic aims we have set out are being met over the next three years. The programme will have an annual delivery plan and this will set out specific outcome and output indicators that together will provide a basis for measuring and evaluating progress. The development of these indicators will be informed by both national guidance and locally agreed measures.

(a) Public Health Outcomes Framework

The Government Public Health Outcomes Framework, Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency is focused on two high-level outcomes: increased healthy life expectancy overall and reduced differences in life expectancy and healthy life expectancy between communities. However, there are 3 outcomes that focus on physical activity participation which are relevant to this strategy. These are:

1. The % of people using green space for exercise/health reasons. (to be measured by the Natural Environment survey)
2. The % of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity (to be measured by the Active People survey)
3. The % of adults classified as “inactive” i.e. do less than 30 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more. (to be measured by the Active People survey).

Data for the Rother District will be made available and reported annually to the Active Communities Steering Group (see section 16) and the LSP for each of these outcome measures.

(b) The Active Communities Outcomes Framework

A local outcomes framework, reflecting the aspirations of the LSP partners has been developed and is set out in appendix 7 of this strategy. This framework will be used as a monitoring tool to ensure that the programme delivers work that will reflect and contribute to achieving these outcomes. The Active Communities Steering Group will monitor this work and report back to the LSP.

(c) Developing standardised evaluation methodology

The data provided in this strategy provides a picture of activity gathered from a number of surveys. To understand more about physical activity in Rother it is recommended that every opportunity is used to assess the impact of work undertaken as part of the Delivery Plan. This data would complement national data sets and can be used to build a local picture to inform current and future work.

The use of a standardised evaluation tool locally would help. Outcome measures should include the following:

- The number of individuals undertaking daily activity with a weekly target of 150 minutes
- The number of individuals who have ‘moved on’ and broadened their engagement in physical activity opportunities as a way of sustaining activity levels
- The uptake (numbers) of individuals involved in volunteer work (physical activity and sport settings)
- The self-reported measures of changes in levels motivation to undertake activity, changes in engagement in activity before, after and at 6 and 12 months after completion of intervention.

A number of other measures are recommended as indicators of performance. These include:

- The number of opportunities to be physically active that are available measured against a local baseline that will be developed
- Facility usage figures
Developing a Delivery Plan

Action to reduce the differences in activity levels among the population of Rother, as well as increasing overall levels of physical activity, will require the combined efforts of community members and a wide range of partners from all sectors working at different levels. An annual Delivery Plan will be therefore be produced to reflect this partnership approach, with quarterly monitoring reports produced in order to determine progress made against our strategic aims.

The actions set out in the Delivery Plan will reflect the LSP aspirations and the issues arising from the Gap Analysis report. In order to ensure this is achieved, the following tables provide a checklist against which the Delivery Plan can be measured.

LSP aspirations

- A need to ensure maximum benefit is achieved from previous investment (Play Pathfinder, Active Rother, Sports Facility Improvement, Open Spaces) by enabling increased use of facilities and participation
- A desire to respond to the needs identified by communities through Local Action Planning (LAP) and other processes, although recognising that it is not feasible to effectively respond to all sectors and that priorities would need to be agreed based on the evidence of effectiveness
- An aspiration to support community stakeholders to develop their capacity and stimulate volunteering.

Issues arising from Gap Analysis report

- Policies and strategies of RDC and partners should set out a commitment to increasing physical activity participation, in line with national public health strategy
- Planning, delivery, output measuring and reporting of interventions should be undertaken down to LSOA level.
- Action should be targeted on high risk population groups and geographical areas.
- Partnership work should be joined up more effectively, in order to support a pathway approach to facilitating physical activity opportunities
- Sharing of project outcomes should be encouraged and supported in order to facilitate a greater understanding of best practice and enable engagement with other communities
- Social marketing should be used to inform the planning and delivery of programmes that aim to reduce health inequalities and promote health and well-being.
- Developing and promoting the Active Rother brand, including the use of the internet and other forms of social media, should be set out in specific communications strategy and plan.
- Contracts for service provision should have clear outcomes and outputs along with performance management procedures, which will support reducing health inequalities and specifically, increasing physical activity participation
- Implementation of East Sussex Children and Young People’s plan should reflect and report on specific physical activity initiatives
- Uptake of existing programmes such as Health Trainers, NHS Health Checks and Active Women should be increased, with opportunities maximised to promote availability in priority areas
- Clear physical activity pathway should be put in place for healthcare professionals, with a range of referral options available, apart from gym based schemes
- In-depth evaluation work should be encouraged and supported to in order to measure impact and enable learning for the future.
Accountability

Rother Local Strategic Partnership has agreed to establish a multi-agency Active Communities Steering Group. This Group is co-ordinated and administered by Rother District Council and provides strategic leadership and support for the development and implementation of the Active Communities programme. Specifically, the Steering Group will:

1. Act as an Active Communities champion to advocate, facilitate and enable the incorporation of a wider range of interventions that contribute to increased levels of physical activity, healthy lifestyles and mental wellbeing as an integral part of all relevant opportunities within the District.

2. Influence and raise the profile of the wider benefits of physical activity to increase investment and resources in Rother.

3. Identify priority groups and communities e.g. older people, young people and families.

4. Guide the development and delivery of support and interventions using actions that are universal, but with a scale and intensity that is proportionate to the level of disadvantage (a Proportionate Universalism approach, as outlined in the Marmot Review).

5. Advise on and support the development of an asset based approach for tackling health inequalities in Rother.

6. Make an effective and active contribution to the development of a strategic Active Communities framework and delivery plan through the provision of advice, guidance and recommendations on how to achieve agreed outcomes.

7. Guide the development and monitoring of an annual delivery plan and where necessary make recommendations to the LSP to facilitate achievement and/or address areas of under achievement.

8. Recognise and agree appropriate action on any emerging priority areas that are in line with the overall purpose of the group.

The LSP receives regular update reports on the progress of the Active Communities programme at its quarterly meetings.
Evidence Base Documents

Evidence of Need

Evidence Base for Strategy and Interventions


31 Sussex County Sports Partnership Trust. A social marketing approach to increasing physical activity across Sussex. ICE 2010. g:\Profile, Policy & Evidence Base\Sussex County Sports Partnership Trust- Insight reportFINAL .pdf


### Guidelines on Recommended Levels of Physical Activity Across the Life-course

(Start Active, Stay Active, DH 2011)

The table below provides a definition of the different activity types used in the guidelines.

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate intensity activity</td>
<td>A moderate intensity physical activity requires an amount of effort and noticeably accelerates the heart rate, e.g. brisk walking, housework and domestic chores.</td>
</tr>
<tr>
<td>Bone strengthening activity</td>
<td>Physical activity primarily designed to increase the strength of the skeletal system. Bone strengthening activities produce an impact or tension force on the bones, promoting bone growth and strength. Running, jumping rope and lifting weights are examples of bone strengthening activities.</td>
</tr>
<tr>
<td>Muscle strengthening activity</td>
<td>Physical activity that increases skeletal muscle strength, power, endurance and mass.</td>
</tr>
<tr>
<td>Vigorous intensity</td>
<td>An activity that requires a large amount of effort, causes rapid breathing and a substantial increase in heart rate, e.g. running and climbing briskly up a hill.</td>
</tr>
</tbody>
</table>

### Life-course Category Summary of guidelines Examples of types of activities

<table>
<thead>
<tr>
<th>Life-course Category</th>
<th>Summary of guidelines</th>
</tr>
</thead>
</table>
| Early Years (Under 5s)     | 1 Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments  
2 Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day  
3 All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping). |
| Children & Young People (5–18 years) | 1 All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day  
2 Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week  
3 All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods. |

Examples of types of activities:

- Climbing frame or riding bike
- Running and chasing games, hopping, skipping
- Water based activities
- Balancing, riding, climbing
- Kicking, catching, throwing, striking, rolling
- Dance, gymnastics
- Walking, skipping to shops, a friend’s home, park, to and from nursery.
- Indoor and outdoor play
- Active travel
- Active travel Social dancing
- Active travel Social dancing Organised small sided games (large racquets, low nets, big balls)
- Educational instruction (through teaching and coaching)
- Sport and dance.
### Adults (19–64 years)

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

### Older Adults (65+ years)

1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
2. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
4. Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
5. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

### Common Activities

- Activities involving lift their body weight or work against resistance
- Jumping and climbing with use of large apparatus and toys
- Resistance type exercise during high intensity sport, dance, water based activities or weight (resistance) training in adult type gyms.

- Risk walking
- Bike riding
- Dancing
- Swimming
- Active Travel
- Running
- Playing sport
- Aerobic Exercise classes
- Using cardio vascular gym equipment
- Weight training, working in resistance bands
- Carrying heavy loads
- Heavy gardening
- Push ups and sit ups.
A Map of Rother (showing District Council Wards)
Demography

- Rother has an estimated population of 89,300. It is the second smallest district in East Sussex.
- Rother has 21% of its total population aged 0-19 years. This is significantly lower than for East Sussex (23%). Salehurst (28%) and Bexhill Sidley (27%) have the highest percentages in Rother. In contrast, Bexhill Collington (14%) and Marsham (16%) have the lowest percentage of their total population aged 0-19 years.
- 51% of Rother’s total population is estimated to be aged 20-64 years. This is the lowest amongst the districts and is significantly lower than East Sussex (54%).
- 28% of Rother’s total population is estimated to be aged 65 years and over. This is significantly higher than the value for East Sussex (23%). The percentage of total population aged 65 years and over in Bexhill Sackville, and Bexhill Collington are in excess of 40% and Bexhill Kewhurst and Bexhill St Marks are in excess of 30%. They are significantly higher than the value for East Sussex.
- The total population of Rother is estimated to grow by 3.1% by 2013 and 4.9% by 2015. This is the second largest increase amongst the districts. The highest percentage increase is predicted to be in those aged 65 years and over.
- The highest live birth rate in Rother is found in Ticehurst & Etchingham (109 per 1,000 females aged 15-44 years) and Bexhill Sidley (93 per 1,000). These are significantly higher rates than for East Sussex (66 per 1,000). The lowest is found in Bexhill Collington (24 per 1,000) which is significantly lower than the rate for East Sussex.
- The percentage of people of non-White ethnicity was 1.9% (2001 data). This was the second lowest in East Sussex and was significantly lower than the value for East Sussex (2.3%). By 2007 it was estimated that 4% of the population were of non-White ethnicities, the lowest amongst the East Sussex districts.
- The percentage of people belonging to main religions other than Christianity (1.1%) is significantly lower than for East Sussex (1.3%).
- New housing commitments are 7% of total dwelling stock. This is the second highest in the county and is significantly higher than the value for East Sussex (5.7%). Old Town has the highest with 64.1% (the highest in the county) and is significantly higher than the East Sussex value.

Social/Environmental Context

- Rother is the third most deprived district in East Sussex with an IMD score of 17.85. This compares to 18.78 for East Sussex. The most deprived ward is Bexhill Sidley, which is ranked in the top decile in East Sussex, with a score of 34.37. Bexhill Central, Eastern Rother, Bexhill Sackville, Rye and Bexhill St Michaels wards are all in the top quartile (most deprived 25%) in East Sussex. Bexhill Sidley is made up of four LSOAs, two of which are in the 20% most deprived in England. Bexhill Central, Eastern Rother, Bexhill Sackville and Rye all have some LSOAs in the 30% most deprived LSOAs in England. The least deprived ward is Bexhill St Marks with a score of 7.70.
- Rother is the third most deprived district in East Sussex for four of the domains of the IMD (income, employment, health and disability and living environment) with the exception of the education, crime and housing and services domain, which are the second least deprived district.
- 12% of older people are affected by income deprivation. This compares to 14% for East Sussex. In Rother, Bexhill Sidley (25%) and Bexhill Central (22%) have the highest percentage of income deprivation affecting older people.
- Rother has 18% of children aged 0-16 years living in poverty. Bexhill Sidley (39.6%), Eastern Rother (27.8%), Bexhill Central (25.8%), Bexhill St Michaels (24.8%) and Rye (23%) have high percentages of children living in poverty and are significantly higher than for East Sussex 18.5%).
• Take up of formal childcare (working families benefiting from the childcare element of working tax credits (WTC)) is significantly lower for Rother (14%) than in East Sussex (16%). Bexhill Sackville (28%, the highest in the county) and Bexhill Central (24%) have significantly higher values than for East Sussex.

• 2.8% of working age people are claiming Jobseekers Allowance. This is the third highest in the county. Bexhill Central (6.6%) and Bexhill Sidley (6.5%) have significantly higher percentages than East Sussex (2.9%).

• About 1 in 9 (11.5%) people claim out-of-work benefits. The highest values are found in Bexhill Sidley (25.4%), Bexhill Central (22.8%), Bexhill St Michaels (17.3%) and in Bexhill St Stephens (15.1%). These are all significantly higher percentages than for East Sussex (12%).

• About 3 in 10 (28.6%) households are on low income, which is defined as less than 60% of the national median income. This is significantly higher than the East Sussex figure (26.5%) in the 6 most deprived wards in Rother. Bexhill Sidley has the highest ward value in Rother with 41.6%, this is the second highest in the county.

• 5.4% of working age people claim incapacity benefit or severe disablement allowance. Bexhill Sidley (11%), Bexhill Central (10.3%) and Bexhill St Michaels (9.6%) have significantly higher values than East Sussex (5.4%).

• 45% of Rother households own their house outright. This is the highest in East Sussex and is significantly higher than the value for East Sussex (38%). Bexhill Collington, Bexhill St Marks, Bexhill Kewhurst and Marsham have some of the highest home ownership in the county ranging between 66% and 59%. All have significantly higher percentages than for East Sussex.

• 1.9% of households are Registered Social Landlords. This is significantly lower than the value for East Sussex (5.4%). In Bexhill Sidley 8% of households are rented from RSLs.

• In Rother (8.7%), Bexhill Sidley (24.7%) and Rye (15.1%) significantly higher percentages of households are rented from a housing association/registered social landlord compared to East Sussex (6.4%).

• In Bexhill Central 29% of households are rented from a private landlord. This is significantly higher than the value for East Sussex (9.9%).

• In Eastern Rother 8.1% of households are rented from other sources (the largest in the county). This is significantly higher than the value for East Sussex (3.2%).

• 4.2% of people live in overcrowded households and 8% of under-18s live in overcrowded homes.

• About 1 in 5 households (20.8%) have no access to a car or van. The highest is in Bexhill Central ward with 44.9%.

• About 1 in 3 (32%) older people aged 65 years and over live alone. The highest in Rother is found in Bexhill Central (49%).

• 63% of licensed cars are in CO2 emissions groups greater than 150g/km. Crowhurst (68%) and Bexhill St Marks (67%) have significantly higher percentages than East Sussex (64%).

• 51% of primary children travel to primary school by car/van or taxi in Rother, which is significantly higher than the value for East Sussex (45%). Marsham (75%) has the highest in the district and this is significantly higher than the value for East Sussex.

• 18% of secondary school pupils travel to school by car/van. Bexhill St Marks, Bexhill St Michaels and Bexhill Collington are all over thirty percent and are significantly higher than the value for East Sussex (19%).

• 62% of households weighted for sensitivity to travel by public transport/walking can access a GP.

Lifestyles and Risk Factors

• In Rother 81% of mothers initiated breastfeeding, the same value as for East Sussex. The percentage of mothers initiating breastfeeding is significantly lower in Bexhill Sidley (70%) than in East Sussex.

• In Rother 54% of infants (of known feeding status) are fully or partially breastfed at 6-8 weeks. This is significantly lower in Bexhill Sidley (31%) than the value for East Sussex (51%).

• 8% of Rother reception year children are obese. Two wards have significantly higher prevalence than East Sussex (8%): Old Town (18%) and Bexhill Sidley (15%).

• The percentage of year 6 children classified as obese in Rother is 17%. Eastern Rother (27%) and Bexhill Sidley (25%) have significantly higher rates than the value for East Sussex (16%).
• The estimated prevalence of obesity for those aged 16 years and over is 22%
• 1 in 5 (20%) persons aged 16 years and over participate in sport and active recreation
• Rother has an estimated prevalence of fruit and vegetable consumption of 38%, which is slightly higher than the value for East Sussex (34%)
• The estimated prevalence of binge drinking for those aged 16 years and over in Rother is 12%. In the most deprived wards the figures are slightly higher
• Hospital admissions due to alcohol-specific conditions are 102 per 100,000 for persons aged 0-17 years
• The rate of hospital admissions due to alcohol-related harm (age standardised) is 1,295 per 100,000 population and this is significantly lower than the rate for East Sussex (1,491 per 100,000)
• 20% of persons aged 16 years and over smoke in Rother. This rises in the more deprived wards. For example, Bexhill Central has an estimated 30% of persons aged 16 years and over who smoke
• About 1 in 5 mothers (22%) are known to be smoking at the time of delivery. This is significantly higher than the value for East Sussex (17%). Bexhill Sidley (34%) and Bexhill Central (33%) have significantly higher percentages than East Sussex (17%)
• Rother has an U18 conception rate of 36 per 1,000 females aged 15-17 years. Bexhill St Stephens (70 per 1,000), Bexhill Sidley (69 per 1,000) and Bexhill Central (66 per 1,000) have significantly higher rates than the East Sussex rate (35 per 1,000).

Burden of Ill-Health

• The percentage of babies of low birth weight (under 2,500 grams) is significantly higher in Bexhill Sidley (10%), than in East Sussex (7%)
• The Mental Illness Needs Index suggests that Rother has 21% less mental illness severe enough to merit periodic hospital treatment from time to time for people aged 16-59 years than the country as a whole. Bexhill Central (108%), Bexhill Sidley (37%) and Bexhill Sackville (36%) have more illnesses severe enough to need hospital treatment than the country as a whole
• The index of common mental illness shows that 11.4% of the population aged 16-64 years living in private households are likely to suffer from a clinically significant level of incidence of both neurotic symptoms and depression. This is significantly lower than in East Sussex (12.8%). Bexhill Central (15.9%) is the only ward that with a significantly higher percentage than East Sussex
• Life expectancy at birth in Rother (81.8 years) is not significantly different from East Sussex (82 years). Bexhill Sidley (78.6 years) and Bexhill St Michaels (78.6 years) have the lowest life expectancy in the district and significantly lower life expectancies than for East Sussex. Bexhill Collington (84.6 years), Bexhill St Marks (84.5 years), Salehurst (84.3 years) and Ticehurst & Etchingham (83.8 years) all have significantly higher life expectancies than in East Sussex
• Life expectancy for Rother at age 65 years is 20.5 years. Bexhill St Michaels (a further 17.7 years), Crowhurst (a further 18.6 years), Bexhill Sidley (a further 18.7 years) and Darwell (a further 18.8 years) have significantly lower life expectancies at age 65 years than East Sussex (a further 20.7 years).

Burden of Ill-Health – Primary Care

• Rother reported a significantly higher cancer prevalence of 19 per 1,000 population than East Sussex (16 per 1,000)
• Rother reported a significantly higher prevalence of Coronary Heart Disease (CHD) (47 per 1,000 population) than East Sussex (40 per 1,000). Several wards are significantly higher than East Sussex. These are Bexhill St Marks, Bexhill Sackville, Bexhill St Michaels, Bexhill Kewhurst, Bexhill Collington, Old Town (Bexhill), Bexhill Central, Bexhill St Stephens and Bexhill Sidley
• Rother reported a significantly higher prevalence of diabetes than East Sussex
• Rother and a majority of wards reported a significantly higher prevalence of heart failure than East Sussex. Nine wards are ranked in the top decile for the county
• Rother reported a significantly higher prevalence of hypertension than East Sussex. Bexhill wards, Rye, Brede Valley and Rother Levels have significantly higher prevalence than East Sussex
• Rother reported a significantly higher prevalence of stroke or transient ischaemic attacks (TIA) prevalence than East Sussex. Bexhill wards have significantly higher prevalence than East Sussex.

Burden of Ill-Health – Hospital Care

• Rother has significantly (8%) less A&E attendances (standardised for age) than expected compared to East Sussex. Two wards, Bexhill Sidley (22%) and Marsham (11%) have significantly more attendances than expected compared to East Sussex.

• The rate of A&E attendances is significantly lower than East Sussex for persons aged 0-4 years, 40-74 years and 65 years and over.

• In Bexhill Sidley the rates of A&E attendances for persons aged 10-19 years, aged 40-74 years, and aged 85 years and over, are significantly higher than for East Sussex.

• Rother has significantly less A&E attendances due to assaults between 9pm and 4am for those aged 10-64 years than East Sussex. However, Bexhill Central has a significantly higher rate than East Sussex.

• Rother has 7% of outpatient appointments where patients did not attend, which is the lowest amongst the districts and significantly lower than East Sussex (9%). However, Bexhill Sidley and Bexhill Central have 10% of patients not attending. This is significantly higher than for East Sussex.

• Rother has significantly (2%) more emergency hospital admissions (standardised for age) than expected compared to East Sussex. Significantly higher than expected compared to East Sussex are Bexhill Sidley (46%), Ewhurst & Sedlescombe (18%), Bexhill Central (14%) and Bexhill St Michael (14%).

• Rye (187 per 1,000 persons aged 1-4 years), Ticehurst & Sedlescombe (168 per 1,000) and Bexhill St Stephens (162 per 1,000) have significantly higher rates of emergency admissions compared to East Sussex (113 per 1,000).

• Ewhurst & Sedlescombe (109 per 1,000 population, highest in county) and Bexhill St Stephens (85 per 1,000) have significantly higher rates of emergency admissions for persons aged 5-9 compared to East Sussex (46 per 1,000).

• In Rother, elective and emergency admissions for persons aged 10-19 years are significantly higher than East Sussex.

• In Rother, the elective admission rate for those aged 40-74 years is significantly higher than East Sussex.

• Elective admission rates for those aged 65 years and over for Marsham and Brede Valley are the highest and second highest in the county and significantly higher than for East Sussex.

• Bexhill St Marks and Bexhill Sidley rates of emergency admissions for persons aged 85 years and over, are significantly higher than for East Sussex.

• Bexhill Sidley, Bexhill St Stephens, Crowhurst and Battle Town have significantly higher emergency hospital admission rates caused by unintentional and deliberate injuries compared to East Sussex.

• Rother has significantly more (12%) (age-standardised) emergency hospital admissions for circulatory diseases than expected compared to East Sussex. Bexhill Sidley (46%) and Bexhill St Michaels (39%) have significantly more emergency admissions due to circulatory diseases than expected.

• Rother has significantly more (21%) (age-standardised) hospital admissions for cancer than expected compared to East Sussex. Marsham (74%), Battle Town (67%), Rye (63%), Brede Valley (49%) and Salehurst (47%) all have significantly higher rates than East Sussex and are all ranked in the top decile for the county.

• Rother has significantly less (18%) and (6%) (age-standardised) elective and emergency hospital admissions for respiratory disease than expected compared to East Sussex.

• Bexhill Sidley (127%) and Bexhill Central (50%) have significantly more (age-standardised) emergency hospital admissions for COPD than expected compared to East Sussex.

• Bexhill Central (170%), Bexhill Sidley (72%) and Bexhill Sackville (72%) have significantly more (age-standardised) emergency hospital admissions for mental and behavioural disorders than expected compared to East Sussex.
Social Care
- Rother has 15.8 per 1,000 adults receiving direct payments and/or individual budgets. This is significantly higher than for East Sussex (13.3 per 1,000)
- Bexhill Sidley, Bexhill Central, Bexhill St Michaels, Old Town and Bexhill Sackville all have significantly higher rates of persons supported to live independently through social services for persons aged 18 years and over and those aged 18-64 years than in East Sussex
- Bexhill Sidley and Bexhill St Stephens have significantly higher rates of persons supported to live independently through social services for those aged 65 years and over than in East Sussex
- Rother has significantly higher rates of persons aged 18 years and over with physical disability, frailty and sensory impairment, supported to live independently through social services compared to East Sussex. Bexhill Sidley, Bexhill Central, Bexhill St Michaels, Old Town and Bexhill Sackville all have significantly higher rates than in East Sussex
- Crowhurst has a significantly higher rate (and highest rate in the county) of persons with learning disability, supported through social services for those aged 18-64 years than in East Sussex
- Bexhill Central has the highest rate in the county for persons aged 18 years and over and aged 18-64 years with mental health needs, supported to live independently through social services. This is significantly higher than for East Sussex
- Rother has 11.5 per 1,000 carers known to social care. This is significantly higher than in East Sussex. Bexhill Sidley (highest in the county with 19.1 per 1,000), Bexhill St Michaels, Bexhill Kewhurst, Bexhill St Marks and Marsham all have significantly higher rates than in East Sussex
- Rother has the highest rate of persons aged 18 years and over who have received community equipment in one year (16.8 per 1,000 population). This is significantly higher than the East Sussex rate (14.2 per 1,000)
- Rother has a significantly higher referral rate to adult social care (44.2 per 1,000 population) than East Sussex (39.5 per 1,000). Bexhill Sidley, Bexhill Central, Bexhill St Michaels, Old Town and Bexhill Sackville have significantly higher rates than East Sussex and rank in the top decile for the county
- Rother has a significantly lower rate of older people discharged from hospital to intermediate care than in East Sussex
- Rother has a significantly higher rate of persons aged 18 years and over receiving permanent residential care than in East Sussex. Crowhurst, Bexhill Sackville, Bexhill St Michaels and Bexhill Central have significantly higher rates than East Sussex
- Bexhill Sackville, Bexhill St Michaels and Darwell have significantly higher rates of persons aged 18 years and over receiving permanent nursing care than in East Sussex.

Education and Children’s Services
- Rother has 12.5% of pupils receiving free school meals, the same percentage as for East Sussex. Bexhill Sidley (30.7%) ranks in the top decile for the county. Bexhill Central, Eastern Rother and Bexhill St Michaels also have significantly higher percentages than East Sussex
- Bexhill Sidley (56 per 1,000 pupils) and Rother Levels (55.6 per 1,000) have a significantly higher rate of pupils with a statement of special education needs than East Sussex (31.5 per 1,000)
- Rother has a significantly lower rate 22.4 per 1,000 pupils with English as an additional language than East Sussex (37.7 per 1,000)
- 9% of Rother pupils are of non-White British ethnicity. This is significantly lower than the value for East Sussex. However, Bexhill Central (18.2%) and Bexhill Sackville (18.4%) have significantly higher percentages
- Rye has significantly lower attainment at key stage 1 than East Sussex
- Rye, Bexhill Sidley and Eastern Rother have significantly lower attainment for key stage 2 English than East Sussex
- Bexhill Sidley, Bexhill Central, Eastern Rother and Salehurst have significantly lower attainment at key stage 4 than East Sussex
- In Rother the rate of children referred to children’s social care is significantly higher than for East Sussex. Bexhill Sidley, Bexhill St Michaels, Bexhill St Stephens, Bexhill Central, and Eastern Rother have significantly higher rates than East Sussex
- Bexhill Sidley has significantly higher rates of children on child protection plan, children allocated a social worker and looked after children than East Sussex.
### The Active People Survey

The Sport England Active People Survey (APS) is the national survey for sport and recreation. The table below shows the data from the 6 main indicators in the 2011 survey and compares it with the first survey in 2006. The figures for Rother are based on the responses of 1,020 participants.

1. The percentage of the adult (age 16 and over) population who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week).

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>19.8%</td>
<td>21.9%</td>
<td>+2.1%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>21.6%</td>
<td>21.3%</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

2. Volunteering to support sport for at least one hour a week.

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>5.4%</td>
<td>9.9%</td>
<td>+4.5%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>5%</td>
<td>7.7%</td>
<td>+2.7%</td>
</tr>
</tbody>
</table>

3. Being a member of a club particularly so that you can participate in sport or recreational activity in the last 4 weeks.

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>5.4%</td>
<td>9.9%</td>
<td>+4.5%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>5%</td>
<td>7.7%</td>
<td>+2.7%</td>
</tr>
</tbody>
</table>

### Appendix 5

4. Having received tuition from an instructor or coach to improve your performance in any sport or recreational activity in the last 12 months.

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>16.4%</td>
<td>14.5%</td>
<td>-1.9%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>17.5%</td>
<td>16.2%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

5. Having taken part in any organised competition in any sport or recreational activity in the last 12 months.

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>15.6%</td>
<td>17.3%</td>
<td>+1.7%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>15%</td>
<td>14.8%</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

6. The percentage of adults who have done at least one of the following - received tuition in the last 12 months, taken part in organised competition in the last 12 months or been a member of a club to play sport.

<table>
<thead>
<tr>
<th></th>
<th>APS1 2006</th>
<th>APS5 2011</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rother</td>
<td>35.1%</td>
<td>37.1%</td>
<td>+2%</td>
</tr>
<tr>
<td>East Sussex</td>
<td>36.9%</td>
<td>38%</td>
<td>+1.1%</td>
</tr>
</tbody>
</table>
Active Sussex (the County Sports Partnership) commissioned a programme of research specifically into the attitudes, motivations and barriers of women aged 25-38 throughout Sussex, currently engaging in less than 3 x 30 minutes of physical activity per week. The overall aim was to understand the life stages, triggers and motivations of inactive women and gain insight into what might help them to become more active.

The following key barriers were identified:

• Perception of activity as boring and a chore
• Stages of life as barriers e.g. work pressures, family pressures
• Time and accessibility of facilities whilst working full-time
• Among BME women, there were additional cultural influences such as pervading notions of the role of women in the family unit
• Women who were happy with their appearance saw little motivation for engaging in regular activity
• Perception that physical activity is costly and out of the reach of those who don’t work or who work part time
• The following life stages tend to be key triggers for changes in attitude and motivations towards activity: school / formal education, work / careers, having children.

Key messages to focus on:

• An individual approach to becoming more active
• Local provision and available support
• Activity as a family or peer group pursuit
• The benefits of activity to improving physical appearance
• Advice on how to fit being active around leading a busy life.

A number of specific communication channels are also suggested including:

• Paid-for advertising e.g. adverts in local free newspapers, local commercial radio, and public spaces
• E-communications e.g. text message support, social media, local and national websites
• Direct marketing e.g. leaflets / items offering advice, information via schools and community centres
• Working with community and religious leaders
• Messaging through workplace channels
• Support programmes e.g. fitness goal related campaigns and buddy schemes.
The Active Communities Outcomes Framework

**Service delivery outcomes**
- Increased awareness of health and wellbeing and quality of life through physical activity
- Increased participation in sport and active recreation
- More people in paid and unpaid work linked to active recreation and healthy lifestyles
- Increased attendances and active participation by young people, older people, disadvantaged and vulnerable adults

**Intermediate outcomes**
- Improved learning, skills and enterprise opportunities
- Increased engagement and participation in community life
- Reduction in falls among older people

**Overarching strategic outcomes**
- Improvement in health indicators
- Active involvement in cohesive communities
- Reduction in health inequalities

Appendix 7