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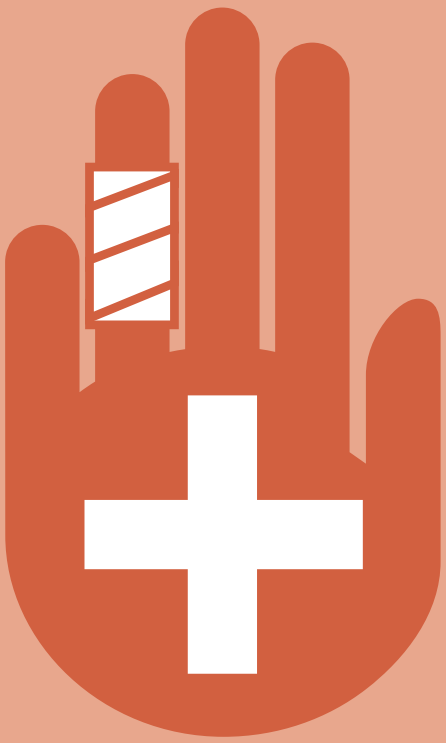
East Sussex
County Council

Preventing and reducing falls, accidents and injuries



Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 4: Preventing and reducing falls, accidents and injuries.

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Phillip Rowcliffe
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Alison Smith
Becky Surman
Jane Thomas
Claire Turner
Anthony Wakhisi
Rachel West
David Wolfe

Cynthia Lyons
Acting Director of Public Health
East Sussex County Council

Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year's report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the East Sussex Health and Wellbeing Board's Health and Wellbeing Strategy for 2013-2016 "Healthy Lives, Healthy People".

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

To make the recommendations more easily accessible a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in the full annual report for that area, including all the recommendations contained in the appropriate appendix.

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries
Booklet 5:	Enabling people to manage and maintain their mental health and wellbeing

Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings;
- may be viewed as potentially contentious or difficult to implement for other reasons.

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 4: Preventing and reducing falls, accidents and injuries.

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 4 – Preventing and reducing falls, accidents and injuries

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 4: Preventing and reducing falls, accidents and injuries		
Fewer children, young people and older people have preventable falls, accidents or suffer deliberate harm by others or themselves.	• Further research and analysis to better understand the causes of falls, accidents and injuries amongst children and young people so that interventions can be targeted at those at greatest risk of harm. • Develop a more integrated, evidence based approach to preventing and reducing falls, accidents and injuries such as coordinated accident prevention activity and campaigns, home safety checks and equipment schemes, and parenting support. • Enhance the falls and bone care pathway with stronger links between community based, primary and secondary care settings and health, care and wider services.	• Fewer childr being admit unintentiona injuries (inc assaults). • Fewer over 6 due to a fall • Fewer over 6 ambulance • Fewer over 6 preventable

	STRATEGIC OUTCOME INDICATORS
ren and young people tted to hospital for al and deliberate luding falls, accidents, 65s use secondary care . 65s use emergency services due to a fall. 65's with first or second fractures.	4.1 Reduce emergency hospital admissions amongst children and young people for accidents and injuries. Indicator definition: Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-17 years, per 10,000 resident population. Baselines: (2010/11) England average 124.3; (2011/12) East Sussex average 121.7; Eastbourne 121.2; Hastings 143.7; Lewes 118.0; Rother 123.4; Wealden 109.6. Target by 2016: 4% reduction for East Sussex between 2011/12 and 2015/16 based on a steady reduction of 1.35% per year. NB: Targets for local areas and/or causes may be proposed following an analysis of research into the causes of falls, accidents and injuries. 4.2 Reduce the number of older people admitted to hospital due to falls. Indicator definition: Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population. Baselines: (2010/11) England average 1,642; (2011/12) East Sussex average 1,543; Eastbourne 1,751; Hastings 1,368; Lewes 1,569; Rother 1,358; Wealden 1,605. Target by 2016: 3% reduction in East Sussex between 2011/12 and 2015/16 based on a steady reduction of 1% per year.

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The reviews focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 4: Preventing and reducing falls, accidents and injuries

Priority area	Sub-topic
Preventing and reducing falls, accidents and injuries	a. Interventions to prevent falls, accidents and injuries amongst children and young people
	b. Interventions to prevent falls, accidents and injuries (adults)
	c. Interventions to prevent falls, accidents and injuries (elderly)
	d. Integration of services to manage falls, accidents and injuries (elderly)
	e. Interventions to prevent road traffic injuries

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality, perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source's methodology. Scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Controlled Trials, or RCTs with a very low risk of bias.
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
2++	High quality systematic reviews of case control or cohort or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
3	Non-analytic studies, e.g. case reports, case series.
4	Expert opinion.

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

2.2 Commissioning prioritisation

This booklet aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings; and
- may be viewed as potentially contentious or difficult to implement for other reasons.

Chapter 3: Preventing and reducing falls, accidents and injuries

Focus on

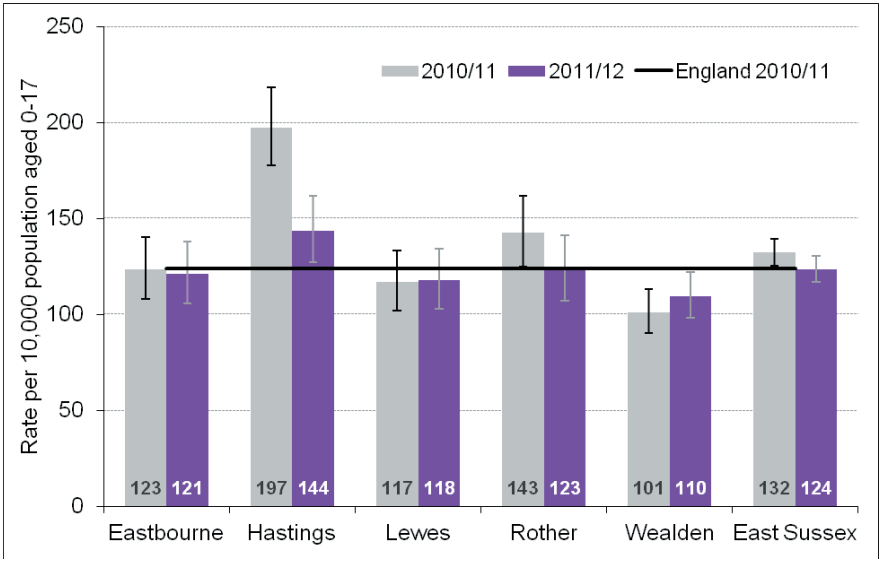
3.1 Interventions to prevent falls, accidents and injuries amongst children and young people
3.2 Interventions to prevent falls, accidents and injuries (adults)
3.3 Interventions to prevent falls, accidents and injuries (older people)
3.4 Integration of services to manage falls, accidents & injuries (older people)
3.5 Interventions to prevent road traffic injuries

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013

Public Health Outcome Indicator	Comparison to England
1.10 Killed and seriously injured casualties on roads	Significantly worse
2.24 Injuries due to falls in people aged 65 and over	
i Female	Significantly better
i Male	Significantly better
i All persons	Significantly better
ii aged 65-79	Significantly better
iii aged 80+	Better
4.14 Hip fractures in people aged 65 and over	
i All persons	Better
ii aged 65-79	Better
iii aged 80+	Better

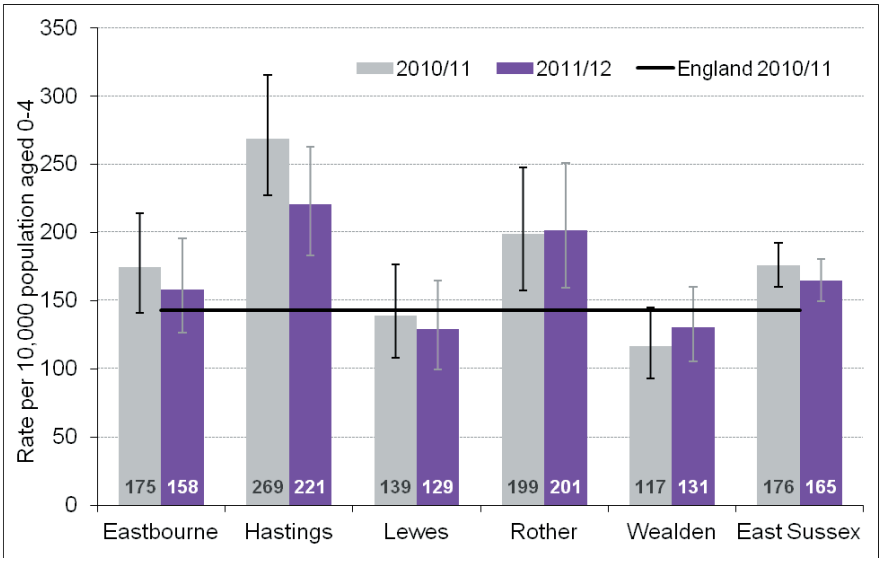
3.1 Key facts and figures: preventing falls, accidents and injuries amongst children and young people

Figure 3.1a: Emergency hospital admissions caused by unintentional and deliberate injuries to under 18s, rate per 10,000 population with 95% confidence intervals, 2010/11 and 2011/12



Source: East Sussex JSNA, Local Briefing - Accidents and injuries in under 18 year olds, July 2012
www.eastsussexjsna.org.uk/briefings

Figure 3.1b: Emergency hospital admissions caused by unintentional and deliberate injuries to 0-4 year olds, rate per 10,000 population with 95% confidence intervals, 2010/11 and 2011/12



Source: East Sussex JSNA, Local Briefing - Accidents and injuries in under 18 year olds, July 2012
www.eastsussexjsna.org.uk/briefings

The rate of admissions to hospital in children and young people under 18 years as a result of accidental injury and deliberate harm is significantly higher than the national average in Hastings. For children under four years, East Sussex as a whole and Hastings and Rother have significantly higher rates than England.

3.2 Key facts and figures: preventing falls, accidents and injuries amongst adults

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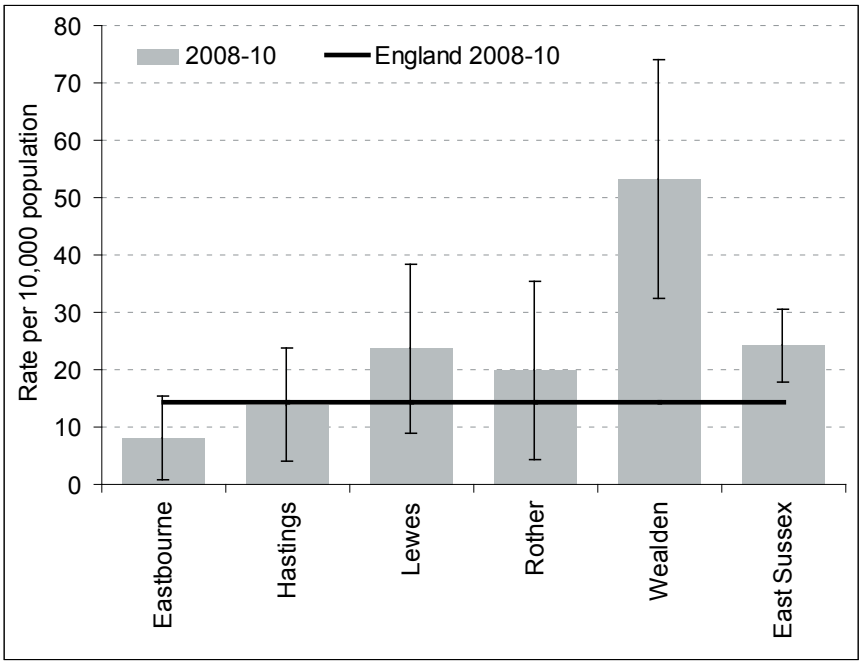
The National Injury Profiles provides a basket of indicators relating to injuries such as land transport injuries, falls, intentional injuries e.g. suicide and self harm, the consequence of injury, such as hospital admissions, injuries by age and mortality from injuries.

Of the 42 indicators in the injury profiles East Sussex is significantly worse than England for 18 indicators including hospital admissions for injuries in young people, land transport injuries, A&E attendances due to injury, hospital admissions due to fall injury (all ages), and hospital admissions due to burns. There is variation across the county with Hastings being significantly worse than the England average for 25 of the 42 indicators, and Wealden being significantly worse for land transport injury (7 of the 9 land transport injury targets).

Figure 3.2: Years of life lost due to land transport injuries, rate per 10,000 population with 95% confidence intervals, 2008-2010



Source: National Injury Profiles, Public Health England, , accessed July 2013
www.eastsussexjsna.org.uk/profiles/Injury

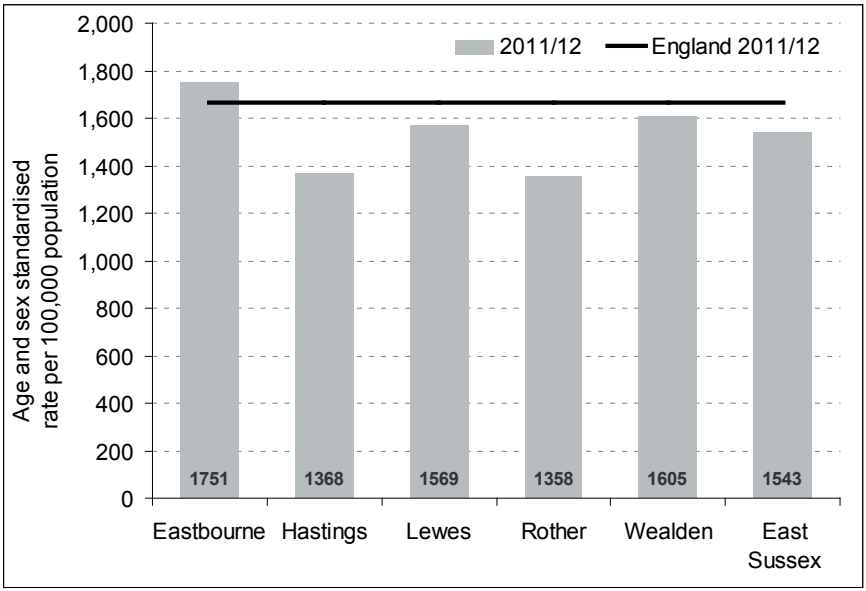
East Sussex as a whole and Wealden District have significantly higher Years of Life Lost due to land transport injuries than the England average.

Years of life lost provides a summary measure of premature mortality. Years of life lost is the years of potential life lost due to premature deaths. It takes into account the age at which deaths occur, giving greater weight to deaths at a younger age and lower weight to deaths at older age.

3.3 Key facts and figures: preventing falls, accidents and injuries amongst older people

The overall rate of admissions due to falls for persons aged 65 years and over is lower than the England average. However there is variation across the county with the lowest rates in Hastings and Rother and the highest rates in Eastbourne, where rates are higher than the England average. Although rates of falls in East Sussex are slightly lower than the UK as a whole, given the size of the older population in East Sussex falls present a significant issue for health and social care services locally.

Figure 3.3: Emergency hospital admissions due to falls injuries for persons aged 65 years and over, rate per 100,000, 2011/12



Source: Local East Sussex SUS extracts, East Sussex Public Health Intelligence Team

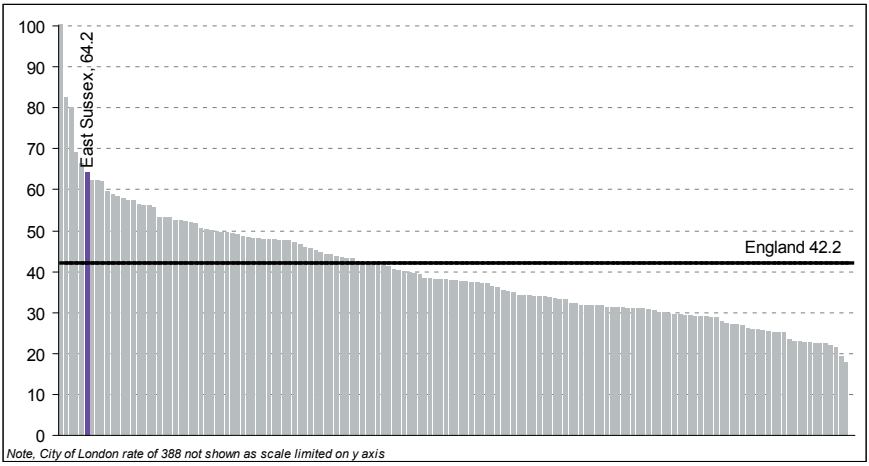
Age standardised rates for emergency admissions due to falls for persons aged 75 years and over show that the rates are nearly twice as high in Eastbourne, Lewes and Wealden than in Hastings and Rother.

3.4 Key facts and figures: managing falls, accidents and injuries in older people

Mortality from fractured neck of femur has been decreasing since 2005/6 at the East Sussex level, in line with national trends. However given the ageing population in East Sussex rehabilitation services for people recovering from falls, to maintain mobility and prevent future falls, remain important. In 2010/11 there were 61 patients in East Sussex who died within 30 days of having an emergency admission to hospital due to a fractured hip.

3.5 Key facts and figures: road traffic accidents

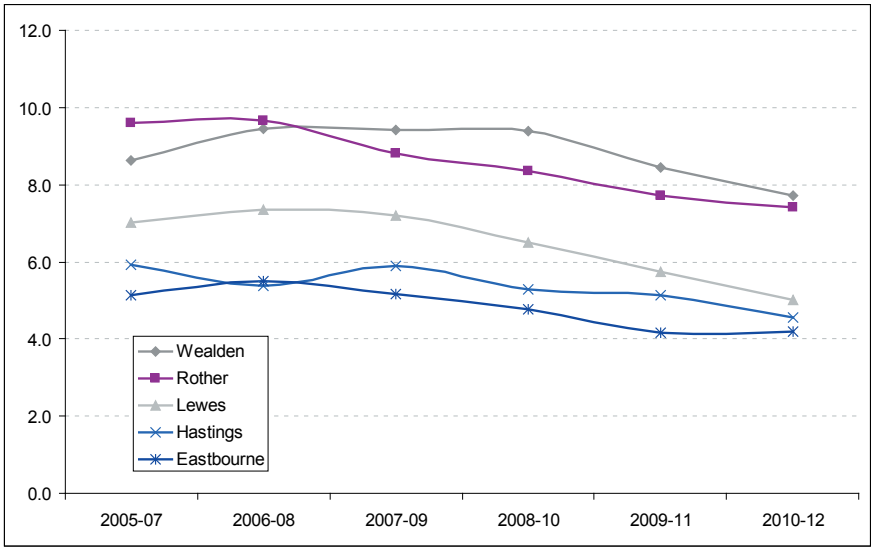
Figure 3.4: People reported killed or seriously injured on the roads by upper tier local authority, rate per 100,000 resident population, 2009-2011



Source: Public Health outcomes Framework, Public Health England
www.eastsussexjsna.org.uk/overviews/PHOF

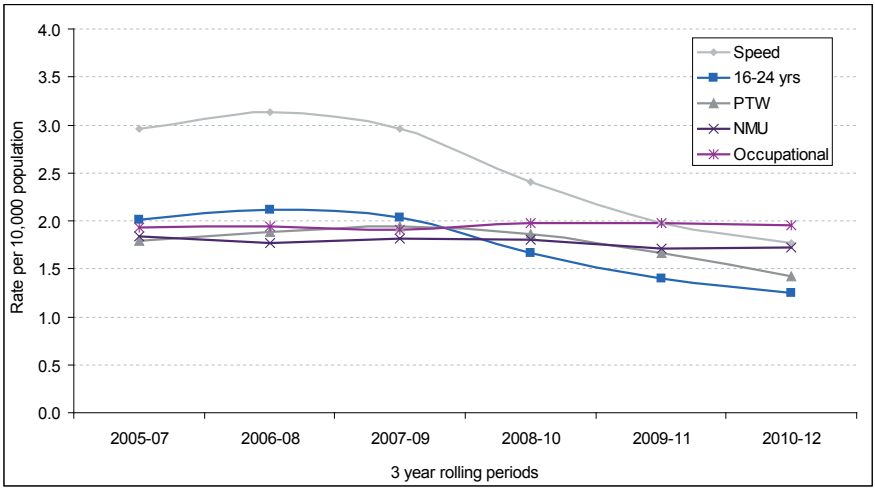
Although rates of people killed or seriously injured on the roads is reducing year on year in line with the national trend East Sussex has the fifth highest KSI rate of any upper tier local authority in England.

Figure 3.5a: Killed and seriously injured on East Sussex roads, by district and borough, 3 year rolling average, rate per 10,000 population



Source: Sussex Safer Roads Partnership

Figure 3.5b: Killed and seriously injured on East Sussex roads, by priority groups, 3 year rolling average, rate per 10,000 population



Source: Sussex Safer Roads Partnership

Rates of people killed and seriously injured on the roads of East Sussex and for each of the district and boroughs appear to be reducing over time. Highest rates are seen in the most rural districts of the county.

Figure 3.5b shows KSI rates for each of the East Sussex priority areas (speed, 16-24 year olds, powered two wheel vehicles (PTW), non motorised users (NMU) and occupational drivers). Rates appear to be reducing for all groups other than occupational drivers and non motorised users, with the most marked reduction seen in KSIs where speed is recorded as a factor.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Chapter 4. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

Chapter 4: Evidence based recommendations for priority area 4

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted in this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK

2.2 Interventions to prevent falls, accidents and injuries amongst children an

Intervention	
2.2.1	Incorporate unintentional injury prevention into local strategies and policie
Establish:	
2.2.2	robust local strategies and policies to prevent falls accidents and injuries a
2.2.3	partnership working across a range of organisations.
2.2.4	high quality professional and voluntary staff training including establishing
2.2.5	Identify households at risk, prioritising households at greatest risk for hom
Ensure:	
2.2.6	home visits to conduct safety assessments include the installation of the n
2.2.8	community engagement, education and involvement to prevent falls, accid
2.2.9	professionals and facilitators who have on-going relationships with familie
2.2.7	Include home safety education, with the provision of safety equipment. Int installation are more effective.
2.2.10	Target interventions to high risk populations to optimise cost-effectiveness

This evidence review does not recommend:

Intervention	
2.2.11	home safety interventions varied by social group.
2.2.12	intervention features found to be barriers related to home injury preventio complex interventions, cultural, socio-economic, physical and behavioural

d young people

	Evidence grade
es.	A
mongst children and young people.	A
	A
g reliable communication pathways.	A
e safety assessments, supply and installation of home safety equipment.	A
ecessary safety equipment.	A
ents and injuries amongst children and young people.	A
s are encouraged to deliver safety home safety messages.	A
erventions providing free or low cost home safety equipment and free	A
.	D

	Evidence grade
	B
n interventions for pre-school children (5 years and under) include: barriers and deliverer constraints.	B

Recommendations for interventions to prevent falls, accidents and injuries (ac

Intervention	
Promote:	
2.3.1	physical activity interventions.
2.3.4	exercise programmes to prevent self-reported back problems in working ag
2.3.2	alcohol reduction initiatives to prevent falls.
2.3.3	the use of mouth guards among previously injured athletes (adolescents ar braces to prevent further injuries (adults).

This evidence review does not recommend:

Intervention	
2.3.5	injury prevention interventions.
2.3.6	the following programmes in preventing self-reported back problems for reducing lifting.

dults)

	Evidence grade
	B
e adults.	A
	B
nd adults, elite and recreational players) and consider promoting ankle	B B

	Evidence grade
	C
working age adults: education alone; shoe inserts, and programs for	A

Recommendations for interventions to prevent falls, accidents and injuries (el

This evidence review recommends:

Intervention	
Multi-factorial:	
2.4.1	risk assessments for elderly people with recurrent falls, including medica
2.4.2	interventions should be offered to high risk elderly people groups followi
2.4.3	Elderly people who have received treatment in hospital following a fall sh modifications in conjunction with follow-up.
2.4.4	Falls prevention programmes for elderly people living in the community, i
2.4.5	Consider promoting Vitamin D supplements to elderly patients at risk.
2.4.6	Health professionals should be encouraged to routinely ask elderly peop
2.4.7	Individuals at risk of falling, and their carers, should be offered informati
2.4.8	All healthcare professionals dealing with patients known to be at risk of f assessment and prevention.
2.4.9	Single interventions (such as the Otago Exercise Programme) targeted at incremental costs.

lderly)

	Evidence grade
ation review.	A
ng treatment for falls.	A B B
hould be offered a home hazard assessment and safety intervention/	A A
including home-based exercise programmes.	A A
	A B B B
le whether they have fallen in the past year.	A
ion orally and in writing.	A
falling should develop and maintain basic professional competence in falls	A
high-risk groups can prevent the greatest number of falls at the lowest	B

Integration of services to manage falls, accidents and injuries (elderly)

This evidence review recommends:

Intervention	
2.5.1	elderly patients with hip fractures should be offered an integrated multic aim of regaining sufficient function to return to their pre-fracture living ar
	Include early integrated multidisciplinary care for:
2.5.2	daily geriatric care to reduce hospital mortality and medical complication
2.5.3	early integrated multidisciplinary care specifically designed for geriatric p
2.5.4	Integrate hip-fracture care pathways.
Promote:	
2.5.5	integrated early mobilisation, early discharge and on-going home-based
2.5.6	integrated extended outpatient rehabilitation for elderly patients with hi
2.5.7	education interventions to prevent future falls, exercise and balance trai osteoporosis as secondary prevention strategies for hip fracture.
2.5.8	Appoint a dedicated coordinator to promote prevention, support the inte patient and medical teams.
2.5.9	Coordinator-based systems to facilitate bone mineral density testing, ost
2.5.10	Ensure fragility fractures are monitored by utilising an access fracture reg

	Evidence grade
disciplinary rehabilitation program specifically designed with the specific rangements.	A B
s in elderly patients with hip fractures.	A B
patients during hospital admission.	A B
	B
rehabilitation.	A B B
p fracture.	A
ning in ambulatory patients, and the education and treatment of	B B
gration of the multidisciplinary team and to act as the link between the	B B
eoporosis education and care in patients following a fragility fracture.	B
gistry and a database.	B

Interventions to prevent road traffic injuries

Intervention	
2.6.1	Coordinated partnership working between health professionals, school s environment to prevent road traffic injuries.
2.6.2	Ensure pedestrians, cyclists and users of other modes of transport that i streets and roads i.e. reallocating road space; restricting motor vehicle a supporting the modification of the built environment.
2.6.3	Authorities should work with other partners to introduce engineering me the risk of injuries.
2.6.6	Review data regarding attendances at emergency departments and mino
2.6.7	Implement multi-component prevention programs in conjunction with co
2.6.9	Support well-executed mass media campaigns to promote reduction in a
Promote:	
2.6.4	purpose-built bicycle only facilities (e.g. bike routes, bike lanes, bike pat
2.6.5	unintentional injury prevention activities aimed at people under the age
2.6.8	adequate street lighting and high visibility safety clothing and equipmen
2.6.12	cycle helmet education interventions in schools and healthcare centres t
2.6.10	education to parents and carers of young children to ensure they use car weight.

This evidence review does not recommend:

Intervention	
2.6.13	Guard rails, crash cushions, and interventions to reduce vehicle speeds.

	Evidence grade
taff, police and local highways authorities to promote changes to the road	A
nvolve physical activity are given priority when developing or maintaining ccess; introducing traffic-calming; creating safe routes to schools;	A A
asures to reduce speed as part of a broad strategy to prevent injuries and	A B
r injuries units to prevent unintentional injuries among the under-15s.	B
mmunity mobilization to reduce alcohol-related crashes.	B
lcohol impaired driving and alcohol-related crashes.	B
hs, cycle tracks at roundabouts) to reduce the risk of crashes and injuries.	A
of 15.	B B
t to improve detection and recognition for cyclists and walkers.	B B
o young and older children.	A
seats or booster seats appropriate to the child's age and height and	B

	Evidence grade
	B

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East Sussex County Council
County Hall
St Anne's Crescent
Lewes BN7 1UE
Phone: 0345 60 80 190
Fax: 01273 481261
Website: eastsussex.gov.uk/contactus

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