Self-harm: An analysis of hospital admissions in 10-24 year olds in Northamptonshire, 2012 to 2017

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Northamptonshire County Council
Introduction

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of motivation or suicidal intent. (1) Self-harm is a major public health challenge not just due to the longer term psychological and physical impact of self-harm but also the association between self-harm and suicide. (2) (3) (4) Although most self-harm is not fatal it highlights signs of emotional distress and can be a sign of increased risk of suicide and prevalence peaks in adolescence. (5)

Estimating self-harm prevalence can be difficult as the behaviour can often be private. (6) Suicide and self-harm presenting to hospital and clinical settings are seen as overt and increasingly becoming more common. (2) The largely hidden aspect is self-harm occurring in the community. Establishing incidence at all levels is important to understand the problem locally, the three levels are referred to as the iceberg model, as shown in figure 1. This analysis focuses on the second level and self-harm presenting to hospitals in adolescence, where also an increased risk of suicide has been attributed. (2) Survey data estimates of self-harm vary greatly, from 6 to 20%. (6) The local 2017/18 Northamptonshire’s Young People’s Health and Wellbeing Survey found nearly a third (29%) of young people in secondary school were concerned about their mental health and nearly one in five (18%) reported self-harm as a way of dealing with worries. (7)

The assessment and treatment of people who self-harm uses a substantial amount of NHS resources. Most of this direct cost is accounted for by A&E attendances and emergency admissions, also with repeated attendance self-harm represents a considerable economic burden to the individual, family, health services and society as a whole. Interventions such as those in schools can be cost-effective, the mental health Return on Investment (ROI) tool has shown on a national level for every £1 invested for the KiVa bullying intervention a return of £1.58 is expected and for every £1 spent on school-based resilience programmes £5.08 is expected to be returned. (8)

Adolescence is a life stage where change is possible, the fastest changing after infancy and therefore an important life stage for intervention with huge potential for development of new skills and capabilities such as resilience. It is an important time to intervene to reduce the risk of suicide and to ensure early intervention is implemented following an episode of self-harm. (9)
Analysis

To understand the data in more detail an in depth analysis was conducted to identify any patterns in admissions for 10 to 24 year olds over the last 5 years, looking at patient characteristics and time trends.

Datasets used were Child and Maternal Health Profile and Hospital Episode Statistics, access granted via NCC public health data access agreement with NHS Digital through the HES Data Interrogation Service (HDIS).

The HES analysis for this report will focus on inpatient admissions and follow the same definition as the outcome indicator in the PHE profiles. “2.10ii - Emergency Hospital Admissions for Intentional Self-Harm”: (4) When self-harm is referred to in this report it is referring to intentional self-harm in those aged 10-24 years.

“The number of first finished emergency admission episodes in patients (episode number = 1, admission method starts with 2), with a recording of self-harm by cause code (ICD10 X60-X84) in financial year in which episode ended. Regular and day attenders to be excluded. “(4)

The following section provides a summary of the analysis covering:
- Age and gender differences
- Deprivation
- Diagnosis
- Length of Stay (LOS)
- Geographic differences
Hospital admissions as a result of self-harm: Trends and comparators

Source: Child and Maternal Health Profile (PHE)

10 to 14 years

15 to 19 years

20 to 24 years

Area | Value | Area | Value | Area | Value
--- | --- | --- | --- | --- | ---
England | 211.6 | England | 619.9 | England | 393.2
Warwickshire | 353.2 | Northamptonshire | 1,158 | Swindon | 711.5
Northamptonshire | 352.2 | Warwickshire | 1,110 | Northamptonshire | 700.4
Lancashire | 327.1 | Warwickshire | 791 | Derbyshire | 580.7
Nottinghamshire | 262.8 | Warwickshire | 727 | Staffordshire | 433.0
Swindon | 258.4 | Derbyshire | 706 | Kent | 427.4
Worcestershire | 222.3 | Worcestershire | 601 | Berkshire | 400.3
Derbyshire | 210.7 | Lancashire | 568 | Berkshire | 399.2
Medway | 174.7 | Notinghamshire | 568 | Berkshire | 375.6
Staffordshire | 165.9 | Worcesterhire | 585 | Berkshire | 349.3
Kent | 116.4 | Gloucestershire | 571 | Berkshire | 340.1
Essex | 85.9 | Medway | 565 | Berkshire | 277.9

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**Age and Gender**

Differences between the genders significantly decreases with age, 86% of admissions are female in 10-14 year age group compared to 65% in the 20-24 year old age group.

There are significantly increasing rates in all age groups and both genders with widening inequalities with England.

**Geographical Breakdown**

Highest number and rate of admissions for self-harm are in Northampton district across 19 wards (see map).

Over the last 5 years the largest absolute increase seen in Northampton and the largest relative increases seen in Daventry, East Northants and Wellingborough.

Majority of districts follow the same pattern as the county average with higher rates in those aged 15-19 years, Northampton and Daventry with the highest rates.

The highest rates in Corby are in those aged 20-24 years. Along with Northampton, this is significantly higher than the county average.

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Hospital admissions as a result of self-harm (10-24 years), 2012/13 to 2016/17

* Time period for GP rates are 2014/15 to 2016/17

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Hospital admissions as a result of self-harm (10 to 24 years), 2012/13 to 2016/17 - wards are identified where areas have significantly higher rates.

**Corby**

*Kingswood and Hazel Leys ward*

**East Northamptonshire**

*Raunds Windmill, Raunds Saxon, Irthlingborough Waterloo and Irthlingborough John Pyel wards*

*Time period for GP rates are 2014/15 to 2016/17*
Hospital admissions as a result of self-harm (10 to 24 years), 2012/13 to 2016/17 - wards are identified where areas have significantly higher rates.

- Kettering
  - St Michaels and Wicksteed
  - Avondale Grange
  - Parts of William Knibb and All Saints wards

- Wellingborough
  - Queensway ward

**Key**
- Hospital sites
- Self harm - rate per 100,000 pop
  - 160 - 365
  - 355 - 467
  - 467 - 616
  - 616 - 773
  - 773 - 1429

**GP self-harm - significant difference to average**
- Higher
- Not significantly different
- Lower

*Time period for GP rates are 2014/15 to 2016/17*

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Analysis for Northamptonshire County Council.
Hospital admissions as a result of self–harm (10 to 24 years), 2012/13 to 2016/17 - wards are identified where areas have significantly higher rates.

**Daventry**

Abbey North and Abbey South and parts of Drayton wards.

**South Northamptonshire**

- Harpole and Grange
- and Heyfords and Bugbrooke wards

* Time period for GP rates are 2014/15 to 2016/17

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Hospital admissions as a result of self–harm (10 to 24 years), 2012/13 to 2016/17 - wards are identified where areas have significantly higher rates.

Kings Heath, Old Dustan, Spencer, Trinity, Rushmills (Northern), Semilong, Kingsley, Phippsville, Headlands, Westone, Eastfield, Boothville (Southern, Northern is sig lower), Brookside, Talavera, Rectory Farm, St Davids, Abington, Castle, St James wards.

Keys:
- Hospital sites
- GP self-harm - significant difference to average
  - Higher
  - Not significantly different
  - Lower

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* Time period for GP rates are 2014/15 to 2016/17
The majority of admissions are due to the use of drugs, specifically nonopioid analgesics, antipyretics and antirheumatics (painkillers) which account for just over half (55%) of all drug admissions.

The diagnosis with the largest increase is ‘intentional self-harm with a sharp object’, more than doubling in the last 5 years.

Significantly higher rates of self-harm admissions in more deprived areas for all three age groups

Those living in the most deprived areas of the county are 3.9 times more likely to be admitted to hospital from self-harm than those in the least deprived areas. The highest inequality is seen in the 20-24 year old age group.

No overall difference between gender in terms of self-harm method, however within poisoning admissions girls are significantly more likely to use painkillers and boys significantly more likely to use prescription only medicines.

There is a significantly lower LOS for 20-24 year olds compared to the other two age groups.

Admissions of self-harm in 2012/13 to 2016/17 are significantly higher in the months January to June.
Prevention of self-harm requires both universal and targeted initiatives focussed on higher risk groups. This analysis allows for higher risk groups to be identified locally and highlights the marked differences geographically and by patient characteristics. The highest risk group for self-harm admissions are females aged 15-19 years, in line with national findings. However, the data and literature indicate a hidden and now emerging issue for self-harm in young males. It also identifies increasing admissions for self-injury alongside the high rates of admissions due to poisoning and high rates of inequality within the county. More research on local patterns is needed particularly in those areas identified with greater prevalence or where rates differ from the average pattern. For example, the high rates of self-harm in males aged 20-24 years in Corby and the shorter length of stay in those aged 20-24 years. This local analysis should be used alongside the literature of higher risk groups identified such as looked after children (also identified as a high risk group in local hospital audit in 2017), lesbian, gay, bisexual and transgender young people and those in the criminal justice system.

Due to the increased risk of suicide for those that are admitted for self-harm, it is an important time to intervene to reduce the risk of suicide and to ensure early intervention is implemented following an episode of self-harm. Mental health problems affect approximately one in ten children and about 70% of children and young people who have a mental health problem have not had sufficient intervention at an early age. These children face unequal chances in their lives, particularly where childhood mental health issues continue into adulthood.
Conclusions

Self-harm is not always linked with mental health problems and the reasons and causes behind self-harm are varied. Self-harm and suicide in adolescents is the end product of a complicated interplay between biological, psychiatric, psychological, social and cultural factors combined with exposure to negative life events including both early and recent adversity and psychiatric disorders. This highlights the complexities in delivering services to young people for self-harm and the important role of working with families and schools to build resilience and help seeking behaviours. It is important young people and their families are involved in the planning and monitoring of services and a number of themes have been identified by the Royal College of Psychiatrists as a priority, such as improving self-esteem, developing coping strategies and increasing knowledge of mental health problems, improving support in schools, targeting resilience, problem solving and help seeking as important skills for young people to develop.

This analysis covers those cases of self-harm that have presented at hospital, and does not include those in the community. Further local research and analysis of community data is recommended to provide a more complete picture of prevalence locally. However, hospital admissions as a result of self-harm is an important outcome measure, particularly in relation to suicide prevention with the links between admissions and increased risk of suicide.

This is an important life stage, good mental health is the foundation of healthy development and problems in childhood can have lasting effects. Population changes will only come about if prevention and treatment are made a public health priority.
References


Appendix A: ICD10 Codes for Self-Harm:

- X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
- X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
- X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
- X63 Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
- X64 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
- X65 Intentional self-poisoning by and exposure to alcohol
- X66 Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
- X67 Intentional self-poisoning by and exposure to other gases and vapours
- X68 Intentional self-poisoning by and exposure to pesticides
- X69 Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
- X70 Intentional self-harm by hanging, strangulation and suffocation
- X71 Intentional self-harm by drowning and submersion
- X72 Intentional self-harm by handgun discharge
- X73 Intentional self-harm by rifle, shotgun and larger firearm discharge
- X74 Intentional self-harm by other and unspecified firearm discharge
- X75 Intentional self-harm by explosive material
- X76 Intentional self-harm by smoke, fire and flames
- X77 Intentional self-harm by steam, hot vapours and hot objects
- X78 Intentional self-harm by sharp object
- X79 Intentional self-harm by blunt object
- X80 Intentional self-harm by jumping from a high place
- X81 Intentional self-harm by jumping or lying before moving object
- X82 Intentional self-harm by crashing of motor vehicle
- X83 Intentional self-harm by other specified means
- X84 Intentional self-harm by unspecified means
Supplementary tables

The follow section provides supplementary tables used for the main analysis.
## Age and Gender breakdown – 10 to 24 years

<table>
<thead>
<tr>
<th>2016/17</th>
<th>10-14 yrs</th>
<th>15-19 yrs</th>
<th>20-24 yrs</th>
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<tr>
<td>Total</td>
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### 10-24 years 2016/17

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### Age and Gender breakdown – 10 to 14 years

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### Age and Gender breakdown – 15 to 19 years

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### Age and Gender breakdown – 20 to 24 years

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NB: Numbers may not add up to totals due to rounding.
### District variation

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### 2014/15 to 2016/17

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### Year

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NB: Numbers may not add up to totals due to rounding.
## Deprivation – national deciles

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<th>Count</th>
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<td>15-19 years</td>
<td>1 and 2 (most deprived)</td>
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</tr>
<tr>
<td>20-24 years</td>
<td>1 and 2 (most deprived)</td>
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</tr>
<tr>
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<td>3-10</td>
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## Deprivation – county deciles

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<th>2016/17</th>
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</thead>
<tbody>
<tr>
<td>1 (most deprived)</td>
<td>90</td>
<td>180</td>
</tr>
<tr>
<td>2</td>
<td>95</td>
<td>140</td>
</tr>
<tr>
<td>3</td>
<td>65</td>
<td>110</td>
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<tr>
<td>4</td>
<td>45</td>
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<tr>
<td>5</td>
<td>55</td>
<td>85</td>
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<tr>
<td>6</td>
<td>30</td>
<td>55</td>
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<td>7</td>
<td>35</td>
<td>80</td>
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<tr>
<td>8</td>
<td>45</td>
<td>55</td>
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<tr>
<td>9</td>
<td>35</td>
<td>45</td>
</tr>
<tr>
<td>10 (least deprived)</td>
<td>25</td>
<td>60</td>
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</tbody>
</table>

## Grand Total

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation (National deciles)</td>
<td>520</td>
<td>910</td>
</tr>
<tr>
<td>3-10</td>
<td>330</td>
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<tr>
<td>1 and 2 (most deprived)</td>
<td>185</td>
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</tbody>
</table>

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NB: Numbers may not add up to totals due to rounding.
## Length of Stay and Diagnosis, 2016/17

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>320</td>
</tr>
<tr>
<td>nonopioid analgesics, antipyretics and antirheumatics</td>
<td>180</td>
</tr>
<tr>
<td>antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified</td>
<td>110</td>
</tr>
<tr>
<td>narcotics and psychodysleptics [hallucinogens], not elsewhere classified</td>
<td>35</td>
</tr>
<tr>
<td>Other drugs</td>
<td>35</td>
</tr>
<tr>
<td>Intentional self-harm by sharp object</td>
<td>70</td>
</tr>
<tr>
<td>Other specified and unspecified means</td>
<td>35</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>10-14 years</th>
<th>15-19 years</th>
<th>20-24 years</th>
<th>10-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted and discharged same day</td>
<td>Count</td>
<td>Count</td>
<td>Count</td>
<td>Count</td>
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<tr>
<td>65</td>
<td>230</td>
<td>160</td>
<td>460</td>
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<tr>
<td>1 day</td>
<td>60</td>
<td>180</td>
<td>90</td>
<td>330</td>
</tr>
<tr>
<td>2 days</td>
<td>15</td>
<td>40</td>
<td>15</td>
<td>70</td>
</tr>
<tr>
<td>3+</td>
<td>15</td>
<td>30</td>
<td>10</td>
<td>55</td>
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<tr>
<td>Grand Total</td>
<td>150</td>
<td>480</td>
<td>280</td>
<td>910</td>
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</table>

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>180</td>
<td>550</td>
</tr>
<tr>
<td>nonopioid analgesics, antipyretics and antirheumatics</td>
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<td>320</td>
</tr>
<tr>
<td>antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified</td>
<td>60</td>
<td>135</td>
</tr>
<tr>
<td>narcotics and psychodysleptics [hallucinogens], not elsewhere classified</td>
<td>25</td>
<td>45</td>
</tr>
<tr>
<td>Other drugs</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Intentional self-harm by sharp object</td>
<td>25</td>
<td>80</td>
</tr>
<tr>
<td>Other specified and unspecified means</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2012/13</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
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<td>760</td>
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<td>400</td>
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<tr>
<td>antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified</td>
<td>105</td>
<td>195</td>
</tr>
<tr>
<td>narcotics and psychodyssleptics [hallucinogens], not elsewhere classified</td>
<td>40</td>
<td>70</td>
</tr>
<tr>
<td>Other drugs</td>
<td>60</td>
<td>95</td>
</tr>
<tr>
<td>Sharp object</td>
<td>40</td>
<td>110</td>
</tr>
<tr>
<td>Contribution to all admissions</td>
<td>40</td>
<td>110</td>
</tr>
<tr>
<td>Other specified means e.g. motor crash, drowning, electrocution</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Other unspecified means</td>
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<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>520</td>
<td>910</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnoses (zero length of stay) 2016/17</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>370</td>
</tr>
<tr>
<td>nonopioid analgesics, antipyretics and antirheumatics</td>
<td>180</td>
</tr>
<tr>
<td>antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified</td>
<td>110</td>
</tr>
<tr>
<td>narcotics and psychodyssleptics [hallucinogens], not elsewhere classified</td>
<td>35</td>
</tr>
<tr>
<td>Other drugs</td>
<td>50</td>
</tr>
<tr>
<td>Intentional self-harm by sharp object</td>
<td>70</td>
</tr>
<tr>
<td>Other specified and unspecified means</td>
<td>20</td>
</tr>
</tbody>
</table>

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## Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Grand Total</th>
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<tr>
<td>NORTHAMPTON GENERAL HOSPITAL NHS TRUST</td>
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<tr>
<td>KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST</td>
<td>270</td>
<td>260</td>
<td>350</td>
<td>880</td>
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<tr>
<td>Other</td>
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<td>115</td>
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<td>160</td>
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### Month of admission

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<tbody>
<tr>
<td>April – June ‘16</td>
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<td>200</td>
<td>185</td>
<td>165</td>
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<td>July – September ‘16</td>
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<td>October – December ‘16</td>
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<td>January – March ‘17</td>
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<td>215</td>
<td>150</td>
<td>120</td>
<td>200</td>
</tr>
</tbody>
</table>

*provisional data

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