A Report on Childhood Injuries in North Yorkshire:

Scale of the issue, evidence base and priorities for action

Report produced by the Public Health Team
2016
Executive Summary

The purpose of the paper is to identify the scale and nature of injuries in children and young people aged between 0 and 24 years old in North Yorkshire. The thematic analysis of “Young and Yorkshire, A Healthy Start to Life 2015” identified injuries in children as an area of concern in North Yorkshire. This report builds on this by providing more detailed analysis of the data, describes evidence-based interventions and programmes of work already in place and highlights key areas for action that will help reduce injuries in children and young people across North Yorkshire.

Nationally, injuries are the leading cause of death among children and young people aged between 1-14 years. The majority of the injuries in children under five occur in the home, whereas road traffic collisions play a more important role in older children and young people. Besides the obvious physical burden (which can be both short and long-term), there are considerable social and economic costs associated with unintentional injuries, including on-going care costs and potential loss of earnings.

The report covers injuries which have resulted in a hospital admission. The indicator used to measure performance is taken from the Public Health Outcomes Framework. Injuries related to road collisions specifically are not discussed in this report as they are a separate indicator and work is being carried out under the 95 Alive Partnership and a new road safety strategy is due for publication in September 2016.

Local picture

The data for North Yorkshire suggests that childhood injuries are an area of particular concern. Many of these injuries are preventable.

In the North Yorkshire Child Health Profile (June 2015), hospital admissions caused by injuries in children (0-14 years) was one of only two areas in which North Yorkshire performed significantly worse than the England average. The Public Health Outcomes Framework (PHOF) confirms this for both the 0-14 year olds and 0-4 year olds categories, with the North Yorkshire figures for 2013-14 at 126.5 per 10,000 in 0-14 year olds and 162.5 per 10,000 in 0-4 year olds (112.2 and 140.8 nationally).

The profile presented in this report provides an overview rather than the complete picture of injuries in North Yorkshire. For a complete analysis to be done, comprehensive data from other sources would be required (including walk in centres, minor injuries units, ambulance call out reports, RIDDOR, fire and rescue reports etc.). It should also be noted that the data is only as accurate as the coding. It is recognised that injuries are not always coded accurately, thus it should be recognised that the data provides a very useful insight, yet may have some limitations.

The chart below provides a summary of the high level findings of this report.
Unintentional & Deliberate Injuries in Children & Young People

North Yorkshire - How do we compare?

Source: PHE, 2014/15

- **Children Aged 0-4**
  - North Yorkshire: 164.3
  - England: 137.5
  - CIFFA Neighbour (York): 188.5

- **Children Aged 0-14**
  - North Yorkshire: 192.8
  - England: 199.6
  - CIFFA Neighbour (York): 275.3

- **Young People Aged 15-24**
  - North Yorkshire: 142.9
  - England: 131.7
  - CIFFA Neighbour (York): 99.9

**Unintentional & Deliberate Injuries by District 2014/15 (Source: PHE)**

In 2014/15 there were over 2000 hospital admissions of children & young people because of unintentional or deliberate injury:

- **0-4 Age Group:** 506 admissions
- **0-14 Age Group:** 1142 admissions
- **15-24 Age Group:** 919 admissions

**Most Common Reasons for Admission in Children & Young People Aged 0-24 (Primary Diagnosis)**

Source: S1S data, 2014/15

- **Fractures:** 25% of admissions
  - 28% in 0-14 Age Group
- **Poisoning:** 22% of admissions
  - 40% in 15-24 Age Group
- **Open Wound:** 14% of admissions
  - 26% in 0-4 Age Group
- **Head Injury:** 13% of admissions
  - 31% in 0-4 Age Group
- **Other causes:** 26% of admissions

**Cost of Unintentional & Deliberate Injuries in Children & Young People**

- **£3m** Total cost of inpatient admissions: £3,026,101 in 2013/14
- **£1325** Average cost per inpatient admission: £1325 in 2013/14

**What would "Average" look like?**

- 10% reduction in admissions
- 220 fewer hospital admissions
- £300k saving in acute care services
UNINTENTIONAL & DELIBERATE INJURIES IN CHILDREN & YOUNG PEOPLE
IS IT JUST THE TIP OF THE ICEBERG?

Across North Yorkshire in 2014/15 there were:

2,000 Hospital Admissions

Approximately 41,000 Attendances at Accident & Emergency

Outpatients?

Primary Care

Non-presenting Morbidity

For every hospital admission there are around 20 attendances at Accident & Emergency

We don’t know how many attendances at primary care settings

We don’t know what else is under the surface
Key areas for action:
Based on local data and evidence based guidance from NICE and Public Health England it is suggested that the main areas that should be prioritised to reduce injuries amongst children and Young People in North Yorkshire are:

1. Develop local multiagency injury prevention action plans to be led and delivered by Children’s Safeguarding and Strategy Groups (CSSGs) reporting to Children’s Trust Board.

   Local action plans should fulfil the following:
   - Identify households at greater risk of unintentional injuries in the home through collaboration between local agencies.
   - Clearly identify how households at greatest risk will be identified and supported to reduce their risk.
   - Help identify gaps in the local provision of measures to reduce unintentional injuries, and suggest ways of addressing these gaps.
   - Address the three key priorities as highlighted in the report concerning children under 5 years old, road safety and reducing inequalities.
   - Joint communications should be considered in injury prevention plans to ensure consistent evidence based messages are given to families.
   - Use NICE guidance and the Public Health Outcomes Framework to monitor the progress of the action plan.

2. Ensure support and training is available for the early years workforce to enable it to strengthen its central role in helping to reduce unintentional injuries.

   The 0-5 healthy child service and other early years providers such as children’s centres and private nurseries have a central role in injury prevention. Ensuring that these services are confident and competent in injury prevention is essential.

3. Prioritise action on under 5s ensuring there are locally based evidence programmes across all the five main kinds of injury for children under 5 years old.

   Unintentional injuries in and around the home are a leading cause of preventable death for children under five years and are a major cause of ill health and serious disability. The five key causes of unintentional injuries to prioritise in the under-fives are; falls, poisoning, choking/suffocation/strangulation, burns/scalds and drowning, all of which predominantly happen in the home.

4. Explore the feasibility of commissioning a home safety service.

   A home safety service should be commissioned in order to provide households at greater risk with a structured home safety assessment that is tailored to their needs. Joint commissioning should be considered.

5. Maximise opportunities to integrate home safety in to other visits.

   Households with children and young people aged under 15 years should receive advice on home safety or be referred for a structured home safety assessment by practitioners providing family support on home visits who identify risks of unintentional injury.
6. Implement and evaluate multiagency pathways to ensure that where families are at increased risk of injury appropriate action is taken across agencies. Developing a pathway that brings together multiple agencies to work collaboratively to deliver evidenced based interventions would ensure a systematic and coordinated approach that helps families reduce the risk of injury.

7. Improve data collection from a wider range of sources to help understand variations in rates.
Triangulation of data from a wider range of sources would enable a closer look at unintentional injuries and would be useful to measure improvements. Looking at data across a CCG footprint as well as local authority footprints would be useful when looking at hospital data.

There are significant geographical inequalities between wards and districts across the County. Further investigation needs to be done to understand the reasons for these inequalities, particularly around Richmondshire and Hambleton and wards within Harrogate.

8. Further analysis of data on 15-24 year olds is required to look at the relationship with self-harm, suicide and emotional and mental health.
Poisoning is a key issue for this age group, with paracetemol poisoning being a significant issue. A number of Health and Well Being board strategies, such as the North Yorkshire’s Mental Health Strategy, the North Yorkshire Alcohol Strategy, and work on Future in Mind, will contribute to making improvements on this indicator. However, further work to understand the reason for below national average performance in this area and ensuring coordinated action is needed. A review of the effectiveness self-harm pathway is also needed.

9. The Children’s Trust Board and other children’s strategic boards could sharpen their focus on the rate of Children Killed and Seriously Injured in road traffic accidents.
Although road traffic collisions and accidents is beyond the scope of this report it is recognised that road safety has a large role in injury prevention. North Yorkshire performs worse than the national average in the PHOF indicator around the killed and seriously injured (KSI) rates on the roads.

The Children’s Trust Board (CTB) could seek assurance from partners who deliver road safety interventions on progress against this indicator as well as support improved connectivity between those who work on road safety and children’s health.
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1. Purpose

The purpose of the paper is to identify the scale and nature of unintentional injuries in children and young people aged between 0 and 24 years old in North Yorkshire. The thematic analysis of Young and Yorkshire 2015 identified injuries in children as an area of concern in North Yorkshire. This report builds on this by providing more detailed analysis of the data, describes evidence-based interventions and highlights key areas for action that will help reduce unintentional injuries in children and young people across North Yorkshire.

The report covers injuries which have resulted in a hospital admission. The indicator used to measure performance is taken from the Public Health Outcomes Framework. Injuries related to road collisions specifically are not discussed in this report as they are a separate indicator and work is being carried out under the 95 Alive Partnership and a new road safety strategy is due for publication in September 2016.

1.1 Definitions

The paper report uses the term injury to cover unintentional and deliberate injuries. An unintentional injury can be defined as ‘an injury occurring as a result of an unexpected event which occurs at a specific time from an external cause’.  

The term ‘unintentional injuries’ is used rather than ‘accidents’ as the latter suggests that these events are inevitable and unpredictable, and therefore unavoidable. However, recent evidence suggests that “most injuries and their precipitating events are predictable and avoidable”, which has led to the change in preferred terminology”.

Unintentional and deliberate injuries are categorised as one in the Public Health Outcomes Framework (PHOF) as it can be difficult to clearly state whether the injury was unintentional or deliberate.

Unintentional injuries are looked at by age group: children under five years old, children and young people under 15 and young people aged between 15-24 years old.

The term ‘vulnerable’ is used to refer to children and young people who are at greater than average risk of an unintentional injury due to one or more factors. As an example, they may be more vulnerable if they:

- are under the age of 5 years (generally, under-5s are more vulnerable to unintentional injuries in the home)
- are over the age of 11 (generally, over-11s are more vulnerable to unintentional injuries on the road)
- have a disability or impairment (physical or learning)
- are from some minority ethnic groups
- live with a family on a low income
- live in accommodation which potentially puts them more at risk (this could include multiple occupied housing and social and privately rented housing)
2. Background

Unintentional injuries are the leading cause of death among children and young people aged between 1-14 years; many of these, as noted above, are preventable. Although the number of deaths from unintentional injuries is falling, injury rates are still significant: in England in 2009-10, around 100,000 children and young people under 15 years were admitted to hospital as a result of unintentional injuries. The locations of particular concern for unintentional injuries are:

1. In and around the home
2. On the roads

This has been recognised in the 2010 NICE guidance on unintentional injuries, with targeted guidance produced in these two areas.

In the UK, the majority of fatal and non-fatal medically-attended injuries in children under 5 occur in the home. Even in older children, for whom road traffic accidents cause the most fatal injuries, significant proportions of unintentional injuries occur in and around the home (40% in 5-9 year olds and 25% in 10-14 year olds). Children and young children are vulnerable to a range of unintentional injuries in the home, including falls, burns and scalds, drowning, suffocation and poisoning. These injuries have different injury profiles; some are often fatal, such as choking and strangulation and drowning. Others, such as burns and scalds, can result in hospitalisation and serious long-term acquired disability, but rarely lead to death. The most common cause of hospitalisation for unintentional injuries in 0-14 year olds is falls, accounting for 45% of hospital episodes.

Unintentional injuries can also have long-term effects on health and wellbeing, causing stress, physical disability, cognitive or social impairment, and lower educational attainment and employment prospects. They may also require lengthy medical treatment, both initially and through follow up over many years.

3. Evidence base and Strategies

3.1 National Guidance

Many evidence reviews have been carried out analysing the efficacy of methods of preventing unintentional injuries in children and young people. This has been done on both a national and international scale. NICE has also set out guidance on methods of tackling unintentional injuries based on appropriate, evidence-based interventions in 'Strategies to prevent unintentional injuries among the under-15s' (2010). It sets out guidance for commissioners and health service providers on strategies, regulation, enforcement, surveillance and workforce development in relation to preventing unintentional injuries in the home, on the road and during outdoor play and leisure. The recommendations are divided into six categories: general, workforce training and capacity building, injury surveillance, home safety, outdoor play and leisure, and road safety.

3.1.2 NICE Guidelines

In 2010, NICE published three sets of guidelines around unintentional injuries in under-15s.

- Strategies to prevent unintentional injuries among children & young people aged under 15 [PH29]
• Preventing unintentional injuries in the home among children & young people aged under 15: home safety assessments & providing safety equipment [PH30]
• Preventing unintentional injuries among under-15’s: road design & modification [PH31]
• Preventing unintentional injuries among under-15’s. Quality Standard (QS107)

General recommendations:
1. Incorporating unintentional injury prevention within local and national plans and strategies
   a. Particularly targeting vulnerable children to reduce health inequalities
   b. Support collaborative working (local partnerships, cross-departmental/cross-agency working)
   c. Ensure plans exist for how partners will collaborate
   d. Support data collection on incidence, severity, type, cause and place of injury
   e. Support monitoring of outcomes of injury prevention initiatives
   f. Support development of workforce capacity (staff training etc.)
2. Coordinating unintentional injury prevention activities
   a. Ensure there is a children and young people injury prevention coordinator who:
      i. Develops a 2-3 year prevention strategy
      ii. Networks at regional and national level
      iii. Raises local awareness
      iv. Monitors progress made
   b. Ensure coordinator is has the right skills/training
3. Identify and respond to attendances at emergency departments and minor injuries units
   a. Staff to provide injury prevention advice
   b. Local protocols (e.g. for children with repeat attendances for unintentional injuries, or single cases raising concerns)

Recommendations for workforce training/capacity building
4. Developing professional standards for injury prevention [National recommendation – Faculty of Public Health etc.]
5. Funding [National – Department of Health /Department for Education]
6. Provide wider childcare workforce with access to injury prevention training

Recommendations for injury surveillance
7. Establishing a national injuries surveillance resource
   a. Ensure this includes local, regional and national injury datasets, including data from: emergency departments, walk-in centres, minor injuries units, Reporting of Injuries, RIDDOR, HES, coroner reports, ambulance call-out reports, fire & rescue reports, road casualty statistics
   b. [National level – ensure integration of datasets, collate/manage/analyse data etc.]
8. Gathering high quality injury data from emergency departments

Recommendations for home safety
9. Installation and maintenance of permanent safety equipment in social and rented dwellings
   a. Consider developing local agreements with housing associations/landlords including appropriate smoke alarms, thermostatic mixer valves for baths, window restrictors, CO alarms
   b. Publicise local agreements

10. Incorporate guidance on home safety assessments within relevant national initiatives [National intervention]

11. Incorporate home safety assessments and equipment provision within local plans and strategies for children and young people’s health and wellbeing
   a. Ensure this is incorporated into local plans, aimed at families with children under five or vulnerable
   b. Commission local agencies to offer assessments and, where appropriate, supply and install equipment
      i. Ensure tailored to meet household’s needs
      ii. Address water risks (baths, ponds)

Recommendations for outdoor play and leisure

12. Developing policies for public outdoor play and leisure
   a. Ensure risk/benefit policy to play environments and activities
   b. Counters excessive risk aversion
   c. Promotes skill for children and young people to manage own risks
   d. Takes into account children and young people’s preferred types of play
   e. Use local data to plan prevention initiatives
      i. Include info from children and young people, their parents and carers

13. Providing education and advice on water safety
   a. Know which groups are at higher risk (boys, older children, some medical conditions)
   b. Provide children and young people, parents etc. with water safety information
      i. Especially during holiday season around heat waves, extreme cold etc.
   c. Encourage children and young people, and parents, to be competent swimmers
   d. Ensure swimming lessons include water safety info

14. Water safety advice for leisure providers
   a. Use risk analysis to identify where there is a risk of drowning. Minimise risk without discouraging swimming.
   b. Provide water safety information (ensure timely; especially holiday season, extreme weather conditions)

15. Advising on off-road cycle safety
   a. Local info campaigns/on-going education to encourage cycle training, promote use of properly fitted helmets
   b. Cycle training in conjunction with schools
   c. Retailers ensure advice on correctly fitting helmets and advantages of wearing them; possibly through certified schemes

16. Conducting local firework safety campaigns
   a. Use emergency department data to inform campaigns
   b. Timely (i.e. festivals – Bonfire Night, New Year’s Eve, Diwali)
   c. Trading standards to ensure adults given firework safety code when buying
Healthy Child Programme
- The first five years of life (2009)
  - Provides advice and information on safety, safety equipment and preventing accidents
- From 5 to 19 years (2009)
  - Recommends accident and injury prevention (including on roads) as part of age-appropriate PSHE

Marmot Review

3.2 Supporting Local Policies and Strategies

Joint Strategic Needs Assessment
The North Yorkshire JSNA 2012 prioritises ‘Keeping children safe and protected from harm’. There is also a focus on road traffic collisions, with particular emphasis on targeting young drivers and road safety around schools.

Young and Yorkshire
Young and Yorkshire (North Yorkshire Children and Young People’s Plan 2014-2017) is committed to improving safety outcomes for all children and young people in North Yorkshire. One of its aims, under ‘Children feel safe and are safe’, targets decreasing hospital admissions caused by unintentional and deliberate injuries to children under 15yrs from 111.2 per 100,000 in 2014 to 100.4 per 100,000 by 2017.12

Children and Young People’s Emotional and Mental Health Strategy 2014-17
This strategy recognises the importance of strengthening protective factors which promote childhood resilience across a child’s physical and emotional attributes, family life and the environment in which the child lives. However, the strategy also acknowledges that the impact of poor mental health or lack of self-esteem can be destructive to young lives and hinder a child’s ability to fulfil their potential. The six outcome measures are as follows:
1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

CAMHS transformation plans - local delivery of Future in Mind
Work includes building capacity and capability within the children’s workforce to identify and intervene early alongside improvement of specialist mental health services.

“Hope Control and Choice” North Yorkshire’s Mental Health Strategy 2015-20
The strategy, called 'Hope, Control and Choice', sets out a new vision and new priorities for mental health services as well as a series of commitments for the next five years.

'Hope, Control and Choice' sets out a series of commitments under three priorities - building resilience, being responsive and reaching out to users and partners. Commitments include:

- Public health awareness-raising campaigns to tackle stigma and discrimination
- Working through the county council’s stronger communities programme to introduce a range of local wellbeing initiatives
- New programmes to promote good mental health from birth onwards to help children and young people stay strong
- Working with employers to promote good mental health in the workplace
- Improving access to "talking therapies" in North Yorkshire
- Timely diagnosis of dementia and the introduction of dementia-friendly communities across North Yorkshire
- Working in new ways in both health and social care to take into account the full range of people's needs, including their physical health
- Bring together annually North Yorkshire mental health champions to share best practice and to offer challenge

Delivering these commitments will have a knock-on effect on injury prevention, especially the injuries that may be related to self-harm.

The North Yorkshire Joint Alcohol Strategy has 3 outcome areas:
- Establish responsible and sensible drinking as the norm
- Identify and support those who need help into treatment through recovery
- Reduce alcohol related crime and disorder

Achieving the outcomes of the strategy will positively contribute to the reduction of injuries in children as a number of injuries are alcohol related, particularly in the 15-24 age category.

4. High Risk and Vulnerable Groups

4.1 Low socio-economic groups
There are notable inequalities between different socioeconomic groups in terms of unintentional injuries. Groups with higher levels of deprivation experience a higher rate of injuries, particularly injuries of a higher severity.\(^1\) This has been shown to be particularly the case for pedestrian injuries, burns and scalds and poisonings.\(^2\) Further, specific indicators have been found for children at risk:\(^3\)

- Children from single parent and step parent families
- Those in larger families, especially where there are more older and fewer younger siblings
- Families with lower levels of (usually maternal) education
- Children and young people from lower socioeconomic groups whose parents have never worked (or who are long-term unemployed)
13 times more likely to die from such an injury than those whose parents are managers and professionals\(^{16}\)

4.2 **Under 5s**
Hospital Episode Statistics (HES) data shows that there are roughly twice as many hospital admissions per year for the under-fives as there are for any other (five-year) age group under 25.\(^{17}\) Most of these injuries occur in the home, and are linked to a number of factors including child development, the physical environment in the home, the knowledge and behaviour of parents/carer, the availability of safety equipment, overcrowding and homelessness.

Children under five suffer a disproportionate number of injuries from falls and burns. They account for nearly 45% of all severe burns and scalds, and 71% of childhood fatalities from fire.\(^{18}\)

4.3 **Gender**
A higher proportion of unintentional injuries occur among boys compared to girls. For example, more than three male children or young people die on the road for every female child or young person who dies.\(^{19}\) It is thought this may be due to an increased prevalence of risk-taking behaviour among boys.

4.4 **Disability and Impairment (physical and learning)**
Some physical and mental disabilities are also associated with an increased risk of unintentional injuries. For example, children with epilepsy are at increased risk of burns and submersion injuries. Children with ADHD are at greater risk of being struck by a car when they cross the street due to taking incorrect decisions about when to cross and how long it will take them to get to the other side.\(^{20}\)

4.5 **Ethnicity**
Recent studies have provided conflicting evidence regarding ethnicity and unintentional injury rates. This sometimes depends upon the type of injury: for example, some studies have suggested that Asian children are at higher risk of pedestrian injury than other children, whereas other studies have suggested that South Asian children have lower numbers of hospital admissions for unintentional injuries overall.\(^{21}\)

5. **Understanding the local picture**

5.1 **Data sources and indicators**
This profile applies to children and young people (0-24 years) living within the boundaries of North Yorkshire County Council. In 2014 there were 165,657 children and young people living within North Yorkshire.\(^{22}\)

This data focuses predominantly on hospital inpatient admissions. This is because:
- This is the most accessible data (through Hospital Episode Statistics and the Secondary Use Service (SUS))
- The PHOF outcome relates specifically to hospital inpatient admissions for unintentional injuries
- It maintains the focus on serious unintentional injuries, which have the worst outcomes in terms of disability and death, and should therefore be prioritised as a target
However, this does mean that this profile presents an overview rather than the complete picture of unintentional injuries in North Yorkshire. For a complete analysis to be done, comprehensive data from other sources will be required (including walk in centres, minor injuries units, ambulance call out reports, RIDDOR, fire and rescue reports etc.). It should also be noted that the data is only as accurate as the coding. It is recognised that injuries are not always coded accurately, thus it should be recognised that the data provides a very useful insight, yet may have some limitations.

It should be noted that the SUS data analysed did not include data from the Airedale, Wharfedale and Craven CCG area. This is because the data was provided by the Yorkshire & Humber Commissioning Support Unit and the Airedale, Wharfedale and Craven CCG is supported by the North West Commissioning Support Unit. Consequently, analysis of 2014/15 district data and ward data does not include the Craven district.

### 5.2 North Yorkshire performance in comparison with national performance and comparator authorities

In the North Yorkshire Child Health Profile (June 2015), hospital admissions caused by injuries in children (0-14 years) was one of only two areas in which North Yorkshire performed **significantly worse** than the England average.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NY no.</th>
<th>NY rate</th>
<th>England rate</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dtap / IPV / Hib vaccination (2 years)</td>
<td>5,826</td>
<td>95.8</td>
<td>96.1</td>
<td>Worse</td>
</tr>
<tr>
<td>Children killed/seriously injured in road traffic accidents</td>
<td>23</td>
<td>22.6</td>
<td>19.1</td>
<td>Worse</td>
</tr>
<tr>
<td>Low birth-weight of all babies</td>
<td>423</td>
<td>7.6</td>
<td>7.4</td>
<td>Worse</td>
</tr>
<tr>
<td>Smoking status at time of delivery</td>
<td>703</td>
<td>12.9</td>
<td>12.0</td>
<td>Sig. worse</td>
</tr>
<tr>
<td>Hospital admissions for injuries in children (0-14)</td>
<td>1,210</td>
<td>126.5</td>
<td>112.2</td>
<td>Sig. worse</td>
</tr>
<tr>
<td>Hospital admissions for injuries in young people (15-24)</td>
<td>949</td>
<td>143.0</td>
<td>136.7</td>
<td>Worse</td>
</tr>
</tbody>
</table>

**Six indicators in the PHE Child Health Profile (2015) with worse scores for NY than England**

Nationally, rates of unintentional injuries have dropped in 0-14 and 0-4 year olds. However, both of these rates have risen in North Yorkshire; between 2012/13 and 2013/14 there was a 15.3% increase in the number of injuries per
10,000 (aged 0-14). The North Yorkshire unintentional injuries rate has decreased in 15-24 year olds, although it still remains above the national average.

However, the diversity of communities and geography across the County mean that a simple comparison against a national measure does not always accurately reflect the contrast between the local and national picture. To try to frame the scale of unintentional injuries in children and young people in context, comparison has been made with similar local authorities identified by the Chartered Institute of Public Finance & Accounting (CIPFA). This enables comparison with 15 other authorities which share many of the characteristics of North Yorkshire.

The data highlights that in 2013/14 for children aged 0-4 years old the admission rate in North Yorkshire was above the similar authority average, although not significantly so, but towards the top of the range recorded across similar authorities. This is illustrated in the following chart.

Mirroring the 0-4 age group, the data highlights that for children aged 0-14, admission rates in North Yorkshire are comparable to those observed in several similar authorities, including Somerset, Warwickshire and East Sussex. The recorded rate in North Yorkshire remains towards the top of the range recorded across similar authorities, and was the second highest among the group of 16 authorities. This is illustrated in the following chart.
The picture is more positive when admission rates in the 15-24 age group. This highlights that the admission rate in North Yorkshire was much closer to the similar authority average in 2013/14 and was ranked 8th out of 16 authorities. This is illustrated in the following chart.

5.3 Most Common Reasons for Admission (Primary Diagnosis)
To identify the most common reasons for admissions for children in North Yorkshire SUS data was analysed.

The five most common reasons for admission in 2014/15 across the 0-24 age group were identified as:

1. Fracture - 25% of admissions
2. Poisoning - 22% of admissions
3. Open Wound - 14% of admissions
4. Head injury - 13% of admissions
5. External Causes - 3% of admissions

However, there was some variation across age groups:

0-4 Age Group - higher proportion of admissions as a result of head injuries (31%), open wounds (26%) and foreign bodies (11%), lower proportion of admissions as a result of poisoning (11%)

0-14 Age Group - higher proportion of admissions as a result of fractures (28%), lower proportion of admissions as a result of poisoning (8%)

15-24 Age Group - higher proportion of admissions as a result of poisoning (40%), lower proportion of admissions as a result of fractures (20%) and open wounds (10%)

Overall, the lower arm/wrist was the most common fracture site, and accounted for just over half of all recorded fractures (51%, 134 admissions).

Paracetamol was the most common substance identified in cases of poisoning, and accounted for 57% of admissions (170 admissions) where poisoning was identified as the primary diagnosis. Of the 170 paracetamol-related admissions, 90 (53%) involved a young person aged 15 to 19.

The following chart illustrates percentage of admissions by district in respect of the top 5 reasons for admission (based on primary diagnosis) in 2014/15. More detailed information at district level can be found in the district summaries at Appendix 1.

The chart illustrates that the proportion of admissions as a result fractures is highest in Ryedale, followed by Scarborough and lowest in Hambleton and Richmondshire. Head
injuries account for the highest proportion of admissions in Harrogate district whilst Scarborough district has the highest proportion of admissions as a result of poisoning.

5.4 Number of Admissions per Child/Young Person

Analysis has been undertaken to identify those children and young people who have experienced repeat admissions for unintentional and deliberate injuries. This has identified that 4.5% of children aged 0-4, 3.8% of children aged 0-14 and 8.8% of young people aged 15-24 were admitted more than once in 2014/15. This is similar to 2013/14 (3.6% of children aged 0-4, 4.7% of children aged 0-14, 10.7% of young people aged 15-24).

Further examination has been undertaken of those individuals who were admitted at least three times in a year. This identified two children aged 0-4, eight children aged 0-14 and 21 young people aged 15-24 who had been admitted on at least three occasions in either 2013/14 or 2014/15. Of the eight children aged 0-14, three were repeatedly admitted as a result of allergic reactions. However, there were a further two individuals (with a total of 11 admissions) as a result of poisoning incidents where there was a history of self-harm. Among the 21 young people aged 15-24 admitted on three or more occasions in a year, incidents of poisoning accounted for almost three-quarters of admissions (66 out of 90 admissions).

Examination at District level indicates that among young people aged 15-24 in both Hambleton and Richmondshire there may be a rising in trend in the proportion admitted on three or more occasions. This is illustrated in the following chart.

The chart illustrates that in Richmondshire the proportion of young people aged 15-24 admitted on 3 or more occasions in 2014/15 was more than double than that observed in 2013/14 and was higher than any other district. Further analysis will be undertaken when data for 2015/16 becomes available to try to ascertain if the emerging trends observed in Hambleton and Richmondshire have become embedded.
5.5 Geographical Variations by District
Across all three age groups there is considerable variation in the rate of admission at district level. This is illustrated in the following charts.

0-4 Age Group
Admissions rates were at their highest in 2012/13 and 2013/14 in Richmondshire. However, SUS data for 2014/15 highlights a dramatic reduction in the rate of admission, from 229 per 10,000 in 2013/14 to 160 per 10,000 in 2014/15. Conversely, admission rates in Ryedale rose from 109 per 10,000 in 2013/14 to 130 per 10,000 in 2014/15.

0-14 Age Group
Admissions rates were at their highest in 2012/13 and 2013/14 in Richmondshire. However, SUS data for 2014/15 highlights a dramatic reduction in the rate of admission, from 169 per 10,000 in 2013/14 to 105 per 10,000 in 2014/15. Similarly, the rate of admission for children from the Selby district has also shown marked reduction in comparison with the previous year. There has been a decrease in the rate of admission observed in 2014/15 in comparison with 2013/14 across all districts for which data was available.

15-24 Age Group
A reduction in the admission rate can be observed in 2014/15 across all districts for which data was available. Again, this reduction was largest in Richmondshire and Selby. In particular, the rate of admission in Richmondshire has fallen by half in comparison to 2013/14 (90 per 10,000 in 2014/15, compared to 181 per 10,000 in 2013/14). Admission rates in 2014/15 were highest in the Harrogate district, although still slightly below those observed in 2013/14.

5.6 Geographical variations by Ward
Analysis of data by ward highlights the wide range in rates of admission observed across the County, which varied from zero admissions in several wards to highs of 538 per 10,000 for children aged 0-4 years old, 365 per 10,000 for children aged 0-14 years old and 710 per
10,000 in young people aged 15-24 years old. Data at ward level was only available for 2013/14 and 2014/15, hampering identification of trends in the rate of admission of children and young people.

Additionally, because of the small populations involved (on average around 500 children aged 0-14 and 380 young people aged 15-24 per ward), a small change in the number of admissions can exert a considerable impact on the rate of admissions. For example, if the number of admission in a ward with an average population of 500 children changed from 8 in 2013/14 to 7 in 2014/15, the rate per 10,000 population would change from 160 to 140 per 10,000. The impact is amplified in some of the more rural, sparsely populated wards across the County – for example, the Thorntons ward recorded an increase in the rate of admission in the 0-14 age group of 72 per 10,000 population between 2013/14 and 2014/15. This increase equated to 2 additional hospital admissions.

Nevertheless the data highlights that in 2013/14 there were a number of wards where the rate of admission was significantly higher than the national average. The following charts illustrate the rate of admission by age group across these wards in 2013/14 and 2014/15. Some caution should be exercised when interpreting the data at ward level given the potential ranges in admission rates presented through the application of 95% confidence intervals. The charts also highlight that at ward level there can be considerable variation in the observed rate from year to year.

The chart above illustrates that in 2013/14 there were 9 wards where the admission rate in the 0-4 population was significantly higher than the national average, and of these 3 were in Richmondshire. Although the highest rates were observed in the Swaledale ward, it should be noted there were fewer than 5 actual admissions from this ward. The chart also illustrates the variability in admission rates at ward level between 2014/15 and 2013/14.
The chart above highlights the top 10 wards in terms of admission rates in the 0-14 population in 2014/15. 6 of the 10 wards are in Hambleton or Richmondshire. Rates in most of these wards rose in 2014/15 in comparison with 2013/14. Although the highest rate was recorded in the Dales ward (413 per 10,000) there were only 6 admissions. However, the Woodfield, Thirsk and Northallerton Central wards recorded both high rates of admission and higher numbers of admissions (between 21 and 24).

The chart above illustrates the top 10 wards in terms of admission rates in the 15-24 population. 4 of the wards are within Harrogate district and 3 are within Richmondshire district. The Hornby Castle ward recorded the highest rate of admission in 2014/15 (710 per 100,000) and related to 13 admissions. Although the Low Harrogate and Granby wards recorded lower rates of admission (319 and 315 per 10,000 respectively) there were a greater number of admissions from these two wards (20 and 22 respectively).

Across the 0-24 age group as a whole, the following 10 wards had the highest rate of admission in 2014/15.
<table>
<thead>
<tr>
<th>Ward</th>
<th>District</th>
<th>No. of Admissions</th>
<th>Rate</th>
<th>LCI</th>
<th>UCI</th>
<th>Significance (to average across all districts excl. Craven)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodfield</td>
<td>Harrogate</td>
<td>40</td>
<td>313.0</td>
<td>229.6</td>
<td>426.7</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Hornby Castle</td>
<td>Richmondshire</td>
<td>16</td>
<td>293.0</td>
<td>179.5</td>
<td>478.3</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Melsonby</td>
<td>Richmondshire</td>
<td>9</td>
<td>281.3</td>
<td>146.3</td>
<td>540.5</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Leeming Bar</td>
<td>Hambleton</td>
<td>12</td>
<td>263.2</td>
<td>149.4</td>
<td>463.4</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Thorntons</td>
<td>Hambleton</td>
<td>10</td>
<td>239.2</td>
<td>128.7</td>
<td>444.6</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Granby</td>
<td>Harrogate</td>
<td>46</td>
<td>235.5</td>
<td>176.4</td>
<td>314.5</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Richmond Central</td>
<td>Richmondshire</td>
<td>17</td>
<td>230.4</td>
<td>143.2</td>
<td>370.5</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Dales</td>
<td>Ryedale</td>
<td>7</td>
<td>226.5</td>
<td>108.0</td>
<td>475.2</td>
<td>Not Significantly Different</td>
</tr>
<tr>
<td>Low Harrogate</td>
<td>Harrogate</td>
<td>31</td>
<td>220.3</td>
<td>154.9</td>
<td>313.3</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>Thirsk</td>
<td>Hambleton</td>
<td>33</td>
<td>202.1</td>
<td>143.7</td>
<td>284.3</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

Analysis suggests that there is no strong correlation between the rate of unintentional and deliberate injury in children and young people and the level of deprivation in the community (as measured by 2015 IMD). This is illustrated in the following chart.

![Graph showing correlation between rate of unintentional & deliberate injuries in children and young people and level of deprivation in the community. The low r-squared value of 0.01 suggests there is no direct correlation between the two variables. Although this does not reflect trends observed nationally, there are a number of points to note:

- Relative to the national picture, an LSOA in North Yorkshire is typically less deprived than an “average” LSOA in England.](image.png)
- Only 6% of North Yorkshire LSOA are among the 20% most deprived LSOA in England
- Examination of the 50 LSOA in North Yorkshire with the highest crude rates of unintentional & deliberate injuries in children and young people highlights that only 12 (24%) are among the 40% most deprived LSOA
- The North Yorkshire sample size is relatively small and reflective of only a single year of data

The following series of maps highlights current hotspots by age group at ward level (based on data for 2014/15), including those wards where admission rates are significantly higher than the County average.

The maps illustrate that wards with a high rate of admission in one age group do not necessarily have a correspondingly high rate of admission in the other age group. For example, wards in rural Richmondshire typically have higher rates of admission in the 0-14 age group but this is not replicated in the 15-24 age group.

The map above highlights significantly higher rates of admission of children aged 0-4 in a number of wards across the County in both urban and rural areas, and in most districts summarised in the following table.

---

1 Based on data for all districts excluding Craven district
<table>
<thead>
<tr>
<th>District</th>
<th>Ward</th>
<th>Rate per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hambleton</td>
<td>Thorntons</td>
<td>394.7</td>
</tr>
<tr>
<td></td>
<td>Northallerton Central</td>
<td>348.8</td>
</tr>
<tr>
<td></td>
<td>Thirsk</td>
<td>259.4</td>
</tr>
<tr>
<td></td>
<td>Easingwold</td>
<td>173.9</td>
</tr>
<tr>
<td>Harrogate</td>
<td>Woodfield</td>
<td>329.3</td>
</tr>
<tr>
<td></td>
<td>Ouseburn</td>
<td>122.7</td>
</tr>
<tr>
<td>Richmondshire</td>
<td>Swaledale</td>
<td>1000.0</td>
</tr>
<tr>
<td></td>
<td>Richmond Central</td>
<td>217.4</td>
</tr>
<tr>
<td>Ryedale</td>
<td>Amotherby</td>
<td>434.8</td>
</tr>
<tr>
<td></td>
<td>Sinnington</td>
<td>405.4</td>
</tr>
<tr>
<td></td>
<td>Wolds</td>
<td>88.5</td>
</tr>
<tr>
<td>Selby</td>
<td>Sherburn in Elmet</td>
<td>241.5</td>
</tr>
</tbody>
</table>

The above map highlights 9 wards where the rate of admission is significantly higher than the County average, described in the following table.
The above map highlights 10 wards where the rate of admission is significantly higher than the County average, described in the following table.

<table>
<thead>
<tr>
<th>District</th>
<th>Ward</th>
<th>Rate per 10,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hambleton</td>
<td>Leeming Bar</td>
<td>293.0</td>
</tr>
<tr>
<td></td>
<td>Thorntons</td>
<td>258.3</td>
</tr>
<tr>
<td></td>
<td>Thirsk</td>
<td>250.5</td>
</tr>
<tr>
<td></td>
<td>Northallerton Central</td>
<td>222.7</td>
</tr>
<tr>
<td>Harrogate</td>
<td>Woodfield</td>
<td>265.7</td>
</tr>
<tr>
<td></td>
<td>Ouseburn</td>
<td>221.9</td>
</tr>
<tr>
<td></td>
<td>Granby</td>
<td>195.3</td>
</tr>
<tr>
<td>Richmondshire</td>
<td>Melsonby</td>
<td>317.5</td>
</tr>
<tr>
<td>Ryedale</td>
<td>Dales</td>
<td>382.2</td>
</tr>
</tbody>
</table>
The maps and accompanying data also highlight that significantly higher rates of admission are recorded from the Granby and Woodfield wards in Harrogate in both the 0-14 and 15-24 age groups.

### 5.7 Analysis of Admissions by Hospital and District of Residence

Over the last two years, nine local hospitals have dealt with around 95% of admissions relating to children and young people presenting with an unintentional or deliberate injury resident in North Yorkshire.

The highest proportion of admissions were to Harrogate District Hospital (28% of admissions in 2014/15), followed by York Hospital (20% of admissions in 2014/15). This is perhaps not surprising, given these two hospitals serve significant population centres. However, when examined at District level the data reveals some trends in patient flow:

- The proportion of children and young people from Richmondshire who were admitted to Darlington Memorial Hospital increased from 26.4% in 2013/14 to 39.1% in 2014/15. In the same period, the proportion of admissions to the Friargate Hospital remained stable (21.2% in 2013/14 compared to 23.6% in 2014/15), whilst the proportion of children and young people admitted to James Cook University Hospital fell from 34.2% in 2013/14 to 22.5% in 2014/15.
- In Harrogate district, the proportion of children and young people admitted to Leeds General Infirmary has decreased from 11.3% in 2013/14 to 4.6% in 2014/15. At the same time, the proportion of children and young people admitted to Harrogate District Hospital increased from 76.3% in 2013/14 to 82.8% in 2014/15.
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Provider</th>
<th>Percentage of Admissions - Unintentional &amp; Deliberate Injuries (Ages 0-24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCARBOROUGH GENERAL HOSPITAL</td>
<td>YORK TEACHING HOSPITAL NHS FOUNDATION TRUST</td>
<td>18.9% 16.1%</td>
</tr>
<tr>
<td>THE JAMES COOK UNIVERSITY HOSPITAL</td>
<td>SOUTH TEES HOSPITALS NHS FOUNDATION TRUST</td>
<td>14.1% 12.8%</td>
</tr>
<tr>
<td>FRIARAGE HOSPITAL SITE</td>
<td>SOUTH TEES HOSPITALS NHS FOUNDATION TRUST</td>
<td>8.6% 8.5%</td>
</tr>
<tr>
<td>LEEDS GENERAL INFIRMARY</td>
<td>LEEDS TEACHING HOSPITALS NHS TRUST</td>
<td>4.8% 3.2%</td>
</tr>
<tr>
<td>DARLINGTON MEMORIAL HOSPITAL</td>
<td>COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST</td>
<td>3.0% 3.9%</td>
</tr>
<tr>
<td>PINDERFIELDS GENERAL HOSPITAL</td>
<td>MID YORKSHIRE HOSPITALS NHS TRUST</td>
<td>1.9% 1.5%</td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL OF NORTH DURHAM</td>
<td>COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST</td>
<td>1.1% 1.2%</td>
</tr>
</tbody>
</table>

The proportion of children and young people admitted to the nine hospitals listed above by district in 2014/15 provides has been examined to provide an indication of each hospitals catchment area. The outcome of this analysis is illustrated in the following chart.
6. Financial Implications

The average medical and ambulance cost to the NHS for every serious injury is estimated to be approximately £14,000.\textsuperscript{23} Around 2 million of the 6 million annual visits to emergency departments in the UK through unintentional injuries involve children, which are estimated to cost the NHS roughly £146 million per year.\textsuperscript{24} There is therefore a strong economic case, as recently highlighted by the Chief Medical Officer, for preventing childhood injuries.\textsuperscript{25}

However, these figures do not take into account ongoing costs, such as long term treatment and social care, or productivity losses. Often these further costs are significantly high; for example, it has been estimated that treatment costs for one severe bath water scald could be as high as £250,000.\textsuperscript{26} Even more significantly, the approximate lifetime medical, educational and social cost for one child with a severe traumatic brain injury is £4.89 million.\textsuperscript{27}

6.1 Local financial costs

Analysis of the overall costs of healthcare resulting from hospital admissions for unintentional and deliberate injuries in North Yorkshire shows that the total healthcare costs during 2013-14 were equivalent to £3.03 million.

- Fracture: £1,519,775
- Open wound: £333,607
- Head injury: £294,868
- Poisoning: £290,966
- Muscle tendon nerve: £84,433

Allocation of healthcare costs by category of injury (top 5 categories)

Hospital admissions resulting from fractures accounted for just over half of the total value, at £1.52 million (50.2% of total spend). The top five injury types accounted for 83.4% of the overall healthcare costs during 2013/14, equivalent to £2.52 million.

6.2 Cost savings from injury presentation interventions

As already discussed, many of these injuries are preventable. Preventative measures can be relatively inexpensive, and provide a beneficial financial return. The European Report of Child Injury Prevention provides some examples of financial savings from selected injury prevention interventions:

<table>
<thead>
<tr>
<th>Expenditure of €1 each</th>
<th>Savings (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke alarms</td>
<td>69.0</td>
</tr>
<tr>
<td>Car child restraints</td>
<td>29.0</td>
</tr>
<tr>
<td>Bicycle helmets</td>
<td>29.0</td>
</tr>
</tbody>
</table>
Motorcycle helmets 16.0
Upgraded marked pedestrian crossings 14.0
Roadside lighting 10.7
Guardrails on roadsides 10.4
Prevention counselling by paediatricians 10.0
Area-wide speed and traffic management 9.7
Poison control centres 7.0
Daytime running lights (normal bulbs) 4.4
Pedestrian bridges or underpasses 2.5

Sources: Data from Cost effective EU transport safety measures (27), Miller & Levy (28) and Cost–benefit analysis of measures for vulnerable road users (29).

Further examples of cost effective safety measures have been analysed in the UK. One example concerns bath water scalds, which are the leading cause of serious scalding injuries among children in the UK and can £39.2 million a year in treatment for 0-14 year olds. A randomised control trial in Glasgow found that fitting thermostatic mixer valves in social housing led to a saving of £1.41 for every £1 spent.\textsuperscript{28}

A reduction of around 220 admissions would see rates return to the England average as a whole. Based on the average cost of admission derived from the 2013/14 data into consideration, achieving this reduction could save health care commissioners around £300,000 per annum.

- 0-4 age group - a reduction in the number of admissions from 505 to approximately 432 (reduction of 73) would bring the rate per 10,000 population down to 140.3 (national 140.8)
- 0-14 age group - a reduction in the number of admissions from 1210 to approximately 1070 (reduction of 140) would bring the rate per 10,000 population down to 112.2 (national 112.5)
- 15-24 age group - a reduction in the number of admissions from 949 to approximately 873 (reduction of 76) would bring the rate per 10,000 population down to 136.7 (national 136.7)

7. Current programmes of work

A number of programmes are in place and are in development. A detailed table of activity can be found in Appendix 8.

7.1 Unintentional injuries 0-19 Pathway

North Yorkshire Public Health Department and its partners, Harrogate and District Foundation Trust and NYCC Prevention Service, believe the Healthy Child Programme is central to the prevention of accidents and injuries to children. Over the last few months they have worked collaboratively to develop a multi-agency pathway aimed at reducing the number of unintentional injuries and hospital admissions across the county. The pathway creates a standardised and systematic approach for professionals involved with all children 0-19 and will support local decision making. Being multi-agency the pathway will ensure all our services are as streamlined and efficient as possible and reduce duplication and gaps in service provision. The pathways overarching aim is to strengthen and improve the county’s approach to reducing unintentional injuries and to keep children safe.
7.2 Toolkit
Both the prevention team and the healthy child programme are also working together to develop an injury minimisation toolkit. The toolkit, primarily developed by health visitors, will provide systematic evidence based tool to assess and reduce risk in and around the home.

This will also be a multi-agency initiative using the latest national evidence base available on what is effective in preventing childhood accidents. The toolkit will consist of a number of interventions for parents to use in the context of their own homes and will be age-specific, focusing on transitional stages of a child’s development. It will reduce accidents in the home in two ways; firstly by raising parental awareness and ability to detect potential accident, and secondly by supporting parents to take action when risks are identified. The toolkit will be individualised to the child in the context of their own home and built on an empowerment model of behaviour change. There are a number of outcomes that may occur when parents use the toolkit and further support will be available to assist them or if they require signposting to other services for early help.

The injury minimisation toolkit is in the early stages of development. Once complete we would like the Children’s Trust Board to support the use of our pathway and injury minimisation toolkit and promote it where possible to partners. The pathway will be launched alongside the toolkit in various locations across the county in the very near future. The toolkit will be evaluated and considered for rollout if considered useful.

7.3 Joint communication plan for accident prevention week
North Yorkshire County Council and Harrogate District Foundation Trust are working together to deliver joint campaigns on accident prevention. The coordinated approach will ensure that families receive the same high quality messages, and that the messages are reinforced multiple times thus strengthening the impact of key messages. Joint communications should be considered in injury prevention plans to ensure consistent evidence based messages are given to families.

7.4 Mental and emotional health and wellbeing work
The data presented within the report highlights admissions for poisoning in 15-24 year olds as an area of concern and seeks to acknowledge self-harm. Work to reduce self-harm within North Yorkshire is reflected within the all ages mental health strategy, ‘Hope, control and choice’. Specific actions linked to children and young people are described in the local CAMHS transformation plans, including work to build capacity and capability within the children’s workforce to identify and intervene early alongside improvement of specialist mental health services.

8. Priority areas for actions and recommendations
8.1 Develop local multiagency injury prevention action plans to be led and delivered by CSSGs reporting to Children’s Trust Board.
The Children’s Trust Board are in an ideal position to provide strategic leadership for injury prevention. There is currently no overall local strategy specifically aimed at addressing unintentional injuries in children and young people. However, there are individual initiatives
that work either wholly or in part towards decreasing the number of unintentional injuries in North Yorkshire.

The plan should be informed by the outcome of the NICE self-assessment tool. The tool should be used to assess their local position in relation to NICE guidance on preventing unintentional injuries in the home among children and young people aged under 15: home safety assessments and providing safety equipment. It also aims to help identify local leads and any action required to meet the recommendations.

Working to build and improve partnerships around unintentional injuries is vital in delivering an efficient, cost-effective service. At this stage, with no existing strategy on unintentional injuries it is particularly important to create a multidisciplinary team based on multiple partnerships to address the level of unintentional injuries in North Yorkshire. The strategic action plan discussed above should be designed and implemented with input from other stakeholders. Improving partnerships will also help increase general awareness of unintentional injuries in children and young people across organisations throughout the County.

Through these partnerships it is important to ensure that child injury prevention is something that is considered in the formation of other, relevant strategies by partnership organisations. This is particularly applicable to road safety, home safety and outdoor play/leisure.

A strategic action plan should be designed and implemented, based on national guidelines, which will allow for better co-ordination and commissioning of actions to prevent unintentional injuries across North Yorkshire.

The action plan should fulfil the following:
- Identify households of greater risk of unintentional injuries in the home through collaboration between local agencies
- Clearly identify how households at greatest risk will be identified and supported to reduce their risk
- Help identify local gaps in the local provision of measures to reduce unintentional injuries, and suggest ways of addressing these gaps
- Address the three key priorities as highlighted in report concerning children under 5 years old, road safety and reducing inequalities
- Implement the formation of a strategy board to review the strategic plan on an annual basis
- Use NICE guidance and the Public Health Outcomes Framework to monitor the progress of the action plan

The overall strategy of the action plan should follow NICE guidance, as summarised below:
8.2 Ensure support and training is available for the early years workforce to enable it to strengthen its central role in helping to reduce unintentional injuries.

The 0-5 healthy child programme and other early years providers such as children’s centres and private nurseries have a central role in injury prevention. Ensuring that the service is confident and competent in injury prevention is essential. Support for the wider early years workforce should also be given. The 0-5 healthy child programme has central role in injury prevention. Ensuring that the service is confident and competent in injury prevention is essential. Injury prevention has been identified as a priority area the commissioning of the new service in North Yorkshire.

8.3 Ensure there are locally based evidence based programmes across all the five main kinds of injury for children under 5 years old or prioritise action on under 5s ensuring there are locally based evidence programmes.

Unintentional injuries in and around the home are a leading cause of preventable death for children under five years and are a major cause of ill health and serious disability. The five key causes of unintentional injuries to prioritise in the under-fives are falls, poisoning, choking/suffocation/strangulation, burns/scalds and drowning, all of which predominantly happen in the home.

8.4 Explore the feasibility of commissioning of a home safety services.

A home safety service should be commissioned in order to provide households at greater risk with a structured home safety assessment that is tailored to their needs. Joint commissioning should be considered.
8.5 Maximise opportunities to integrate home safety in to other visits.
Households with children and young people under 15 years old should receive advice on home safety or are referred for a structured home safety assessment by practitioners providing family support on home visits who identify risks of unintentional injury. The pathway should initially be developed by Public health, the Healthy Child Programme and the Prevention Service. This should then be extended out to include wider partners including the fire & rescue service, GP practice staff and other organisations who work with children and families.

8.6 Implement and evaluate multiagency pathways to ensure that where families are at increased risk of injury appropriate action is taken across agencies.
Developing a pathway that brings together multiple agencies to work collaboratively to deliver evidenced based interventions would ensure a systematic and coordinated approach that helps families reduce the risk of injury.

8.7 Improve data collection and analysis especially to understand variations in rates.
A wider range of data would enable a closer look at unintentional injuries and would be useful to measure improvements. Looking at data across a CCG footprint as well as local authority footprints would be useful for looking at hospital data. There are significant geographical inequalities between wards and districts across the County. Further investigation needs to be done to understand the reasons for these inequalities, particularly around Richmondshire and Hambleton and wards within Harrogate. The Child Accident Prevention Trust recommends the following as valuable data sources for unintentional injuries:

- A+E statistics
- Child Death Overview Panel (CDOP) data
- Child Mortality Statistics
- ChiMat data
- ChiMat health schools profiles
- Demographic data
- Deprivation scores
- Hospital admissions data (national and local authority)
- National fire statistics data
- Road casualty data

NICE also recommends the use of data from walk-in centres, minor injuries units, RIDDOR, coroner reports, ambulance call-out reports and fire & rescue reports in addition to the above.29

National data suggests that socioeconomic factors such as deprivation level, parental employment and housing status have a strong effect on unintentional injuries. More work is required to determine whether this is the case for the unintentional injuries hotspots in North Yorkshire or whether there are other significant factors involved.

This work should include:
- Further data analysis, including:
  - Mapping of injuries by frequency and type
  - Comparison of injury maps with maps of socioeconomic factors, e.g. social housing levels, domestic violence, prevalence of households with children under 5
• Discussion with key figures in the localities (such as CCGs) to better understand the reasons behind these differences, along with collaboration on potential ways they could be addressed.

8.8 The Children’s Trust Board and other children’s strategic boards could sharpen their focus on the rate of Children Killed and Seriously Injured in road traffic accidents. Although road traffic collisions and accidents is beyond the scope of this report it is recognised that road safety has a large role in injury prevention. North Yorkshire performs worse than the national average in the PHOF indicator around the killed and seriously injured (KSI) rates on the roads. This is true of all ages between 0-25, but particularly so in 15-24 year olds, who are usually occupants of cars. The highest rates of both emergency hospital admissions and police-reported serious and fatal casualties result immediately after young people can start legally using cars and motorcycles.30

The Children’s Trust Board (CTB) could seek assurance from partners who deliver road safety interventions on progress against this indicator as well as support improved connectivity between those who work on road safety and children’s health.

The 95 Alive Partnership has responsibility for delivering a coordinated road safety strategy to tackle this issue, with a new road safety strategy due for publication in September 2016. Working with partners of the CTB.

8.9 Further analysis of 15-24 year old data is required to look at the relationship with self-harm, suicide and emotional and mental health. Poisoning is a key issue for this age group, with paracetemol poisoning being a significant issue. There is evidence from a population-based cohort study to suggest the rate of positioning has increased between 1992 and 2002 (Tyrrell, Orton and Tata, 2016).31 Poisonings that are likely to be intentional in this age group needs to be further explored and understood.

A number of Health and Wellbeing Board strategies such as the North Yorkshire’s Mental Health Strategy, the North Yorkshire Alcohol Strategy, and work on Future in Mind will contribute to making improvements in this area. However, further work to understand the reason for below national average performance in this area and ensuring coordinated action is needed. A review of the effectiveness self-harm pathway is also needed.
9. Appendices

Appendix 1 Craven District Profile

Admission Rates by Age Group

Top 5 Reasons for Admission by Age Group

Not Available for Craven District.

Admission Rates by Ward – 2013/14 & 2014/15

Not Available for Craven District
Appendix 2: Hambleton District Profile

Admission Rates by Age Group

Hambleton District
Unintentional & Deliberate Injuries in Children Aged 0-4
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Hambleton District
Unintentional & Deliberate Injuries in Children Aged 0-14
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Hambleton District
Unintentional & Deliberate Injuries in Children Aged 15-24
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
### Top 5 Reasons for Admission by Age Group

#### Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td>18</td>
<td>24.3%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>17</td>
<td>23.0%</td>
</tr>
<tr>
<td>Fracture</td>
<td>7</td>
<td>9.5%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>7</td>
<td>9.5%</td>
</tr>
<tr>
<td>General symptoms</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Respiratory Disorders</td>
<td>3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Toxic substances</td>
<td>3</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

#### Children Aged 0-14

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>42</td>
<td>37.5%</td>
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<tr>
<td>Open Wound</td>
<td>42</td>
<td>37.5%</td>
</tr>
<tr>
<td>Head injury</td>
<td>29</td>
<td>25.9%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>17</td>
<td>15.2%</td>
</tr>
<tr>
<td>Respiratory Disorders</td>
<td>5</td>
<td>4.5%</td>
</tr>
<tr>
<td>Toxic substances</td>
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</table>

#### Children Aged 15-24

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<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
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<tr>
<td>Poisoning</td>
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<td>Fracture</td>
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<tr>
<td>Open Wound</td>
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<tr>
<td>Foreign Body</td>
<td>5</td>
<td>2.7%</td>
</tr>
<tr>
<td>Head injury</td>
<td>4</td>
<td>2.2%</td>
</tr>
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</table>
Admission Rates by Ward – 2013/14 & 2014/15

Children Aged 0-4

Children Aged 0-14
Young People Aged 15-24
Appendix 3 Harrogate District Profile

Admission Rates by Age Group

Harrogate District
Unitentional & Deliberate Injuries in Children Aged 0-4
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Harrogate District
Unitentional & Deliberate Injuries in Children Aged 0-14
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Harrogate District
Unitentional & Deliberate Injuries in Children Aged 15-24
2010/11 to 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Top 5 Reasons for Admission by Age Group

Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td>47</td>
<td>32.6%</td>
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<tr>
<td>Fracture</td>
<td>19</td>
<td>13.2%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>16</td>
<td>11.1%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>13</td>
<td>9.0%</td>
</tr>
<tr>
<td>Toxic substances</td>
<td>6</td>
<td>4.2%</td>
</tr>
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</table>

Children Aged 0-14

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>88</td>
<td>39.1%</td>
</tr>
<tr>
<td>Head injury</td>
<td>68</td>
<td>30.2%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>39</td>
<td>17.3%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>24</td>
<td>10.7%</td>
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<tr>
<td>External causes</td>
<td>12</td>
<td>5.3%</td>
</tr>
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</table>

Children Aged 15-24

<table>
<thead>
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<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
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<td>30.2%</td>
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<tr>
<td>Fracture</td>
<td>34</td>
<td>10.8%</td>
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<tr>
<td>Open Wound</td>
<td>22</td>
<td>7.0%</td>
</tr>
<tr>
<td>Head injury</td>
<td>15</td>
<td>4.8%</td>
</tr>
<tr>
<td>External causes</td>
<td>6</td>
<td>1.9%</td>
</tr>
<tr>
<td>Musculoskeletal disorders</td>
<td>6</td>
<td>1.9%</td>
</tr>
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</table>
Admission Rates by Ward – 2013/14 & 2014/15

Children Aged 0-4

Harrogate District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-4
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Children Aged 0-14

Harrogate District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-14
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Children Aged 15-24

Harrogate District by Ward
Unintentional & Deliberate Injuries in Children Aged 15-24
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Appendix 4 Richmondshire District Profile

Admission Rates by Age Group

Richmondshire District
Unintentional & Deliberate Injuries in Children Aged 0-4
2010/11 to 2014/15
Source: PHE Children & Young People's Benchmarking Tool, SUS

Richmondshire District
Unintentional & Deliberate Injuries in Children Aged 0-14
2010/11 to 2014/15
Source: PHE Children & Young People's Benchmarking Tool, SUS

Richmondshire District
Unintentional & Deliberate Injuries in Children Aged 13-24
2010/11 to 2014/15
Source: PHE Children & Young People's Benchmarking Tool, SUS
Top 5 Reasons for Admission by Age Group

Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Wound</td>
<td>13</td>
<td>28.3%</td>
</tr>
<tr>
<td>Head injury</td>
<td>8</td>
<td>17.4%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>6</td>
<td>13.0%</td>
</tr>
<tr>
<td>External causes</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Injuries to wrist, hand</td>
<td>3</td>
<td>6.5%</td>
</tr>
<tr>
<td>Toxic substances</td>
<td>3</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Children Aged 0-14

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Wound</td>
<td>20</td>
<td>32.3%</td>
</tr>
<tr>
<td>Fracture</td>
<td>18</td>
<td>29.0%</td>
</tr>
<tr>
<td>Head injury</td>
<td>13</td>
<td>21.0%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>10</td>
<td>16.1%</td>
</tr>
<tr>
<td>External causes</td>
<td>5</td>
<td>8.1%</td>
</tr>
<tr>
<td>Injuries to wrist, hand</td>
<td>5</td>
<td>8.1%</td>
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</table>

Young People Aged 15-24

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>22</td>
<td>24.7%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>13</td>
<td>14.6%</td>
</tr>
<tr>
<td>Fracture</td>
<td>10</td>
<td>11.2%</td>
</tr>
<tr>
<td>Head injury</td>
<td>3</td>
<td>3.4%</td>
</tr>
<tr>
<td>Injuries to wrist, hand</td>
<td>3</td>
<td>3.4%</td>
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</tbody>
</table>
Admission Rates by Ward

Children Aged 0-4

Richmondshire District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-4
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Children Aged 0-14

Richmondshire District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-14
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Children Aged 15-24

Richmondshire District by Ward
Unintentional & Deliberate Injuries in Children Aged 15-24
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Appendix 5 Ryedale District Profile

Admission Rates by Age Group

[Graphs showing admission rates by age group for different age brackets (0-4, 5-14, 15-24) over the years 2010/11 to 2014/15.]
### Top 5 Reasons for Admission by Age Group

#### Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Wound</td>
<td>9</td>
<td>28.1%</td>
</tr>
<tr>
<td>Fracture</td>
<td>6</td>
<td>18.8%</td>
</tr>
<tr>
<td>Head injury</td>
<td>5</td>
<td>15.6%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>External causes</td>
<td>3</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

#### Children Aged 0-14

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>34</td>
<td>58.6%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>17</td>
<td>29.3%</td>
</tr>
<tr>
<td>External causes</td>
<td>7</td>
<td>12.1%</td>
</tr>
<tr>
<td>Head injury</td>
<td>7</td>
<td>12.1%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>6</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

#### Young People Aged 15-24

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>20</td>
<td>23.8%</td>
</tr>
<tr>
<td>Fracture</td>
<td>17</td>
<td>20.2%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>5</td>
<td>6.0%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>3</td>
<td>3.6%</td>
</tr>
<tr>
<td>Head injury</td>
<td>3</td>
<td>3.6%</td>
</tr>
</tbody>
</table>
Admission Rates by Ward

Children Aged 0-4

Ryedale District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-4
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Children Aged 0-14

Ryedale District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-14
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
Young People Aged 15-24

Ryedale District by Ward
Unintentional & Deliberate Injuries in Children Aged 15-24
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Rate per 10,000 Population

2013/14  2014/15

Sheriff Hutton
Skerton
Norton West
Poolegh East
Ampleforth
Heath
Kirbymoorside
Holt
Manton
Inewerst
Wiltshire
Ripon
Henderson
Kirkby Malzeard
Thirsk
Tearne
Skipton
Grewton
Whitby
Longfield

53 | P a g e
Appendix 6 Scarborough District Profile

Admission Rates by Age Group

Children Aged 0-4

[Graph showing admission rates for children aged 0-4]

Children Aged 0-14

[Graph showing admission rates for children aged 0-14]

Children Aged 15-24

[Graph showing admission rates for children aged 15-24]
### Top 5 Reasons for Admission by Age Group

#### Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td>16</td>
<td>23.9%</td>
</tr>
<tr>
<td>Fracture</td>
<td>15</td>
<td>22.4%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>11</td>
<td>16.4%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>6</td>
<td>9.0%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>4</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

#### Children Aged 0-14

<table>
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<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>54</td>
<td>40.3%</td>
</tr>
<tr>
<td>Head injury</td>
<td>29</td>
<td>21.6%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>22</td>
<td>16.4%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>14</td>
<td>10.4%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>6</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

#### Young People Aged 15-24

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>58</td>
<td>38.2%</td>
</tr>
<tr>
<td>Fracture</td>
<td>41</td>
<td>27.0%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>10</td>
<td>6.6%</td>
</tr>
<tr>
<td>Head injury</td>
<td>7</td>
<td>4.6%</td>
</tr>
<tr>
<td>Digestive disorders</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Dislocation</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Injuries to abdomen, spine, pelvis</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Injuries to hip, thigh</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Skin conditions</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Toxic substances</td>
<td>2</td>
<td>1.3%</td>
</tr>
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</table>
Admission Rates by Ward

Children Aged 0-4

Children Aged 0-14
Young People Aged 15-24

Scarborough District by Ward
Unintentional & Deliberate Injuries in Children Aged 15-24
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Rate per 100,000 Population

2013/14 - 2014/15
Appendix 7 Selby District Profile

Admission Rates by Age Group

Children Aged 0-4

Children Aged 0-14

Young People Aged 15-24
## Top 5 Reasons for Admission by Age Group

### Children Aged 0-4

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Body</td>
<td>12</td>
<td>20.7%</td>
</tr>
<tr>
<td>Head injury</td>
<td>12</td>
<td>20.7%</td>
</tr>
<tr>
<td>Fracture</td>
<td>8</td>
<td>13.8%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>6</td>
<td>10.3%</td>
</tr>
<tr>
<td>External causes</td>
<td>3</td>
<td>5.2%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>3</td>
<td>5.2%</td>
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</table>

### Children Aged 0-14

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</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>30</td>
<td>38.0%</td>
</tr>
<tr>
<td>Head injury</td>
<td>21</td>
<td>26.6%</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>13</td>
<td>16.5%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>13</td>
<td>16.5%</td>
</tr>
<tr>
<td>External causes</td>
<td>4</td>
<td>5.1%</td>
</tr>
<tr>
<td>Poisoning</td>
<td>4</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

### Young People Aged 15-24

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>No. of Admissions</th>
<th>Percentage of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>29</td>
<td>25.9%</td>
</tr>
<tr>
<td>Fracture</td>
<td>18</td>
<td>16.1%</td>
</tr>
<tr>
<td>Injuries to wrist, hand</td>
<td>6</td>
<td>5.4%</td>
</tr>
<tr>
<td>Open Wound</td>
<td>6</td>
<td>5.4%</td>
</tr>
<tr>
<td>Head injury</td>
<td>4</td>
<td>3.6%</td>
</tr>
</tbody>
</table>
Admission Rates by Ward

Children Aged 0-4

Selby District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-4
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Rate per 10,000 Population

Children Aged 0-14

Selby District by Ward
Unintentional & Deliberate Injuries in Children Aged 0-14
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS

Rate per 10,000 Population
Selby District by Ward
Unintentional & Deliberate Injuries in Children Aged 15-24
2013/14 & 2014/15
Source: PHE Children & Young People’s Benchmarking Tool, SUS
## Appendix 8 Scoping of current accident prevention intervention across North Yorkshire

<table>
<thead>
<tr>
<th>Service/Provider</th>
<th>Intervention</th>
<th>Reach Area/Target Population</th>
<th>Comments</th>
<th>Evidence Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY Trading Standards</td>
<td>Bling Kids – funded by BIZ (regional project cost £1800)</td>
<td>Children and young people</td>
<td>Trading standards identify, test purchase and test children’s clothing against safety standards (e.g. hood cords, flammability).</td>
<td></td>
</tr>
<tr>
<td>NYCC Prevention Service</td>
<td>Baby first aid courses</td>
<td>Under 5’s and parents</td>
<td>Some areas commission outside providers to deliver short paediatric first aid courses to parents. Not universally provided in all CC’s.</td>
<td></td>
</tr>
<tr>
<td>NYCC Prevention Service</td>
<td>Child safety week/ Safety topics</td>
<td>Under 5’s and their families</td>
<td>Displays and activities run during this national awareness week to highlight the issues associated with child safety. General safety sessions delivered as part of the Children’s Centre programme.</td>
<td></td>
</tr>
<tr>
<td>NYCC Prevention Service</td>
<td>Home safety checks</td>
<td>Under 5’s and their families</td>
<td>Family Outreach Workers complete home safety checks for the families they are working with as part of their initial assessment. Safety equipment can be</td>
<td></td>
</tr>
<tr>
<td><strong>NYCC Prevention Service</strong></td>
<td><strong>Home safety pack</strong></td>
<td><strong>Children aged 0-19 and their families living in homeless accommodation</strong></td>
<td>A pack of information and equipment given to families in homeless accommodation.</td>
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<td>----------------------------</td>
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<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>NYCC Schools</strong></td>
<td><strong>PSHE – safety topics</strong></td>
<td><strong>School aged children 5-18</strong></td>
<td>It is recommended that schools offer PSHE education and there is a suggested curriculum entitlement framework. Topics include; road safety, fire safety, farm safety, accident prevention. Core skills suggested include identifying and managing risk and keeping yourself safe. Schools do not have to deliver this and there is no information about the numbers of schools who deliver this or quality assurance of the info given.</td>
<td></td>
</tr>
<tr>
<td><strong>HDFT 5-19</strong></td>
<td><strong>Injury Minimization Programme for Schools (I.M.P.S)</strong></td>
<td><strong>School aged children (Key Stage 2 – 11&amp;12 years) in the Scarborough area</strong></td>
<td>National scheme delivered locally in Scarborough for 12 years, 12000 children have taken part in the programme over this time. First aid, basic life support and accident prevention covered with a visit to a hospital.</td>
<td></td>
</tr>
<tr>
<td><strong>Community Partnerships</strong></td>
<td><strong>Richmondshire Area Motorcycle Proficiency Scheme (RAMPS)</strong></td>
<td><strong>Young people aged 13-19 in the Richmond area</strong></td>
<td>Motorcycle course to encourage young people to act</td>
<td></td>
</tr>
<tr>
<td>HDTF 0-19 services</td>
<td>Paediatric Liaison Health Visitor/Nurse (Fiona Birt/Sandra Cooper)</td>
<td>Children and young people aged 0-19</td>
<td>responsibly but enjoy the sport of off-road motorcycling.</td>
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<tr>
<td></td>
<td></td>
<td>Liaison staff who provide a link from A&amp;E departments to HV's/SN's. All attendance cards for 0-16 aged C&amp;YP are given to liaison HV/Nurs for review.</td>
<td>Gap in provision for children and young people aged 16-19 years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HDH: 0-5’s HV notified of all attendances via covering snapshot of incident and outcome.</td>
<td>OOH – can see children and young people for minor injuries. Reports from this not sent to paed liaison or HV/SN but managed by GP.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5-19 Triaged by liaison HV and selected notifications sent to SN team.</td>
<td>HDTF – paediatric liaison notified of adult A&amp;E attendance if there are C&amp;YP in the family and where the attendance was in relation to DV/Alcohol abuse/Mental health and self-harm. Other area paediatric liaison not notified of these types of attendance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>James Cook/Friarage: 0-5 &amp; 5-19 staff are notified routinely via liaison staff of attendance – paper free system can cause issues for teams.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scarborough: If chid seen in Minor Injuries unit info not sent to community practitioners so there is no knowledge of the attendance. If seen in A&amp;E the liaison nurse in notified and these are sent to HV’s/SN’s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Provision</td>
<td>Children and their families aged 0-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| York          | No paediatric liaison staff. HV’s/SN’s notified of every child seen in A&E | York: No paediatric liaison staff. HV’s/SN’s notified of every child seen in A&E  \[\text{Universal provision} \]
|               | Leeds: No paediatric liaison now. Notifications sent to HV’s/SN’s directly | Leeds: No paediatric liaison now. Notifications sent to HV’s/SN’s directly  \[\text{Routine core discussions about age appropriate safety topics universally. Topics include home safety, sun safety, water safety, road safety, fire safety, topical safety – button batteries, cord blinds.} \]
|               | Airedale/Bradford: Paediatric liaison receive notification and forward to HV’s/SN’s | Airedale/Bradford: Paediatric liaison receive notification and forward to HV’s/SN’s  \[\text{A&E notifications – HV’s aware of all attendances at A&E for their caseload. Information triaged and decision is taken at individual professional level as to what action, if any, needs to be taken.} \]
| HDFT 0-5      | Universal provision                |
| HDFT 5-19 | Universal provision | Children and young people and their families | A&E notifications – SN’s receive various levels of information of A&E attendances for those on their caseload. Information triaged and decision is taken at individual professional level as to what action, if any, needs to be taken. |
10. References


4. The Information Centre for Health and Social Care (2010)


26 http://www.makingthelink.net/costs-bath-water-scalds


