The impacts of COVID-19 on Health Visiting Services in England: FOI Evidence for the First Wave

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1. Executive summary

The early years of life are a crucial period for a child's development, and both investments and environments at this stage can have significant impacts throughout the life cycle. Home visiting programmes can provide invaluable support to children and families, with the aim to prevent and reduce inequalities in early development (Almond, Currie and Duque, 2018; Conti, Mason and Poupakis, 2019; Conti, 2020). The universal health visiting service in England is fundamental in delivering the Healthy Child Programme and ensuring that children under five get the best possible start in life; however, it was under severe strain at the beginning of 2020, after years of cuts to funding. The COVID-19 pandemic has exacerbated the pressures faced by health visiting services, both in the ensuing redeployment of health visiting staff to support COVID-19 efforts, and in the increased concerns around children's and parent's well-being during the lockdown period. However, the exact scale and variation in the redeployment experienced by the health visiting stuff is not precisely known, with existing evidence (Conti & Dow, 2020; Barlow, J. et al., 2020; Institute of Health Visiting, 2020) being based on survey data.

In this brief we present new evidence based on primary data collected through Freedom of Information (FOI) requests from the providers of health visiting services in England on the state of these services before the pandemic and on the redeployment of staff (both health visitors and clinical skill mix staff not defined as health visitors) in health visiting teams between 19 March and 1 September 2020. For the 141 out of 151 local authorities that have submitted responses, we document the following key facts.

- Before the pandemic (February 2020), health visitors made up on average 70% of health visiting teams, and clinical skill mix staff (not defined as health visitor, such as community nurses and nursery nurses) made up the rest. Additionally, health visitors were not the only ones to hold caseload: in 42% of the local authorities, they were supported by clinical skill mix staff.
- In 80% of local authorities, caseloads were greater than 250 children per staff, the maximum caseload size recommended by the Institute of Health Visiting. In 66% of local authorities, caseloads were greater than 300 children per staff; in 22% of them, caseloads were greater than 500 children per staff; and in 10% of them, caseloads were greater than 700 children per staff.
- There has been widespread redeployment of staff in health visiting teams (both health visitors and clinical skill mix staff), and significant variation in the level of redeployment across local authorities in England. Many local authorities did not redeploy at all, but 65% redeployed at least one full-time equivalent (FTE) member of staff in health visiting teams.
- Redeployment of FTE health visitors ranged from 0 to 63%, with 11% of local authorities losing over 25% of their FTE health visitors.
- Redeployment of FTE clinical skill mix staff (e.g. staff nurses) in health visiting teams ranged from 0 to 100% (in one local authority), suggesting that providers redeployed other clinical skill mix staff in health visiting teams as a first port of call. 13% of local authorities redeployed over 50% of their FTE clinical skill mix staff.
- Redeployment of staff started as soon as the NHS guidance was published, from 19 March 2020, and it was sustained, until at least 1 September. In 95% of local authorities that redeployed staff, redeployment started before May.
- The average duration of redeployment up to September 1 (i.e. the number of days since the date from which the first staff member was redeployed up to the last date at which a staff member returned) was 67 days, just over 2 months.

The variation in redeployment of health visiting staff means that young children and families received different levels of care and support based on where they lived. The lockdown period was extremely challenging for many families, and particularly so for new parents.[1] The differences in health visiting service provision during the lockdown due to geographical location are inequitable and undermine the universality of health visiting in England.

[1] *Expecting alone: The isolation of pregnancy during Covid* (2020). BBC Radio 4 Fileon4, 27 September.

2. Background on COVID-19 redeployment

On 17 March 2020, NHS England and NHS Improvement published a letter detailing measures to transfer staff and resources towards the COVID-19 response. In this letter, registered nurses in non-patient facing roles were called to support direct clinical practice in the NHS. Health visitors, as registered nurses, and nurses working in health visiting teams were redeployed out of their roles in providing services for young children and families. Based on a survey of health visiting professionals that we have conducted (Conti & Dow, 2020), health visiting staff were redeployed to a variety of locations, including COVID-19 wards, COVID-19 swabbing teams and other community services such as district nursing.

Days later, on 19 March, NHS England issued further guidance setting out a COVID-19 prioritisation plan within community health services. The guidance ordered a partial stop to pre-birth and 0-5 services - including health visiting services. All services were to stop except for "antenatal contact (virtual), new baby visits (or when indicated virtual contact), and other contacts to be assessed and stratified for vulnerable or clinical need (e.g. maternal mental health)." Vulnerable families under the FNP (Family Nurse Partnership) and MECSH (Maternal Early Childhood Sustained Home-visiting) [2] were identified as likely candidates for continued health visiting contact. In addition, local authorities were asked to assess and stratify contacts for safeguarding work, such as statutory child protection home visits, and phone and text advice to vulnerable families in need. Under the COVID-19 prioritisation, there was a pause to three of the five mandated Healthy Child Programme (HCP) contacts for families who were not identified as vulnerable or in clinical need.

Guidance on the restoration of community health services was published on 3 June, but a return to pre-COVID-19 service provision was far from the reality for many health visiting teams at this date, based on the responses to our survey of health visiting professionals (Conti & Dow, 2020) – and confirmed by the evidence that we report here.

3. Data collection

We collected primary data through Freedom of Information (FOI) requests to the providers of health visiting services across all upper tier local authorities (n=151) in England. We submitted the first FOI requests on 19-20 August 2020, and the remaining FOI requests between 2-7 September. We received the first response on August 27, and finalised data collection on December 17.

Since 01 October 2015, health visiting services have been commissioned by local authorities. This has resulted in a mixed service provision across NHS Trusts, private providers and local councils themselves. The majority of health visiting providers are NHS Trusts: 115 local authorities (76%) commission health visiting services from NHS Trusts, which serve an estimated 76% of total children under 5 in England (based on 2019 ONS mid-year population data); 16 councils (11%) provide services themselves, serving 9% of the 2019 under-5 population; and 19 (13%) local authorities commission health visiting services from private health visiting providers, which serve 13% of the under-5 population. In 1 local authority (<1%) health visiting services are provided by a joint private-NHS Trust community health service, serving 2% of the under-5 population.

We have received responses for 141 local authorities. The remaining 10 local authorities have either refused our request or have not responded. Of these 141 local authorities, not all have submitted complete data on staff numbers, redeployment, and caseload, as reflected in the reduced sample sizes reported for some of the figures of this brief.[3] We have received complete data on FTE staff numbers and redeployment for 136 local authorities (90%). Private organisations are not covered by the FOI Act, so they can refuse our requests. Nonetheless, a number of these private providers (for 10 local authorities) kindly supplied the information requested, but two providers refused to provide the full data, and two more have not responded to our communications (accounting for 50% of the missing complete responses). This translates to a 71% response rate for private providers. We have then data on 97% of local authorities served by NHS Trusts, and on 91% of local authorities served by councils.

[2] The FNP is an intensive, preventative home visiting programme for first-time teenage parents. The MECSH is a preventative home visiting programme for families at risk of poor child health and development and maternal health outcomes.
[3] A full breakdown by local authority can be found in the appendix.

We asked providers for both the number of full-time equivalent (FTE)[4] health visitors and the number of FTE clinical skill mix staff (not defined as health visitors) that were employed in their health visiting teams for a certain local authority on 1 February 2020. We also requested the number of children under 5 in a certain local authority that the health visiting teams were responsible for. We then asked providers for both the maximum number of FTE health visitors and the maximum number of FTE clinical skill mix staff working in health visiting teams (not defined as health visitors) who have been/were redeployed due to COVID-19 to date. We also asked providers to specify the start and end dates of redeployment: as redeployment occurred in waves in some local authorities, these dates represent the date at which the first health visiting team member was redeployed and the date at which the last redeployed staff member returned back to her post. We set a cut-off date of September 1 to consider redeployment for the first COVID-19 wave.

4. The state of health visiting services before the COVID-19 pandemic

Health visiting teams are made up of a range of roles, with community nursery nurses, community staff nurses, student health visitors and other clinical skill mix staff supporting health visitors in the delivery of the 0-5 Healthy Child Programme. This configuration of health visiting teams developed following the 2009 publication of updated[5] guidance on the 'Healthy Child Programme – Pregnancy and the First Five Years of Life', which emphasised the use of integrated services to deliver the HCP and stated that health visiting teams would include a range of health professionals and practitioners supporting the health visitor role, working across general practice and Sure Start children's centres.

Prior to COVID-19 (on 1 February 2020), the average number of FTE health visitors in a local authority was 58.4, and the average number of other clinical skill mix staff working in health visiting teams was 27.3. On average, health visiting teams were predominantly composed of band 6 health visitors, the minimum grade for qualified health visitors. The most common pay band for clinical skill mix staff working in health visiting teams is band 4, but as shown in table 1, team composition varies greatly.

Table 1: Distribution of health visiting staff across English UTLAs on 1st February 2020

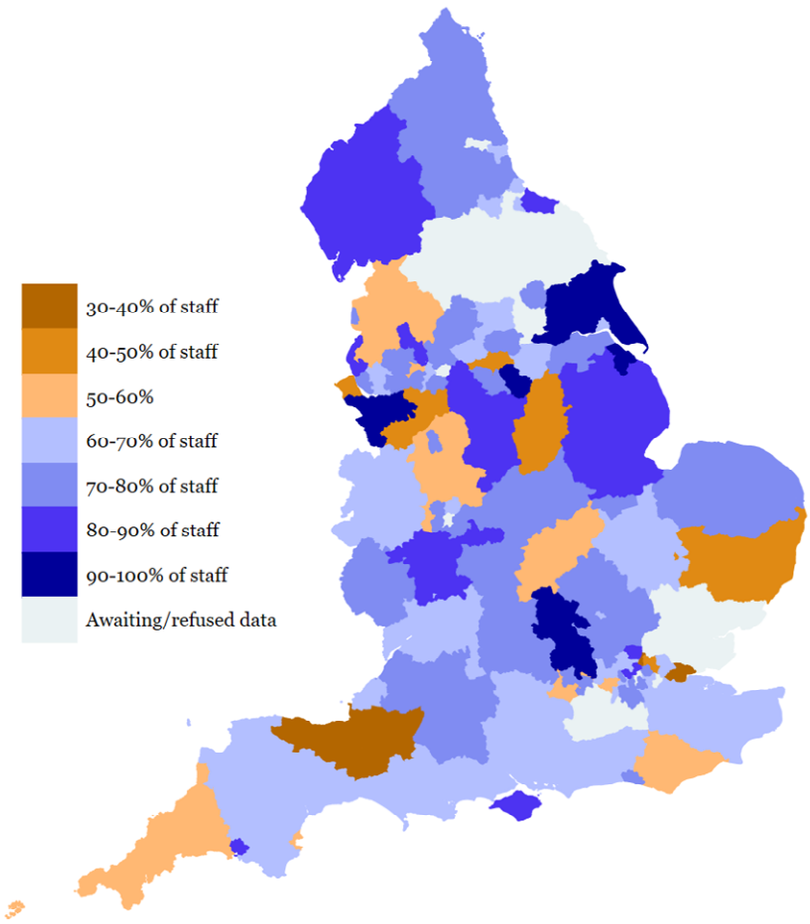
	Mean	Std. Dev.	Min.	Max.
Total no. of FTE health visitors	58.4	38.1	10.9	190.9
Total no. of FTE other clinical skill mix staff	27.3	26.5	0.0	147.1
No. of FTE band 6 health visitors	48.2	32.8	9.1	161.4
No. of FTE band 7 health visitors	8.9	9.1	0.0	50.1
No. of FTE band 8 health visitors	1.0	1.5	0.0	7.2
No. of FTE band 2 clinical skill mix staff	0.1	1.2	0.0	14.3
No. of FTE band 3 clinical skill mix staff	0.8	3.5	0.0	26.4
No. of FTE band 4 clinical skill mix staff	16.3	13.6	0.0	79.8
No. of FTE band 5 clinical skill mix staff	6.0	8.8	0.0	41.9
No. of FTE band 6 clinical skill mix staff	1.6	6.0	0.0	57.0
No. of FTE band 7 clinical skill mix staff	1.9	9.8	0.0	112.5
No. of FTE band 8 clinical skill mix staff	0.3	0.7	0.0	4.0
Observations	139			

Note: FTE staff numbers include both caseload holders and staff without caseload. Std. Dev. = standard deviation. Min. = minimum. Max. = maximum. UTLA = Upper Tier Local Authority.

On 1 February 2020, health visitors made up, on average, 70% of health visiting teams. Figures 1 and 2 show that there was substantial variation across local authorities in England and London boroughs, respectively, with health visitors constituting between 33% and 100% of all FTE staff working in health visiting teams.

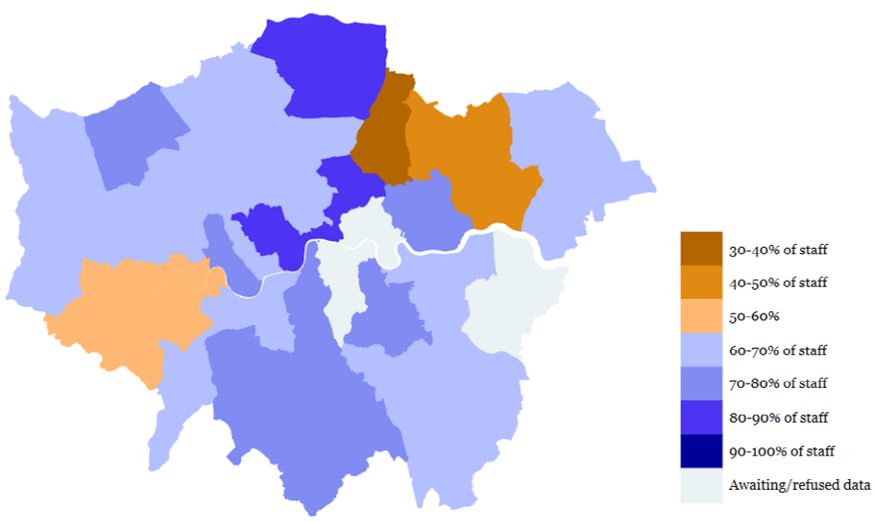
[4] Note that one FTE is not necessarily equivalent to one employee, as staff can work part-time. This means that two individuals working 0.5 FTE is the same as 1 FTE in our data.

[5] Update of Standard One (incorporating Standard Two) of the National Service Framework for Children, Young People and Maternity Services, 2004, Department of Health and Social Care.



N=139

Figure 1: FTE health visitors as percent of all FTE staff working in health visiting teams on 1st February 2020, by Upper-Tier Local Authority in England



N=30

Figure 2: FTE health visitors as percent of all FTE staff working in health visiting teams on 1st February 2020, by London Borough

In addition to being heterogeneous with respect to their skills and qualifications, staff in health visiting teams also differ in terms of caseload. In February, health visitors were responsible for caseloads of families with children under 5 in all local authorities; and in 42% of them, clinical skill mix staff (not health visitors) also held caseload. Within a local authority, on average, 90% of health visitors held caseload, with a minimum of 63% and a maximum of 100%; for clinical skill mix staff, 28% held caseload, with a wide range between 0% and 100%. Moreover, on average 89% of all caseload holders in a local authority were health visitors, with clinical skill mix staff working in health visiting teams making up the remainder. The minimum percentage of health visitor caseload holders was 36%, but - as shown in figure 3 - the distribution was highly skewed to caseload holders being solely health visitors. Figures 4 and 5 present this in map form.

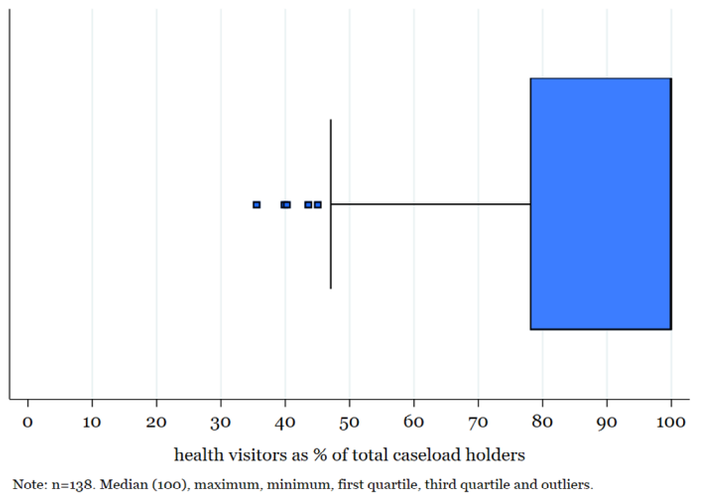


Figure 3: Distribution of percent of caseload holders who are health visitors, 1st February 2020

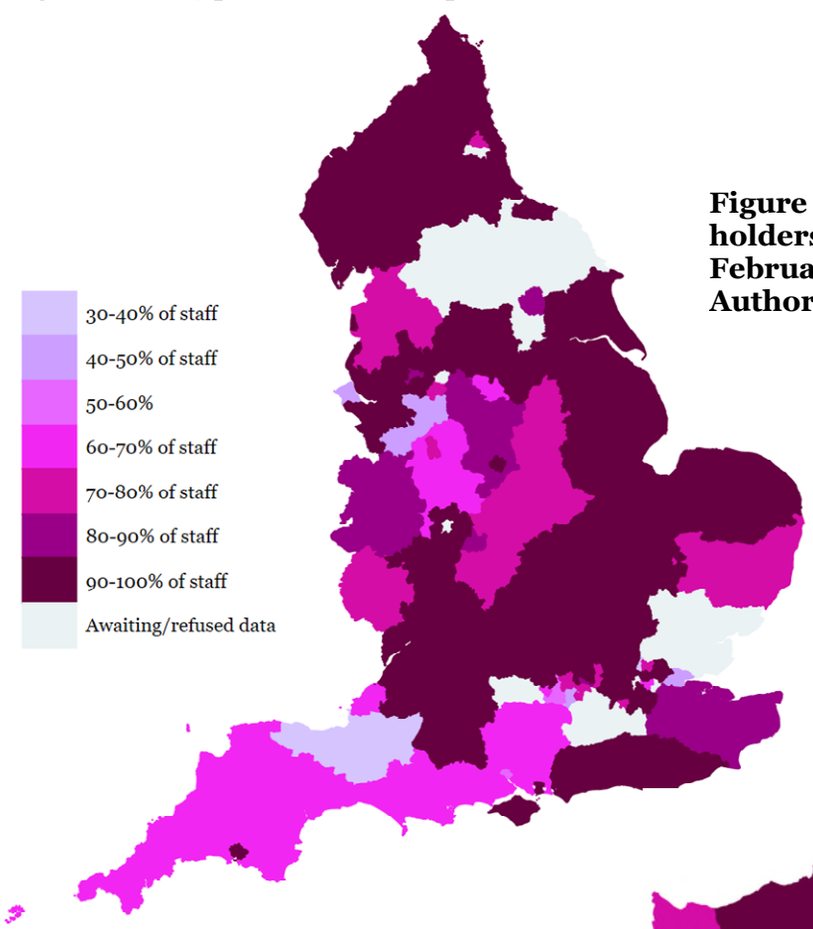


Figure 4 (left): Percentage of caseload holders who are health visitors on 1st February 2020, by Upper Tier Local Authority in England

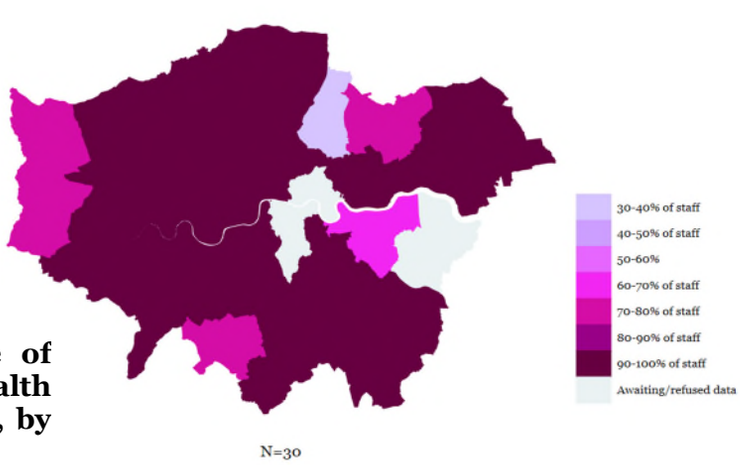
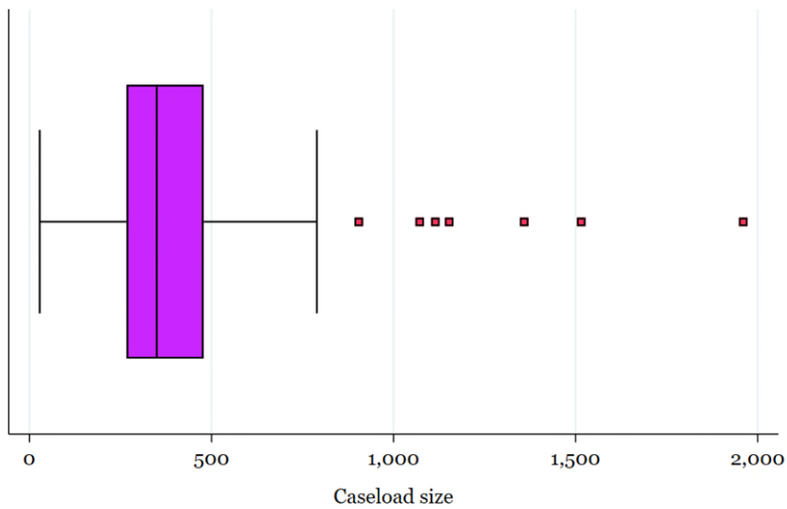


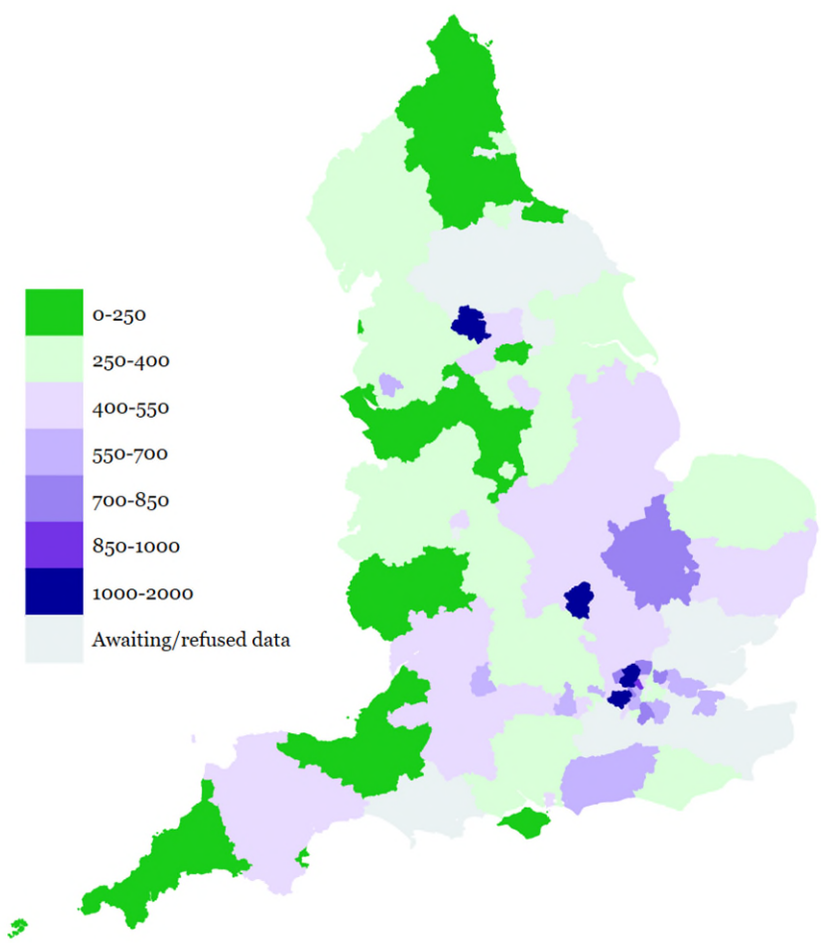
Figure 5 (right): Percentage of caseload holders who are health visitors on 1st February 2020, by London Borough

Even before the COVID-19 pandemic, health visiting teams were over-stretched. We compute the caseload by dividing the total number of children under five that a health visiting team is responsible for by the total number of FTE caseload holding staff. Across local authorities, the mean caseload on 1 February was 422 children per FTE staff member, and the median 349. The Institute of Health Visiting recommends a maximum of 250 children per health visitor[6]. We find that 80% of the local authorities in our sample had caseloads greater than 250 children per FTE caseload holding staff. In some areas, the caseload was over 1,000 children per staff member, as shown in figure 6. The maximum caseload size was 1,960 per FTE staff member in one UTLA. Figures 7 and 8 highlight the differences in caseload size across England UTLAs and London boroughs, respectively.[7]



Note: N=136. Median, maximum, minimum, first quartile, third quartile and outliers.

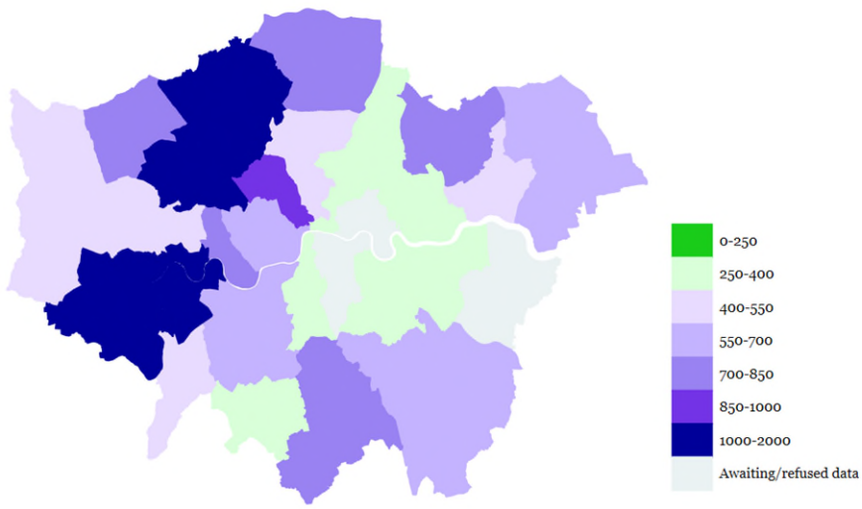
Figure 6: Distribution of caseload of health visiting staff across local authorities, 1st February 2020



Note: N=136. Caseload is no. of children <5 divided by no. of FTE caseload holding health visiting staff.

Figure 7: Caseload size on 1st February 2020, by Upper-Tier Local Authority in England

[6] Institute of Health Visiting, 2018, "Three years on from a move to local authority commissioning in England, what has changed?"
[7] We note that some local authorities have a corporate or shared caseload model and/or clinical skill mix staff supporting caseload holders, and that our figures are based on the number of caseload holding staff which has been indicated in the FOI responses (see Annex).

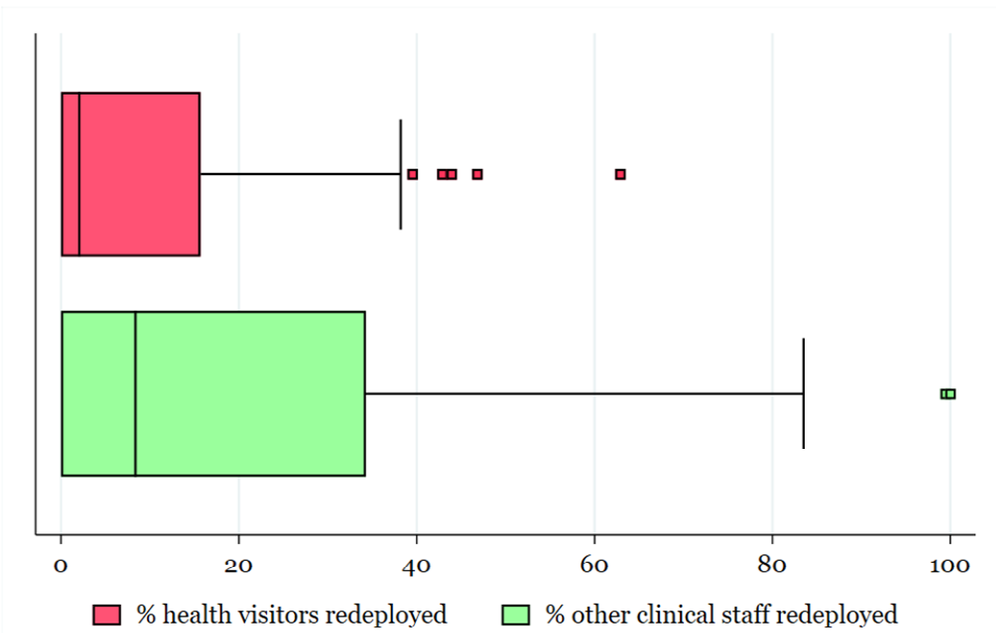


Note: N=30. Caseload is no. of children <5 divided by no. of FTE caseload holding health visiting staff.

Figure 8: Caseload size on 1st February 2020, by London Borough

5. Redeployment of staff working in health visiting teams

We now present findings on the redeployment. We examine the percent of total FTE health visitors, total FTE clinical skill mix staff, and total FTE staff in health visiting teams (health visitors plus clinical skill mix staff) who were redeployed during the first COVID-19 wave[8], as a percentage of FTE staff on February 1st 2020. Figure 9 reports the distribution of percent redeployed for health visitors and clinical skill mix staff, showing that clinical skill mix staff suffered greater redeployment than health visitors.

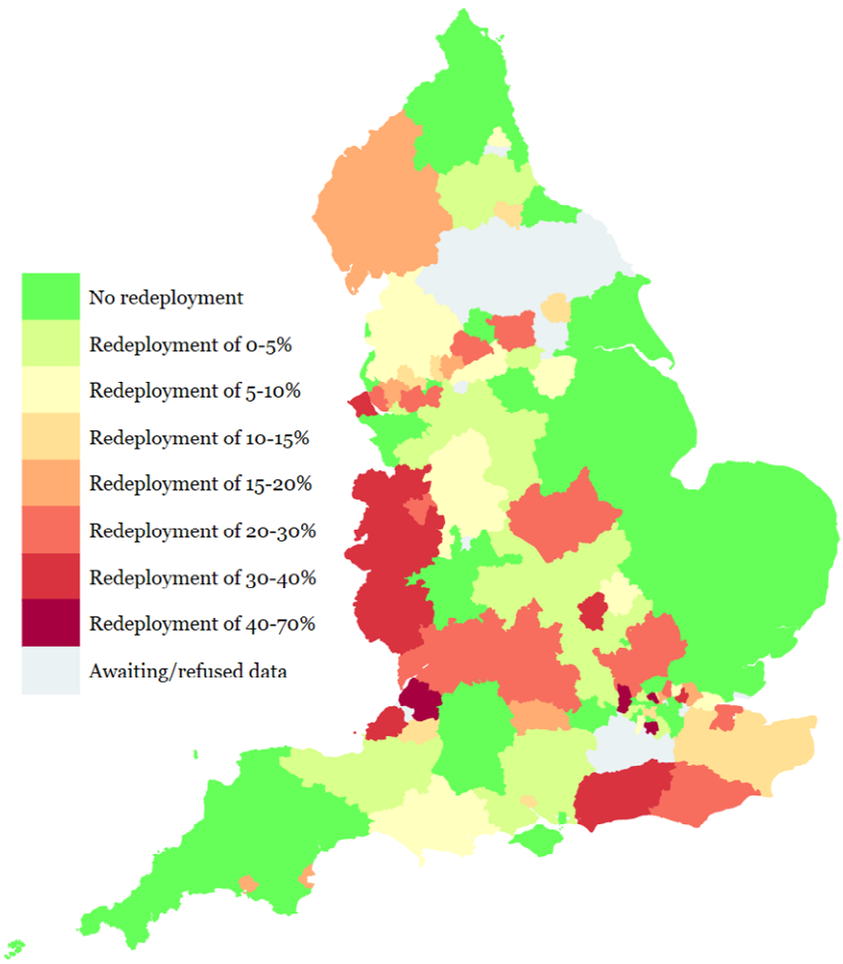


Note: N=136. Median, maximum, minimum, first quartile, third quartile and outliers.

Figure 9: Distribution of percent of health visitors and clinical skill mix staff redeployed up to 1st September 2020 due to COVID-19

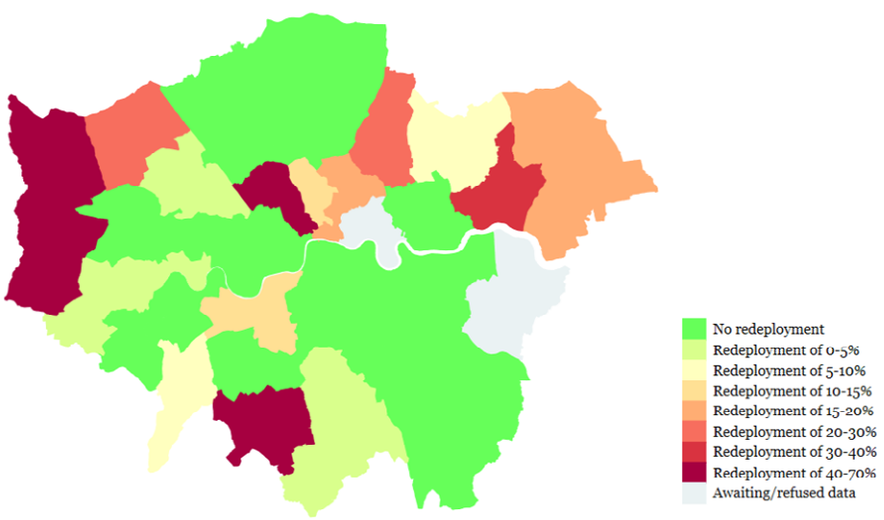
[8] Note that the data on redeployment is not disaggregated by caseload status, since this information was not routinely collected: both caseload holding and non-caseload holding staff are included in the following figures and analysis.

A. Redeployment of health visitors. Although in many local authorities providers managed to avoid any redeployment of health visitors, 53% of local authorities redeployed at least one FTE health visitor. Figures 10 and 11 show that redeployment was high in some areas, up to 63% of health visitors in post on 1 February 2020.



N=141

Figure 10: Percent of health visitors redeployed up to 1st September 2020 due to COVID-19, by Upper-Tier Local Authority in England



N=31

Figure 11: Percent of health visitors redeployed up to 1st September 2020 due to COVID-19, by London Borough

B. Redeployment of clinical skill mix staff. 54% of local authorities redeployed at least one FTE clinical skill mix staff member. Across a number of local authorities, clinical skill mix staff working in health visiting teams were redeployed in greater percentages than their health visitor colleagues, as shown in figures 12 and 13. 13% of local authorities in our sample lost over 50% of their clinical skill mix staff. As highlighted above, in over half of local authorities clinical skill mix staff do not hold caseload. This might have been a motivation for redeploying clinical skill mix staff, or more clinical skill mix staff than health visitors, when decisions on redeployment were made.

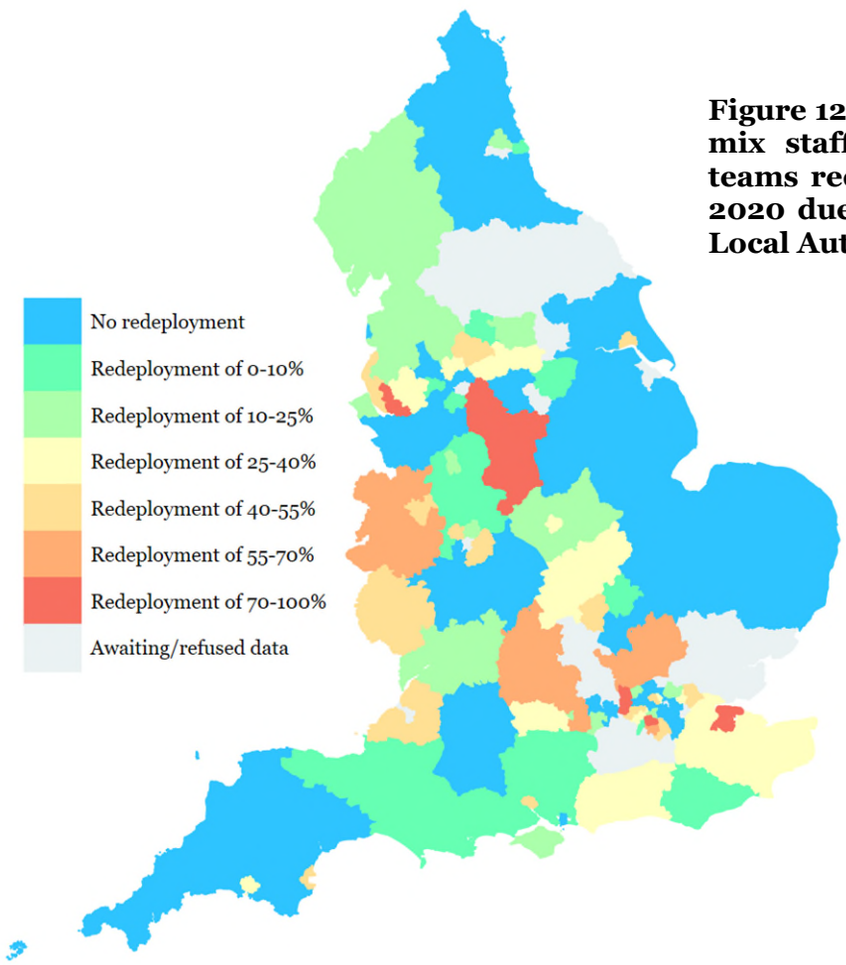


Figure 12 (left): Percent of clinical skill mix staff working in health visiting teams redeployed up to 1st September 2020 due to COVID-19, by Upper-Tier Local Authority in England

N=136

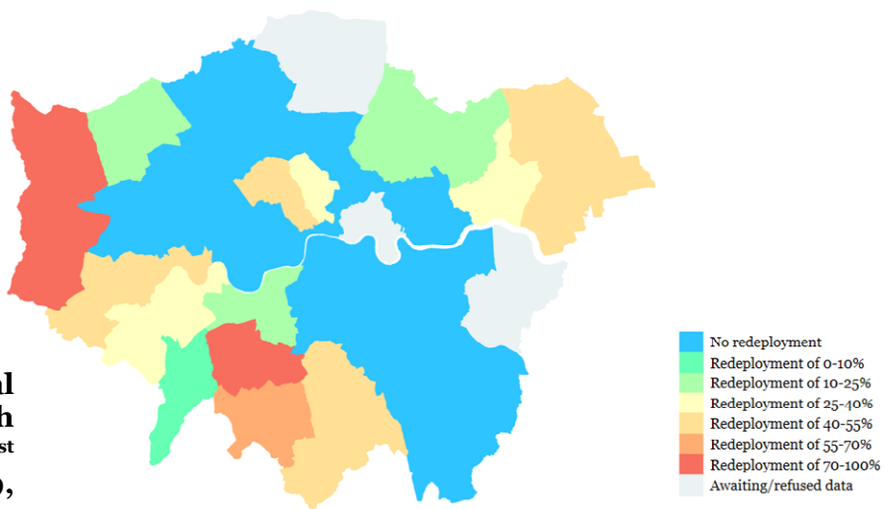
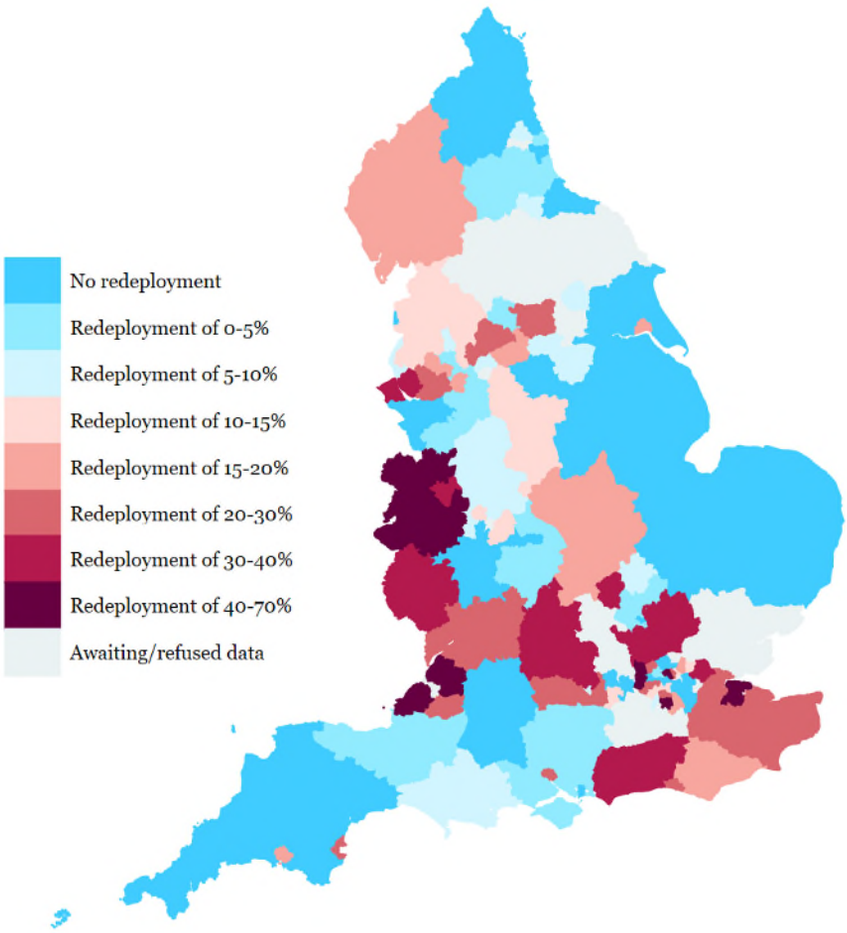


Figure 13 (right): Percent of clinical skill mix staff working in health visiting teams redeployed up to 1st September 2020 due to COVID-19, by London Borough

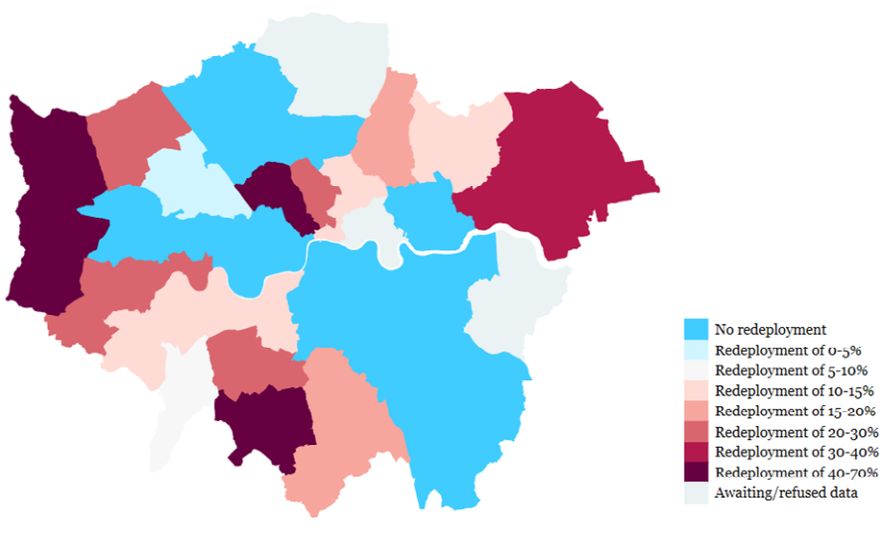
N=30

C. Redeployment of all staff in health visiting teams. In Figures 14 and 15 we combine the health visitors and other clinical skill mix staff to show the extent of redeployment of total FTE staff in health visiting teams across local authorities, which reached a maximum of 63%. We find that the percent of health visitors and of clinical skill mix staff redeployed are significantly positively correlated.



Note: N=138.

Figure 14: Percent of total staff in health visiting teams redeployed up to 1st September 2020 due to COVID-19, by Upper-Tier Local Authority in England

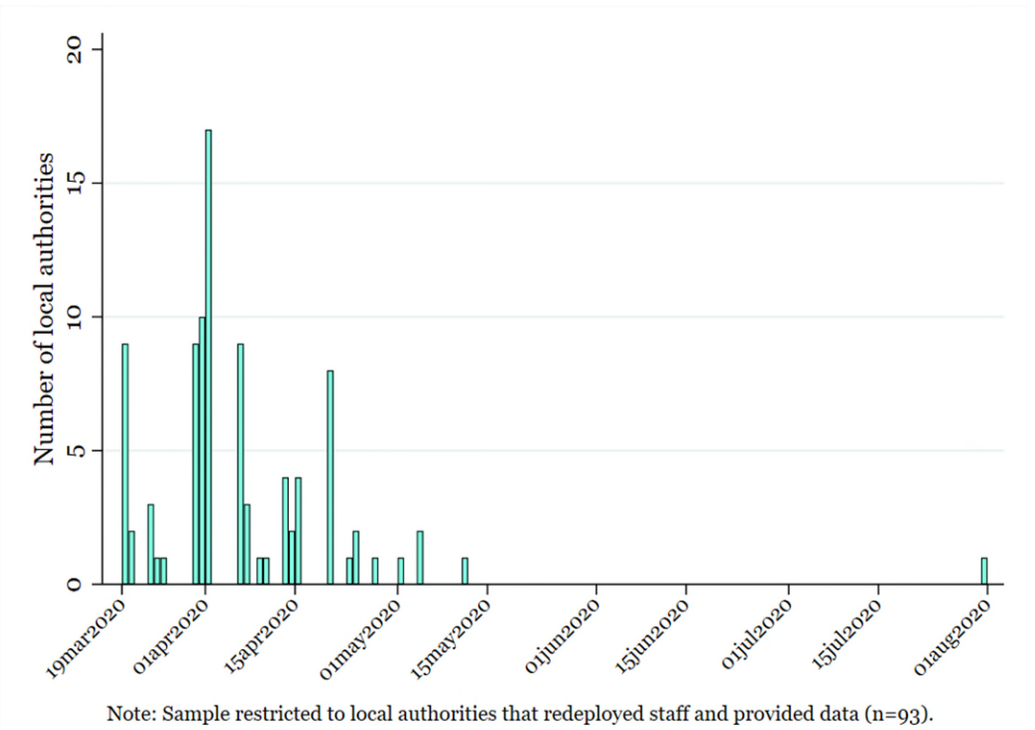


N=30

Figure 15: Percent of total staff in health visiting teams redeployed up to 1st September 2020 due to COVID-19, by London Borough

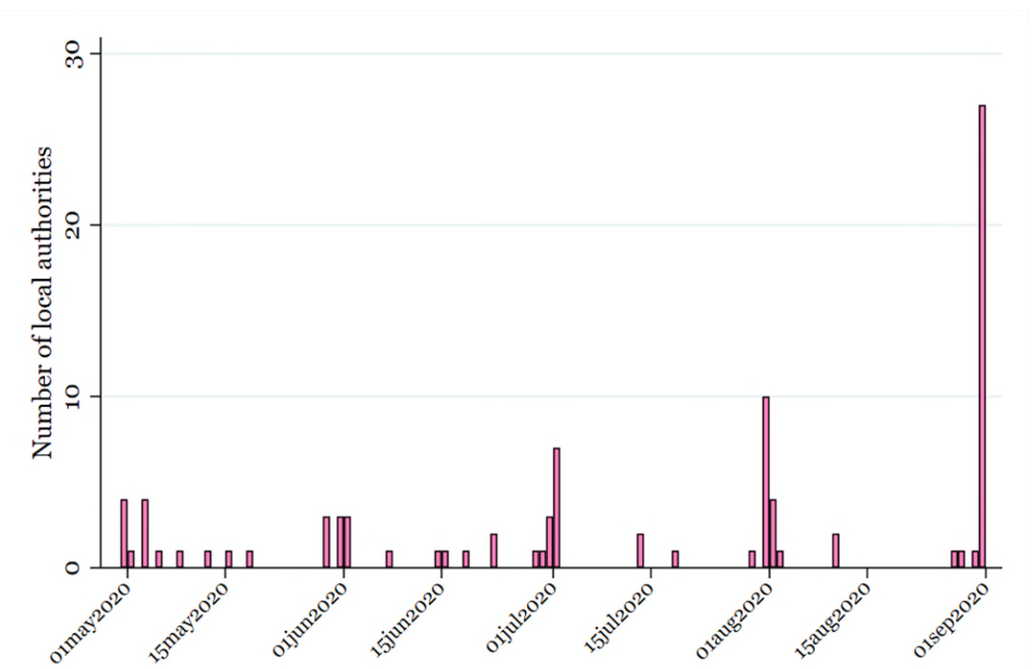
6. Dates and duration of redeployment for the first COVID-19 wave

Redeployment started as soon as the NHS guidance was issued, with staff leaving their health visiting teams on 19 March 2020. In 95% of local authorities that redeployed staff, redeployment started before May (figure 16). We then consider the end date as the date in which the last health visiting staff member who was redeployed returned to her team. Where redeployment was ongoing, we set September 1 as cut-off date for the first COVID-19 wave. Despite the supposed restoration of health visiting services issued on 3 June 2020, redeployment of staff was still in place well past this date and up to September 1 (figure 17). In 75% of local authorities that redeployed staff, redeployment still occurred past June 3.



Note: Sample restricted to local authorities that redeployed staff and provided data (n=93).

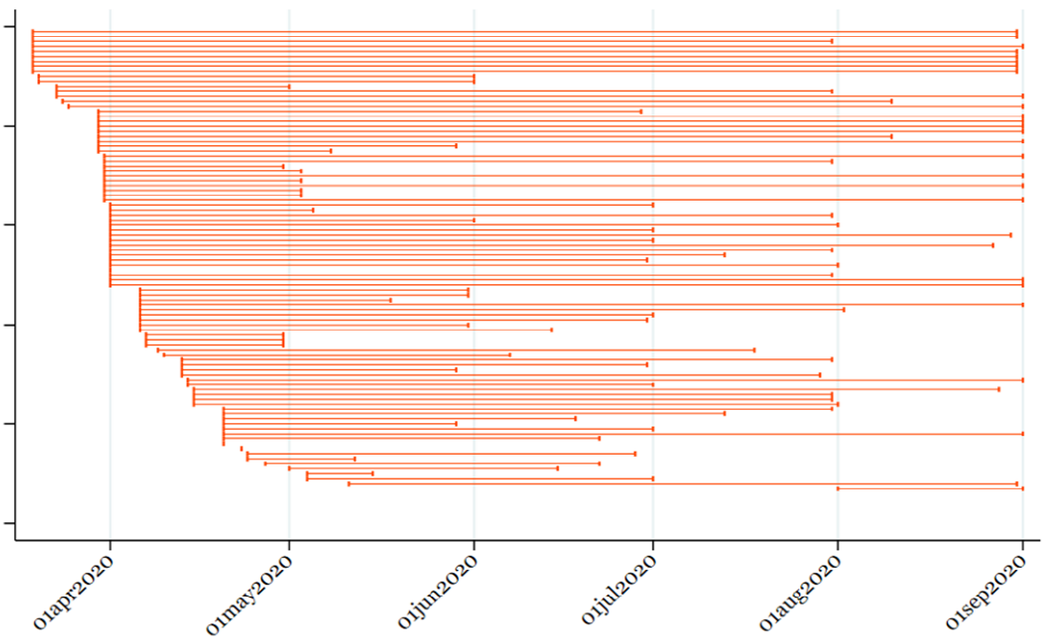
Figure 16: Earliest date at which health visiting staff was redeployed



Note: Sample restricted to local authorities that redeployed staff and provided data (n=92).
Where redeployment was ongoing end date coded as 1 September.

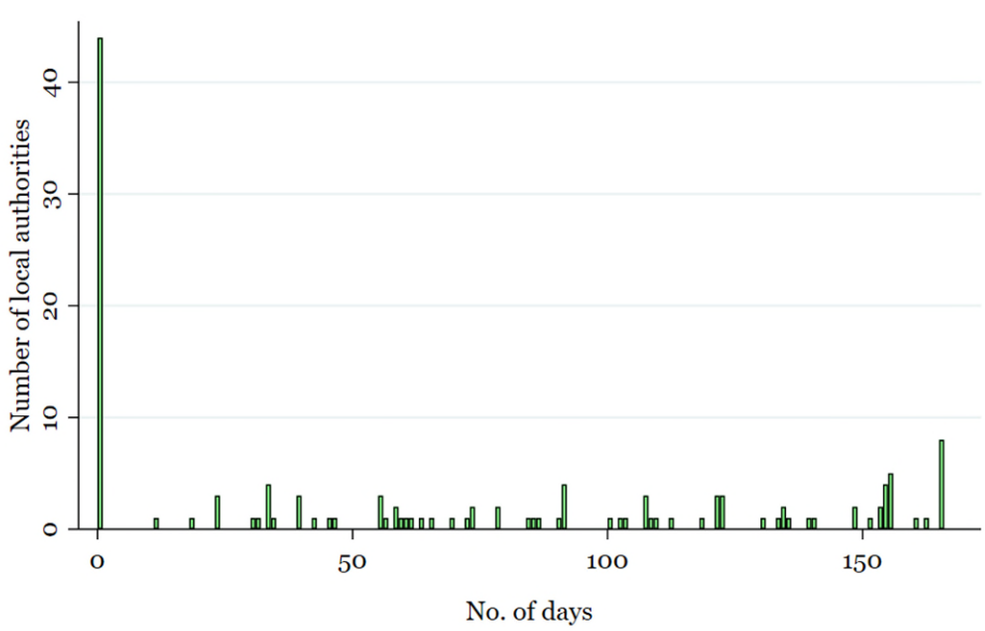
Figure 17: Latest date at which health visiting staff returned from redeployment

Last, we look at the duration of any redeployment of health visiting staff up to September 1, by calculating the time between the start and end dates of redeployment. We note that redeployment of staff may not have been continuous throughout March to September; staff returning and leaving, however, can still be viewed as disruptions to the health visiting service. The average duration of redeployment up to September 1 was 66.5 days (2.2 months). Around a quarter (23%) of local authorities in our sample that redeployed staff had staff redeployed for over 4 months by the September 1 cut-off. Figure 18 presents a visualisation of the spells of redeployment by date, starting with those that redeployed staff from the 19th of March (NHS England guidance issued). Figure 19 shows the distribution of duration spells. There is a large mass at zero, but otherwise duration of redeployment is dispersed across the range of 0 to over 150 days.



Note: Sample restricted to local authorities that redeployed staff and provided data (n=92).
Where redeployment was ongoing end date coded as 1 September

Figure 18: Duration of redeployment up to 1st September 2020



Note: Sample restricted to local authorities that provided data (n=134).
Where redeployment was ongoing end date coded as 1 September.

Figure 19: Distribution of duration of redeployment up to 1st September 2020

7. Conclusions

In this brief we have presented new evidence from FOI data on the state of health visiting services before the pandemic and on redeployment of members of health visiting teams during the first COVID-19 wave across England. The FOI data shows significant variation in the composition of health visiting teams on 1 February 2020, with health visitors making up on average 70% of them, and clinical skill mix staff (not defined as health visitor, such as community nurses and nursery nurses) making up the rest. In 80% of local authorities, caseloads were greater than 250 children per staff, the maximum caseload size recommended by the Institute of Health Visiting. The FOI data further reveals significant variation in redeployment, with 0% to 63% of FTE health visiting staff being redeployed across local authorities. Staff were first redeployed as soon as NHS England released guidance on prioritisation of community services, and continued to be redeployed past 1 September 2020 in some areas. The average duration of redeployment was over 2 months. During this time families were unlikely to be receiving their normal health visiting service, given that three of the five mandated Healthy Child Programme contacts were paused for families who were not identified as vulnerable or in clinical need (under NHS England guidance).

Although we have focused on redeployment during the first wave of COVID-19 (up to 1 September), we wish to highlight recent guidance on redeployment for the second wave. On 7 October, a joint letter on winter planning for COVID-19 from Public Health England, the NHS and the Local Government Association advised *"that professionals supporting children and families, such as health visitors, […] should not be redeployed to other services"*. The letter also stated that these professionals should be supported in providing front line services during pregnancy and the early years (0-19), and to vulnerable families. The letter, however, also noted: *"Where these public health and specialist nurses have specific skills and experience that is required locally (for example, training in ITU) then individual discussions should take place, and if these individuals are redeployed this should be for shortest possible time."* We are currently collecting information on the second wave, and we will update this brief in due course.[9]

The COVID-19 pandemic and its associated lockdown have been extremely difficult for many families, especially for new parents. Redeployment will likely have had material impacts on children and families who rely on health visiting professionals for care, support, and health and child development advice. Previous findings from our survey of health visiting staff have revealed that redeployment meant that in many cases the number of children staff were responsible for increased (Conti & Dow, 2020). As documented here, health visiting services were already stretched prior to COVID-19, following years of public health funding cuts. The COVID-19 pandemic has further exacerbated existing pressures. With redeployment rates differing substantially across local authorities, young children and families' access to health visiting services and level of care and support available will have been determined by their postcode.

We make the following policy recommendations.

- A clear workforce plan is needed to ensure that the health visiting service has sufficient capacity to manage the backlog of missed appointments, as well as the demand for support due to the secondary impacts of the pandemic.
- We recommend additional support and contact for new parents who had their first child during the pandemic, with a focus on those with vulnerabilities.
- A cross-government strategy is needed to reduce inequalities - this will require sustained investments to strengthen the health visiting service, which plays a crucial role in the early identification and support of the most disadvantaged families.
- A boost in public health funding to local authorities is required to counteract the cuts to health visiting teams as a result of public health budget cuts over the past years. The 2020 increase in the public health grant is a positive step, but more is needed.

[9] Preliminary evidence shows that, in a small number of local authorities, staff had yet not come back from the 1st wave redeployment after 7 October 2020.

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Annex

1. FOI request template

Regarding your health visiting teams for <local authority> on the 1st February 2020:

How many full time equivalent (FTE) health visitors were employed in your health visiting teams? Please provide this information broken down by NHS pay band.

How many full time equivalent (FTE) health visitors with caseload were employed in your health visiting teams? Please provide this information broken down by NHS pay band.

How many FTE clinical skill mix staff who are NOT coded as health visitors were employed in your health visiting teams? Please provide this information broken down by NHS pay band.

How many FTE clinical skill mix staff who are NOT coded as health visitors with caseload were employed in your health visiting teams? Please provide this information broken down by NHS pay band.

What was the total caseload (number of children under-5 years of age) of your health visiting teams?

Regarding how Covid-19 and NHS England's "Covid-19 prioritisation within Community Health Services" that was announced on the 19th March 2020 has affected your health visiting teams for <local authority>:

What is the maximum number of FTE health visitors that have been/were redeployed because of COVID-19 to date? Please also provide the date that the information refers to.

What is the maximum number of FTE clinical skill mix staff working in your health visiting teams (NOT coded as health visitors) that have been/were redeployed because of Covid-19 to date? Please also provide the date that the information refers to.

These staff may be in the following roles: skill mix staff community nursery nurses, staff nurses in health visiting teams, student health visitors and other skill mix staff working directly with families.

Regarding the questions above:
Please provide the date that the data refers to, if you hold this information. For your answers, please either use the NHS Digital definition of health visitor or alternatively provide the definition that you are using in your answer.

Definitions:

Definition used by NHS Digital re. Health visitors (notes 28 and 29 from the nursing, midwifery and health visiting staff matrix of Occupation Code Manual):

28. Please ensure to code the following as Health Visitors:
* qualified nurses/midwives who also hold a qualification as a Registered Health Visitor under the Specialist Community Public Health Nursing part of the NMC Register working directly with children and families;
* qualified and registered Health Visitors who perform specific activities such as providing breastfeeding advice to parents;
* family nurses working within the Family Nurse Partnership Programme who are qualified and registered as Health Visitors;
* Sure Start Children's Centre qualified and registered named Health Visitors;
* managers within a Health visiting team who hold a health visiting qualification and registration and are involved in clinical work or safeguarding.

29. Please ensure that the following employees are not coded as Health Visitors:
* any person working in a health visiting team who does not hold a qualification and registration as a Health Visitor;
* any person who holds a qualification and registration as a Health Visitor but is not employed in a role where this is a requirement;
* managers within a health visiting team who hold health visiting qualification and registration but are not involved in clinical work or safeguarding.

Please see below the general definition for 'health visitor' from the Occupation Code Manual:
Health Visitor: an employee who holds a qualification as a Registered Health Visitor under the Specialist Community Public Health Nursing part of the NMC Register and who occupies a post where such a qualification is a requirement. Not below Agenda for Change Band 6.

2. FOI request - follow up query

(To those providers that did not provide this information initially)

Would you be able to confirm the start and end date of the staff redeployment please?

3. Status of responses by local authority

Upper tier local authority	Full data?	Full redeployment data?	Full caseload data?	Full staff data?
Hartlepool	Yes	Yes	Yes	Yes
Middlesbrough	Yes	Yes	Yes	Yes
Redcar and Cleveland	Yes	Yes	Yes	Yes
Stockton-on-Tees	No	Yes	No	No
Darlington	Yes	Yes	Yes	Yes
Halton	Yes	Yes	Yes	Yes
Warrington	Yes	Yes	Yes	Yes
Blackburn with Darwen	Yes	Yes	Yes	Yes
Blackpool	Yes	Yes	Yes	Yes
Kingston upon Hull, City of	Yes	Yes	Yes	Yes
East Riding of Yorkshire	Yes	Yes	Yes	Yes
North East Lincolnshire	Yes	Yes	Yes	Yes
North Lincolnshire	Yes	Yes	Yes	Yes
York	Yes	Yes	Yes	Yes
Derby	No	Yes	No	No
Leicester	Yes	Yes	Yes	Yes
Rutland	No	Yes	No	Yes
Nottingham	No	No	No	No
Herefordshire, County of	No	Yes	No	No
Telford and Wrekin	Yes	Yes	Yes	Yes
Stoke-on-Trent	Yes	Yes	Yes	Yes
Bath and North East Somerset	Yes	Yes	Yes	Yes
Bristol, City of	Yes	Yes	Yes	Yes
North Somerset	Yes	Yes	Yes	Yes
South Gloucestershire	Yes	Yes	Yes	Yes
Plymouth	Yes	Yes	Yes	Yes
Torbay	Yes	Yes	Yes	Yes
Swindon	Yes	Yes	Yes	Yes
Peterborough	Yes	Yes	Yes	Yes
Luton	Yes	Yes	Yes	Yes

Southend-on-Sea	No	No	No	Yes
Thurrock	Yes	Yes	Yes	Yes
Medway	Yes	Yes	Yes	Yes
Bracknell Forest	No	Yes	No	Yes
West Berkshire	No	Yes	No	Yes
Reading	No	Yes	No	Yes
Slough	Yes	Yes	Yes	Yes
Windsor and Maidenhead	Yes	Yes	Yes	Yes
Wokingham	No	Yes	No	Yes
Milton Keynes	Yes	Yes	Yes	Yes
Brighton and Hove	Yes	Yes	Yes	Yes
Portsmouth	Yes	Yes	Yes	Yes
Southampton	Yes	Yes	Yes	Yes
Isle of Wight	Yes	Yes	Yes	Yes
County Durham	Yes	Yes	Yes	Yes
Cheshire East	Yes	Yes	Yes	Yes
Cheshire West and Chester	No	Yes	No	Yes
Shropshire	Yes	Yes	Yes	Yes
Cornwall	Yes	Yes	Yes	Yes
Isles of Scilly	Yes	Yes	Yes	Yes
Wiltshire	Yes	Yes	Yes	Yes
Bedford	Yes	Yes	Yes	Yes
Central Bedfordshire	Yes	Yes	Yes	Yes
Northumberland	Yes	Yes	Yes	Yes
Bournemouth, Christchurch and Poole	Yes	Yes	Yes	Yes
Dorset	No	Yes	Yes	Yes
Bolton	Yes	Yes	Yes	Yes
Bury	Yes	Yes	Yes	Yes
Manchester	Yes	Yes	Yes	Yes
Oldham	Yes	Yes	Yes	Yes
Rochdale	Yes	Yes	Yes	Yes
Salford	Yes	Yes	Yes	Yes
Stockport	Yes	Yes	Yes	Yes
Tameside	No	No	No	No
Trafford	Yes	Yes	Yes	Yes
Wigan	Yes	Yes	Yes	Yes
Lewisham	Yes	Yes	Yes	Yes
Knowsley	Yes	Yes	Yes	Yes
Liverpool	Yes	Yes	Yes	Yes
St. Helens	Yes	Yes	Yes	Yes
Sefton	Yes	Yes	Yes	Yes
Wirral	Yes	Yes	Yes	Yes
Barnsley	Yes	Yes	Yes	Yes
Doncaster	Yes	Yes	Yes	Yes
Rotherham	Yes	Yes	Yes	Yes
Sheffield	Yes	Yes	Yes	Yes
Newcastle upon Tyne	Yes	Yes	Yes	Yes
North Tyneside	Yes	Yes	Yes	Yes
South Tyneside	Yes	Yes	Yes	Yes

Sunderland	Yes	Yes	Yes	Yes
Birmingham	Yes	Yes	Yes	Yes
Coventry	Yes	Yes	Yes	Yes
Dudley	Yes	Yes	Yes	Yes
Sandwell	No	No	No	No
Solihull	Yes	Yes	Yes	Yes
Walsall	Yes	Yes	Yes	Yes
Wolverhampton	Yes	Yes	Yes	Yes
Bradford	Yes	Yes	Yes	Yes
Calderdale	Yes	Yes	Yes	Yes
Kirklees	Yes	Yes	Yes	Yes
Leeds	Yes	Yes	Yes	Yes
Wakefield	Yes	Yes	Yes	Yes
Gateshead	No	Yes	No	No
City of London	Yes	Yes	Yes	Yes
Barking and Dagenham	Yes	Yes	Yes	Yes
Barnet	Yes	Yes	Yes	Yes
Bexley	No	No	No	No
Brent	Yes	Yes	Yes	Yes
Bromley	Yes	Yes	Yes	Yes
Camden	Yes	Yes	Yes	Yes
Croydon	Yes	Yes	Yes	Yes
Ealing	Yes	Yes	Yes	Yes
Enfield	No	No	Yes	Yes
Greenwich	Yes	Yes	Yes	Yes
Hackney	Yes	Yes	Yes	Yes
Hammersmith and Fulham	Yes	Yes	Yes	Yes
Haringey	Yes	Yes	Yes	Yes
Harrow	Yes	Yes	Yes	Yes
Havering	Yes	Yes	Yes	Yes
Hillingdon	Yes	Yes	Yes	Yes
Hounslow	Yes	Yes	Yes	Yes
Islington	Yes	Yes	Yes	Yes
Kensington and Chelsea	Yes	Yes	Yes	Yes
Kingston upon Thames	Yes	Yes	Yes	Yes
Lambeth	Yes	Yes	Yes	Yes
Merton	Yes	Yes	Yes	Yes
Newham	Yes	Yes	Yes	Yes
Redbridge	Yes	Yes	Yes	Yes
Richmond upon Thames	Yes	Yes	Yes	Yes
Southwark	No	Yes	No	No
Sutton	Yes	Yes	Yes	Yes
Tower Hamlets	No	No	No	No
Waltham Forest	Yes	Yes	Yes	Yes
Wandsworth	Yes	Yes	Yes	Yes
Westminster	Yes	Yes	Yes	Yes
Buckinghamshire	Yes	Yes	Yes	Yes
Cambridgeshire	Yes	Yes	Yes	Yes
Cumbria	Yes	Yes	Yes	Yes
Derbyshire	Yes	Yes	Yes	Yes

Devon	Yes	Yes	Yes	Yes
East Sussex	Yes	Yes	Yes	Yes
Essex	No	No	No	No
Suffolk	Yes	Yes	Yes	Yes
Surrey	No	No	No	No
Warwickshire	Yes	Yes	Yes	Yes
West Sussex	Yes	Yes	Yes	Yes
Worcestershire	Yes	Yes	Yes	Yes
Gloucestershire	Yes	Yes	Yes	Yes
Hampshire	Yes	Yes	Yes	Yes
Hertfordshire	Yes	Yes	Yes	Yes
Kent	Yes	Yes	Yes	Yes
Lancashire	Yes	Yes	Yes	Yes
Leicestershire	Yes	Yes	Yes	Yes
Lincolnshire	Yes	Yes	Yes	Yes
Norfolk	Yes	Yes	Yes	Yes
Northamptonshire	Yes	Yes	Yes	Yes
North Yorkshire	No	Yes	No	No
Nottinghamshire	Yes	Yes	Yes	Yes
Oxfordshire	Yes	Yes	Yes	Yes
Somerset	Yes	Yes	Yes	Yes
Staffordshire	Yes	Yes	Yes	Yes