City of Wolverhampton
Health & Wellbeing Together

Wolverhampton Health Inequalities Strategy 2021-2023

Supporting Relight and Recovery for the City

Appendix 1

Contents

Front cover: 'Playing Out' – Great Hampton Street, Wolverhampton

Foreword

In Wolverhampton stark inequalities continue to exist in the conditions in which people are born, grow, work, live, and age. In turn these inequalities have an adverse effect on people's health and wellbeing.

Covid-19 has further exacerbated these existing health inequalities with negative impacts falling disproportionately on more deprived, disadvantaged and excluded groups and individuals. Alongside the bereaved, there are many people who are suffering from long term physical and mental impacts of Covid-19. There are also many who have been affected financially, which brings its own health consequences. This strategy represents our combined response to pro-actively addressing these inequalities with a renewed sense of urgency and pace. We aim to do this by building on the strengthened partnership working galvanised through our collective efforts to address the pandemic.

Health and Wellbeing Together is the forum where key leaders from the health, care and wider system come together to improve the health and wellbeing of the local community. The board works towards reducing health inequalities and supports the development of improved and joined up health and social care services. It is therefore particularly well placed to be the system catalyst for the development and delivery of a strategy to address health inequalities as we seek to 'relight' and recover as a city from Covid-19.

The aim of this strategy is to provide a framework for addressing the board's growing well, living well and ageing well priorities with the aim of enabling Wolverhampton and the wider system to "Build Back Fairer."[1] It is a deliberately short action-orientated document. It outlines our joint commitment to understand health inequalities in the city and undertake a systematic and joined-up approach to ensure no-one is left behind.

Councillor Jasbir Jaspal

Cabinet Member for Health and Wellbeing

Chair of the Health and Wellbeing Together Board

Paul Tulley

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1 https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review

Introduction:

Understanding what we mean by ‘health inequalities’

Health Inequalities are systematic, unfair and preventable differences in health across the population, and between different groups within society. The Kings Fund[2] describe health inequalities in the following way:

Inequalities of what?

Health inequalities are ultimately about differences in the status of people’s health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status.

Health inequalities can therefore involve differences in:

- **Health status,** for example, life expectancy and prevalence of health conditions
- **Access to care**, for example, availability of treatments
- **Quality and experience of care**, for example, levels of patient satisfaction
- **Behavioural risks to health**, for example, smoking rates
- **Wider determinants of health**, for example, quality of housing.

https://www.kingsfund.org.uk/publications/what-are-health-inequalities

The 'inequalities of what' question then leads to another question:

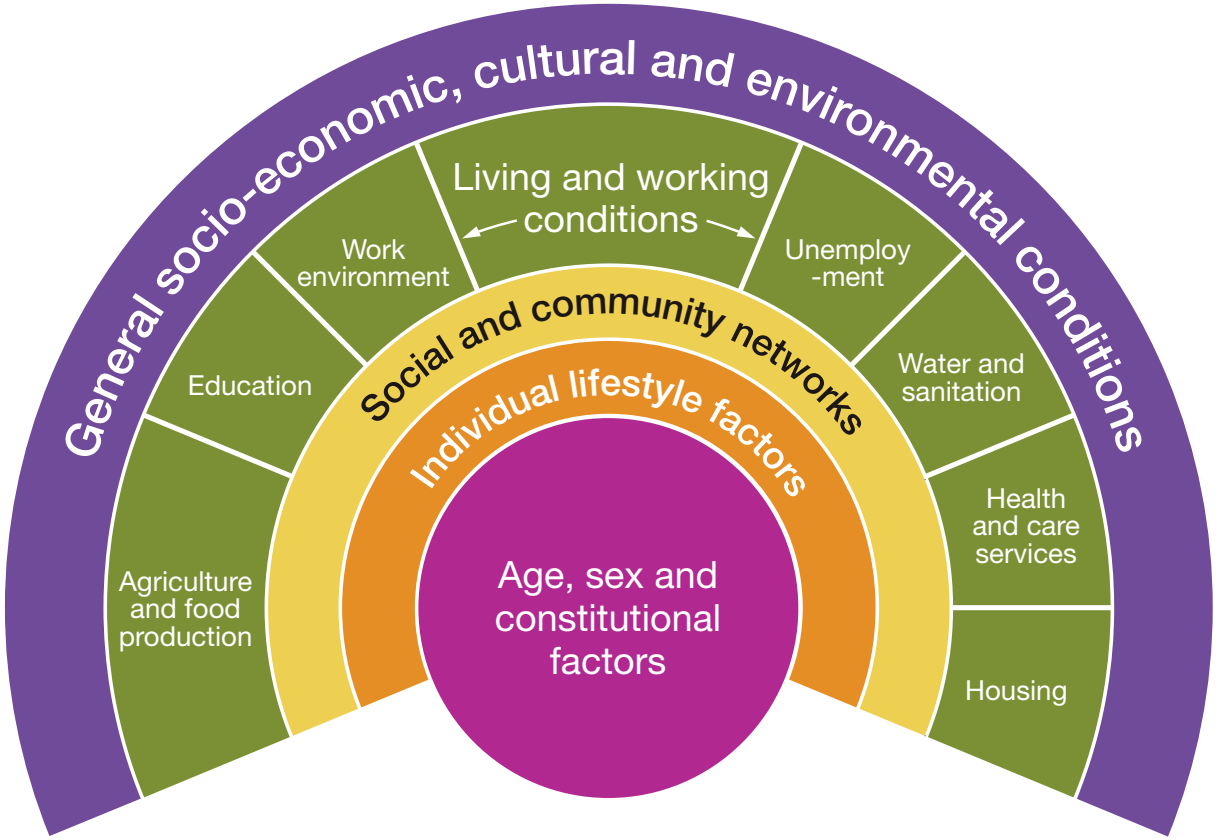
Inequalities between whom or between which groups?

Differences in the status of people's health and the things that determine it can be experienced by people grouped by a range of factors. For this reason, in England, health inequalities are often analysed and addressed by policy across four factors:

- **Socio-economic factors** e.g. a person's lived social and economic experiences and realities. This can include education, income and occupation, place of residence etc.
- **Geography**. Evidence demonstrates that people living in the most deprived areas face worse health inequalities in relation to health access, experiences and outcomes. A definition of deprived area is based on a number of characteristics included in the index of Multiple Deprivation – Income Deprivation, Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability; Crime; Barriers to Housing and Services; Living Environment Deprivation. Both urban and rural areas can be deprived.
- **Specific characteristics or 'protected groups'** including those protected in law by the Equality Act 2010 e.g. age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race—this includes ethnic or national origins, colour or nationality; religion or belief—this includes lack of belief, sex, sexual orientation.
- **Socially excluded groups**, sometimes referred to as 'inclusion health groups'. This is used to refer to a number of groups of people who are not usually well provided for by healthcare services, and have poorer access, experiences and health outcomes. The definition covers people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Gypsy, Roma and Traveller communities.

People can experience different combinations of these factors and there can also be multiple interactions between the factors.

The ways in which social, economic and physical environments interact with individual biological factors and behaviours to shape health status is often visually represented using this diagram.



Source: Dahlgren and Whitehead, 1991

By seeking to understand what health inequalities are and define who may experience them, we can then focus on how to respond as a system. Currently health inequalities shorten people's lives and lead to avoidable years of people living with impaired health and wellbeing. They also cost the NHS, wider public sector and national and local economies billions of pounds.

Effectively tackling differences in health outcomes starts with a recognition of the different inter-related drivers of health inequalities. While we can improve access to and quality of services, it is clear an NHS response cannot deal with these disparaties alone. It requires local systems to work together with strong leadership, joint planning, ambition and scale.

As an outcome of this strategy we seek not to worsen health inequalities and to proactively work to reduce them. To achieve this requires a multi-agency approach.

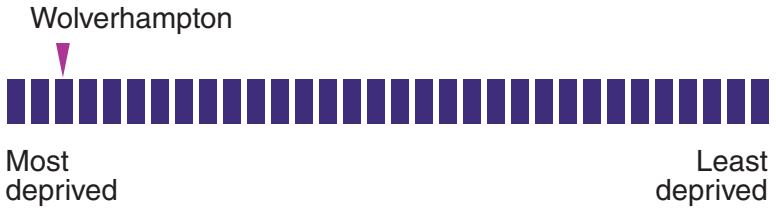
Where are we starting from?

Life expectancy

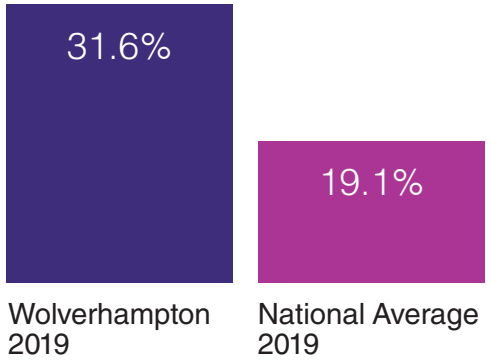
Life expectancy is a key measure of a population's health status. We already know there is a large difference in life expectancy in our city, driven in part by deprivation. This is illustrated on pages 8 and 9 of this document. Increasing life expectency is one of the goals of Wolverhampton's vision for Public Health 2030.[2]

Even before Covid-19, Wolverhampton was ranked 24th out of 317 using the indices of deprivation measure. The city also experienced high levels of child poverty, 31.6% in 2019 compared to a national average of 19.1%.[3] Early indications are that Covid-19 will have worsened deprivation for people living in the city. For example, Wolverhampton is in the top five in the country for the highest unemployment rate amongst young people aged 18 – 24 years and top ten in the country for unemployment overall (age 16-64).

Indicies of Deprivation Index



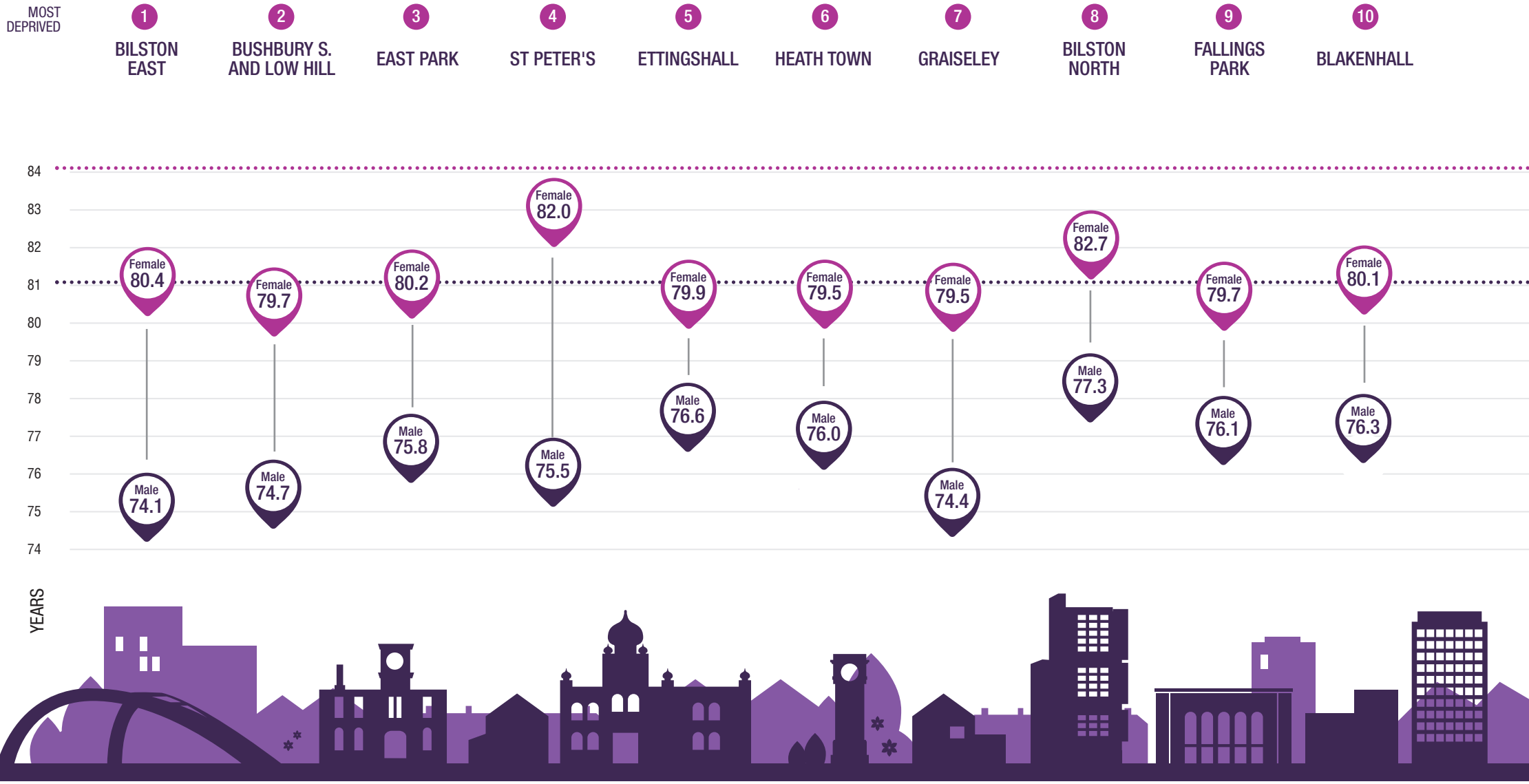
Child poverty

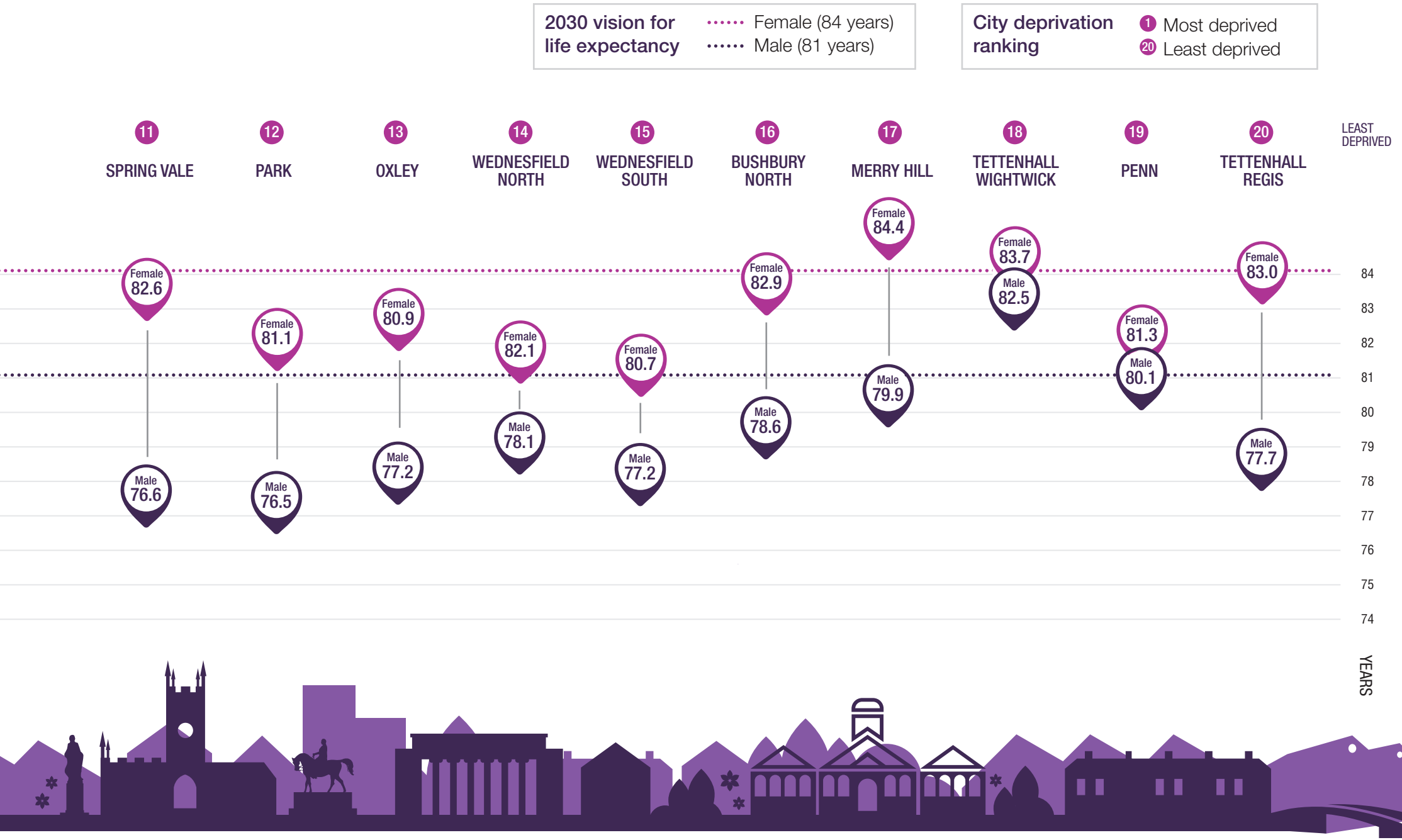


2 https://www.wolverhampton.gov.uk/sites/default/files/pdf/The_vision_for_Public_Health_2030.pdf

3 https://insight.wolverhampton.gov.uk/Home/Report/8ce971cf-f973-4148-9f98-abac58b27f7a

Life expectancy at birth




2030 vision for life expectancy
Female (84 years)
Male (81 years)
City deprivation ranking
1 Most deprived
20 Least deprived
11 SPRING VALE
12 PARK
13 OXLEY
14 WEDNESFIELD NORTH
15 WEDNESFIELD SOUTH
16 BUSHBURY NORTH
17 MERRY HILL
18 TETTENHALL WIGHTWICK
19 PENN
20 TETTENHALL REGIS
LEAST DEPRIVED
Female 82.6
Male 76.6
Female 81.1
Male 76.5
Female 80.9
Male 77.2
Female 82.1
Male 78.1
Female 80.7
Male 77.2
Female 82.9
Male 78.6
Female 84.4
Male 79.9
Female 83.7
Male 82.5
Female 81.3
Male 80.1
Female 83.0
Male 77.7
84
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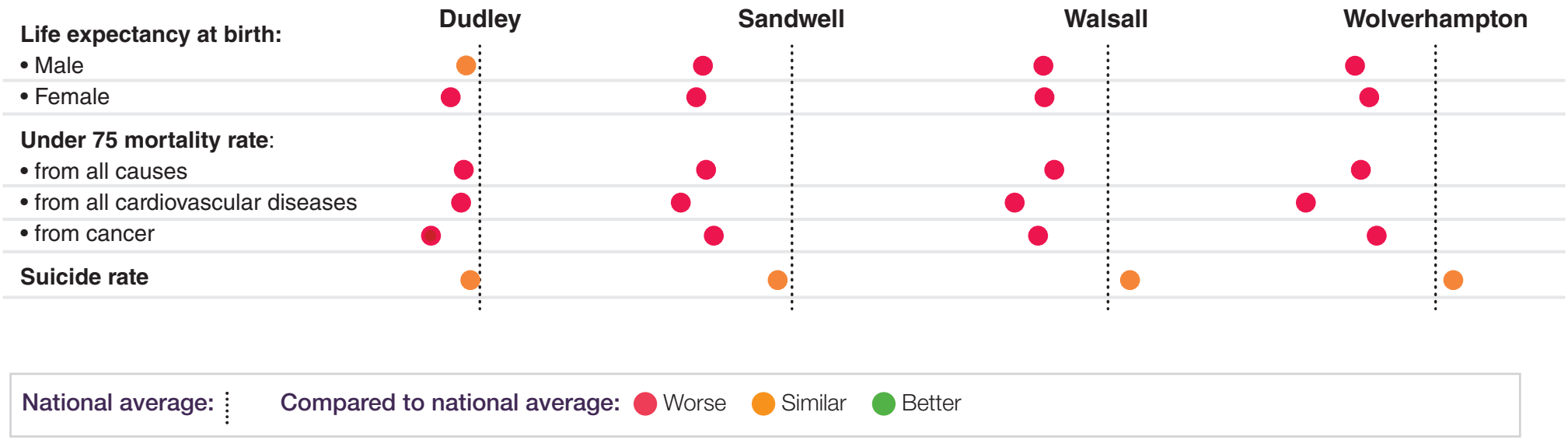
75
74
YEARS

Across the Black Country mortality from conditions considered preventable is relatively high and there is a high prevalence of long-term conditions, especially in relation to hypertension, diabetes, chronic kidney disease, chronic heart disease, depression, and dementia.

The Black Country has some of the highest infant mortality rates in the country – smoking rates in pregnancy remain high, and breast-feeding rates are low.

Rates of falls and hip fractures in older people are high, as are households living in fuel poverty meaning people are exposed to the risk of cold housing in winter exacerbating long-term conditions.

Those in contact with mental health services have a life expectancy 18.4 and 15.2 years shorter, respectively, than the rest of the local population.



https://fingertips.phe.org.uk/profile/health-profiles/area-search-results/E12000005?search_type=list-child-areas&place_name=West%20Midlands

Where are we starting from?

Healthy life expectancy

Another key measure of health inequality is how much time people spend living in good health. Before Covid-19, healthy life expectancy in Wolverhampton for both men and women was already worse than the national average. This means people in the city are likely to spend less years of their life in a state of 'good' general health in comparison to the rest of the country. This has significant implications for people's quality of life and demand on local health and social care services.

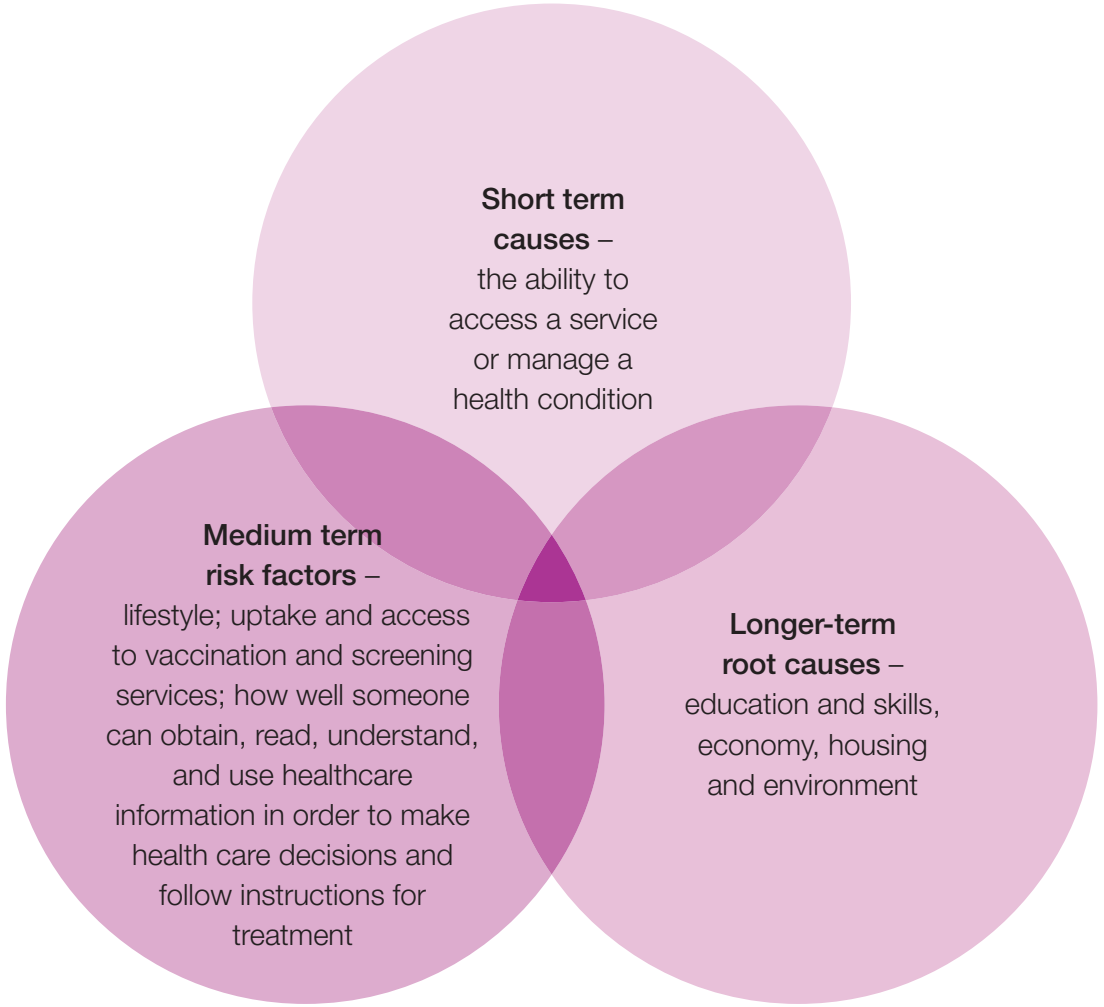
As highlighted in the introduction a range of factors including socio-economic conditions, geography, belonging to a protected group or socially excluded group can all impact on people physical health and mental wellbeing, resulting in health inequalities. They shape the environmental, social and economic contexts of people's lives through education, income, employment, housing, exposure to air pollution and digital exclusion.

For example:

- Socio-economic conditions can trigger chronic stress hormone pathways affecting mental health and inflammatory responses.
- Where people live and work can impact on their level of exposure to pollutants, including air pollution, which in turn impacts on respiratory and cardiovascular disease.
- There can be disparity of experience related to different protected characteristics - mental health, substance misuse problems (depression and anxiety, drug and alcohol misuse) and involvement in criminal activity dominate in young adulthood. Musculoskeletal problems (including back pain, neck pain and arthritis) become increasingly common in later working age. Other non-communicable diseases including neurological disorders and sense organ diseases (such as hearing and sight loss), and unintentional injuries (especially falls) become more prominent in older age.
- Belonging to a socially excluded group can impact on your ability to access a service, for example homeless people can find it difficult to register with a GP.

The environments in which people are born, live, learn and work can also inform people's lifestyle choices. For example, we know that in Wolverhampton smoking is the biggest preventable cause of inequalities and accounts for over half of the difference in risk of premature death between social classes. We also know that hospital related stays for alcohol harm is one of the top four causes of premature death and poor quality of life related to deprivation; and alcohol specific conditions for Wolverhampton residents are worse than the national average and West Midlands region.

Healthy life expectancy can therefore be understood as being a result of the interplay between short term causes, medium term risks and longer-term root causes:



Addressing these factors requires a system response, with each member of the board having a part to play. To do this effectively requires a robust understanding of the lived experience of people. The board notes that whereas data on age, sex, deprivation and ethnicity is widely collected, data on health outcomes for socially excluded groups is not often readily available. As a board we are therefore committed to making a collected and concerted effort across the system on proactive engagement and better data capture in this area and then use this data to inform policy and improve outcomes for these groups.

In addition, as we emerge out of the pandemic, we want to have the fullest picture possible of the impact of health inequalities on residents in the city. This will involve seeking to have a better understanding of quality of life by taking into account a wide range of indicators, such as mental wellbeing, community assets and local conditions.

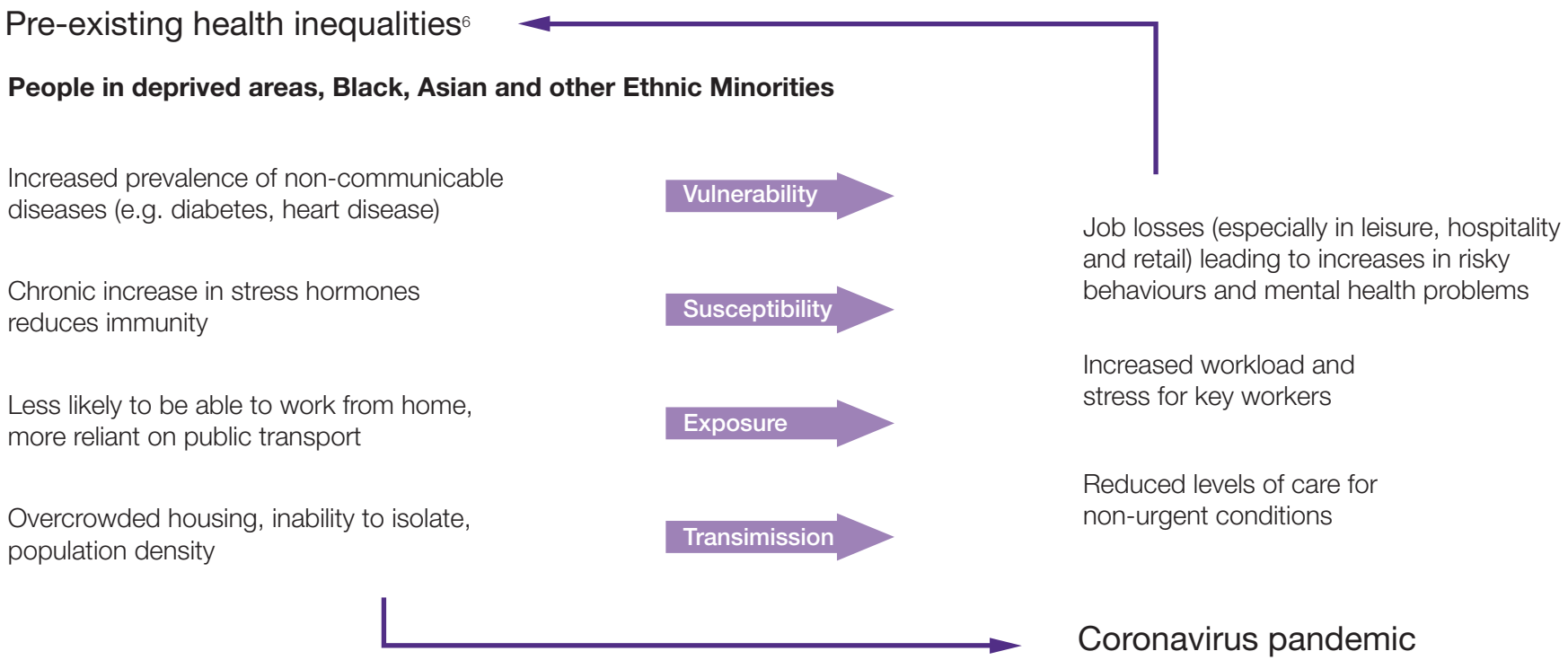
Vision and rationale

Our collective vision is based on an understanding that health inequalities are not inevitable and that taking action to tackle health inequalities requires improving the lives of those with the worst health outcomes, fastest. Covid-19 recovery needs to be predicated on a response that accurately recognises where health inequalities exist in the city, the impact of the pandemic on health inequalities and consensus on how partners can work together at pace to prevent inequalities getting worse and reduce them. This sense of urgency is heighted by a view that we cannot allow the legacy of Covid-19 in the city to be one that further entrenches poverty and inequalities.

Before Covid-19, Health and Wellbeing Together and partners across the system, both locally and regionally, were already committed to tackling health inequalities with associated work programmes and activity in train. The impetus for a strategy at this point in time is the recognition that Covid-19 has accelerated existing health inequalities and that the actions we take in response will have direct consequence on people's health and wellbeing – now and in the future.

The Wolverhampton Public Health Annual Report 2020-21[5] provides an overview of the pandemic to date including the impact of Covid-19 upon different populations in the city. It illustrates that people's experience of the pandemic has not been uniform. The report discusses the factors most associated with Covid-19 transmission and mortality. For example, people experiencing deprivation are more likely to be exposed to Covid-19.[6] They are more likely to live in overcrowded accommodation, or work in jobs in sectors where they are likely to be at higher risk of exposure to the virus. They are also less likely to be able to work from home, self-isolate, or access adequate sick pay. Deprived communities are more likely to experience poorer general health and people with existing poor health are at greater risk from Covid-19 should they contract it. There has also been a disproportionate impact of Covid-19 on people from Black, Asian and Minority Ethnic Groups. Underlying health conditions, occupational exposure and a range of other factors are also likely to be important when considering ethnicity. The report also addresses the indirect implications of Covid-19 and the associated restrictions, for example the increased risks to victims of abuse and exploitation who may have been at an increased risk from abusers and felt less able to seek support.

5 https://www.wolverhampton.gov.uk/health-and-social-care/health-and-wellbeing



It is not just the immediate impact of Covid-19 that has a health inequalities dimension. It is likely that the longer-term impacts of the pandemic will disproportionately impact particular groups, communities and individuals too.

6 Adapted from https://jech.bmj.com/content/jech/early/2020/06/13/jech-2020-214401.full.pdf

While the on-going health complications associated with Long Covid are not yet fully understood, it is reasonable to think that where particular groups, communities or geographical locations have experienced a higher rate of Covid-19 they are also more likely to experience higher rates of Long Covid. This will lead to a double hit that keeps people out of work and places additional pressure on the health and care system.

The Public Health 2020-21 annual report also highlights the impacts of the pandemic and associated lock-downs upon access to primary and secondary care. For example, cancer screening and cardiovascular checks were significantly reduced during 2020 creating a legacy that will impact on both life expectancy and healthy life expectancy going forward.

The economic, social and educational impacts of Covid-19 are also likely to disproportionately impact particular groups and individuals. We are already aware that disruption to education during the pandemic risks widing the gap in future health outcomes, with children and young people from disadvantaged backgrounds more likely to experience a greater deterioration in their educational outcomes. Issues such as digital exclusion also disproportionally impacted some individuals, young people and families more than others, affecting their ability to access remote learning and services.

Measures to protect people from Covid-19 in the future, such as the roll out of the vaccination programme, also need to have a commitment to equitable distribution so there are no barriers to participation for any individual or community.

This strategy recognises that community empowerment is central to efforts to reduce health inequalities. For some communities this will mean 'removing structural barriers to participation and for others facilitating and developing capacity and capability through personal and community development'.[7] Health and Wellbeing Together recognise this and has already committed to a place-based approach which builds on local assets and works with local people to 'co-produce' sustainable solutions to local issues, creating capacity and resilience.

7 https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Striving for a city with a physically and mentally healthy and resilient population is not only a moral and social imperative, it also has a positive economic benefit. The City of Wolverhampton's council led Covid-19 recovery commitment Relighting Our City, highlights the need to develop an approach to both employment and health inequalities, acknowledging the critical influences that social determinants of health can and do have. Supporting the Council's pandemic recovery is the Wolverhampton Pound initiative, a pledge from major public sector organisations in the city to drive more of their collective £834 million pound spend back into communities to generate new opportunities and local jobs.

To achieve our vision Health and Wellbeing Together constituent partners will adopt a set of guiding principles supported by an agreed high-level monitoring framework and tools. This framework and related tools will be applied to the future activity of the board in the realisation of its growing well, living well and ageing well priorities as outlined in the Joint Health and Wellbeing Strategy 2018-2023.[8] They will also support a culture that seeks to embed a commitment to tackling health inequality across new and emerging shared priorities in the wake of Covid-19 and wider service design and delivery going forward.

Wolves at Work Team supporting residents into work

8 http://wellbeingwolves.co.uk/pdf/Joint%20H&W%20Strategy%202018-23.pdf

Our guiding principles

The local health and social care landscape is composed of multiple overlaid geographical areas often extending beyond the city boundary. To achieve our collective vision the role of the Health and Wellbeing Together board is to act as 'enabler' and 'connector', ensuring system join-up, both at city level and via our contribution to the wider regional activity. It will achieve this by providing an overarching set of guiding principles and tools that facilitate and embed an agreed approach to tackling health inequalities for the citizens of Wolverhampton in a way that is tangible and outcome focused.

To support this the member organisations of Health and Wellbeing Together are committing to adopting the following:

In our decision making and use of intelligence:

- Adopting an agreed approach to data capture, linkage and sharing across the system to understand and respond to population need.
- Using a framework approach, for example by making use of the tools in the toolkit section of this report, to provide a systematic assessment of health inequalities across the system so as to collectively identify gaps and areas of alignment and to use this intelligence to inform action.

In our design and delivery of services:

- Exploring the impact of decisions on health inequalities early in the decision-making process and actively considering how the design of a service may increase inequalities or disproportionately disadvantage one community.
- Using linked data to understand and address equity of access to services and design services that are easy to navigate.
- Creating a culture that promotes and enables communities to be actively involved in shaping and coproducing activity to reduce health inequalities.
- Working collaboratively to promote and enhance digital inclusion.
- Being innovative and ambitious, with a firm view that health inequalities are not inevitable.

In our allocation of resources

- Committing to needs-based commissioning, allocating health and care resources proportionate to need.
- Collectively taking pro-active action across the life course to reduce health inequalities including investing in prevention, the wider determinants and giving every child the best start in life.
- Embedding measures that promote and enable an inclusive economy, for example working in partnership with anchor network groups on the adoption of Community Wealth Building principles to reorganise and control the local economy so that wealth is not extracted but broadly held and is generative.
- Exploring opportunities to re-shape procurement frameworks aligned to the Wolverhampton Pound initiative.
- Using our collective assets to create economic and social value in the local community.

As employers:

- Valuing staff through parity of recruitment, promotion and employment, with a commitment to build a workforce representative of the local area.
- Supporting career opportunities for local residents and under-represented groups including through the use of apprenticeships.
- Embedding workforce wellbeing initiatives to promote work-life balance and recognise where staff have been particularly impacted by being on the front-line of Covid-19.

As advocates

- Considering the impact on the environment and climate change of our policy decisions including raising environmental awareness, reducing carbon emissions and increasing sustainability.
- Pro-actively identify opportunities to have a positive impact on the wider determinants of health for example through planning, licensing and housing functions, use of assets and green space and provision of facilities for usage by community groups.

Collectively, as a strategic board

- Through delivery of our strategic plans and a commitment to hold ourselves and each-other to account.

Our local priorities

Our guiding principles articulate a shared commitment and agreed method for addressing health inequalities across the city and wider health and care system. Our local priorities are underpinned by the board's Joint Health and Wellbeing Strategy and will also flex over time both as we achieve progress, and in response to forthcoming changes due to national policy or context.

In 2021 Health and Wellbeing Together has agreed the following local priorities up until 2023 when the board's Joint Health and Wellbeing Strategy is next up for review.

We have committed to:

- Increase our understanding around health inequalities and our local population – including developing and implementing an agreed approach to data capture, data linkage and data sharing
- Work collaboratively across all parts of the health and care system to join-up and promote and embed action to reduce health inequalities
- To work in partnership with local people, groups and forums to ensure health and care pathways are informed and co-produced by people with lived experience, under-represented and protected groups.

If we achieve this, outcomes for local people should feel like this:

As a citizen living in Wolverhampton:

- We will not worsen health inequalities; we will work to reduce them.
- We will have a better understanding of how health inequalities impact on local people, or groups of people, and be able to improve access to health and care services and the quality of those services as a result.
- We will support our population by providing them with the skills, training and tools to access digitally enabled services, ensuring no-one is left behind in doing so.
- We will listen and engage with communities who need most support, deepening partnerships with community and voluntary sector.
- We will seek to improve green space and make it easier and safer for people to be physically active.
- We will work together to increase opportunities for local people to access jobs and training, including in health and care related professions.

As a person receiving support from our health and care system:

- Health and care services are more accessible, particularly those at risk of exclusion because of personal, economic or social factors.
- We will improve how we proactively identify the health and care needs of our population in order to identify and put in place support and treatment that our population need in order to stay well.
- We will invest in preventative programmes which proactively engage those at greatest risk of poor health outcomes.
- We will work together to make best use of funding for the benefit of local people.

Each organisation represented on the Health and Wellbeing Together Board will have a unique part to play in achieving these outcomes:

Health and Wellbeing Together Board sets the strategy for population health and wellbeing inequalities

Health and Wellbeing Strategy priorities

1 Early years **2** CYP mental wellbeing **3** Workforce **4** City centre
5 Embedding prevention **6** Integrated care **7** Dementia friendly city

Direct influence on equity of access and outcomes

NHS and care providers

Informed by One Wolverhampton Place-based Partnership initial priorities

Integrated care for people with complex needs, including end of life
Mental health
Healthy ageing
Children and young people

Council

Informed by the 'Relight' recovery plan to

Support people who need us most
Create more opportunities for young people
Generate more jobs and learning opportunities
Grow or vital local businesses
Stimulate vibrant high street and communities

Commissioners

Informed by Wolverhampton's Local Commissioning Board place-based priorities and Black Country wide ICS strategy, including a focus on:

Diabetes, obesity and smoking
Elective treatment restart
Mental health and early intervention
Vaccination

Wider public sector
including West Midlands Police and West Midlands Fire Service

Anchor institutions
e.g. University of Wolverhampton

Healthwatch

Voluntary and community sector
– early intervention and prevention activities and mitigating the impact of Covid-19 on citizens

Faith sector and other partners

--Direct Influence wider determinants

Influence of actions taken as anchor institutions (workforce, contracts, estates)

Health and Wellbeing Together recognises it has a strategic, not an operational role, and looks to all system partners to be able to demonstrate their organisational contribution to tackling health inequalities both at place and within the wider context of Integrated Care System arrangements. This will be an iterative process with each partner identifying activity to support the implementation of the strategy and the Board will be asking for evidence that the principles have been applied in practice through the delivery of this activity. Partners, supported by experts in Public Health, will hold each other to account for defining action and measuring progress. Wherever possible, action will be aligned and coordinated between partners, to maximise impact across the system.

How we will measure impact

A high-level monitoring framework will be used by Health and Wellbeing Together to measure the impact of the implementation of the guiding principles and tools included in this strategy. The framework recognises that board partners will be responsible for the delivery of their individual workstreams. This includes the One Wolverhampton Place-based Partnership on behalf of the health and care system.

Thematic update reports will be presented to the board providing a summary of partnership activity, the lead partner for delivery and a status update. The sharing of regular progress reports will provide both assurance and the opportunity for partners to align activity, enable system join-up, identify gaps and prevent duplication. It will also enable the board to identify where data and insight may be limited and new research or engagement needed.

Toolkit

To present and measure impact in addressing health inequalities in the city requires a systematic approach supported by evidence. This includes data, expertise and experience of health inequalities and success of interventions. There is a wealth of existing guidance and evidence that partners can utilise. Board partners are committed to paying due regard to these tools and in particular the Health Equity Assessment Tool.

Health Equity Assessment Tool (HEAT)

A template which poses a series of questions and prompts, designed to help the user systematically assess health inequalities related to their work programme and identify what you can do to help reduce inequalities.

https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

Other sources of information and data can also be used to inform decision making:

Wolverhampton Joint Strategic Needs Assessment

Public Health led resource of high-quality needs assessments, situated within the WVInsight microsite, a repository for local data.

https://insight.wolverhampton.gov.uk/Help/JSNA

Local Authority Health Profiles

An online resource providing an overview of health for each local authority in England intended as 'conversation starters' to help local government and health services make plans to improve the health of their local population and reduce health inequalities.

https://fingertips.phe.org.uk/profile/health-profiles

Conclusion

Health and wellbeing issues are complex and multifaceted. To meet the needs of local people requires partners to work together strategically and in a coordinated way. It is this approach that has the power to maximise the health and wellbeing impact of everything we do.

This strategy and collective commitment to the guiding principles represents our ambition to create environments and opportunities for everyone to thrive and stay well, making Wolverhampton a City where people want to live and work, where people's health is improving and health inequalities are diminishing.

When health and care services are required, we want to ensure they are built around the people who need them - focussed on improving their experiences and their outcomes. By working together to tackle health inequalities we are committed to ensuring everyone has the best chance to grow, live and age well.

Supporting Documents

City of Wolverhampton 2020/21 Public Health Annual Report

https://www.wolverhampton.gov.uk/sites/default/files/2021-08/Public-Health-Annual-Report-2020-21.pdf

Health Equity in England: The Marmot Review 10 Years On

Produced by the Institute of Health Equity and commissioned by the Health Foundation to mark 10 years on from the landmark study Fair Society, Healthy Lives (The Marmot Review).

The report highlights that:

- people can expect to spend more of their lives in poor health
- improvements to life expectancy have stalled, and declined for the poorest 10% of women
- the health gap has grown between wealthy and deprived areas
- place matters – living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report

The Health Foundation's COVID-19 impact inquiry has draws on a broad range of available evidence to consider two main questions:

1. How were people's experiences of the pandemic influenced by their pre-existing health and health inequalities?
2. What is the likely impact of actions taken in response to the pandemic on the nation's health and health inequalities – now and in the future?

https://www.health.org.uk/sites/default/files/upload/publications/2021/HEAJ8932-COVID-Impact-210705.pdf

You can get this information in large print, braille, audio or in another language by calling 01902 551155

wolverhampton.gov.uk 01902 551155

WolverhamptonToday Wolverhampton_Today @WolvesCouncil

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WCC 1659 09/21