



Early activity and impact of a neighbourhood multidisciplinary team that integrates health and social support for underserved children and young people in Birmingham, UK: an observational study

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ABSTRACT

Background The Sparkbrook Children's Zone (SCZ) is an integrated health and social care offer for children and young people (CYP) in an economically marginalised area of Birmingham, UK. This study sought to measure: clinic reach to CYP living in deprivation; proportion of CYP receiving preventive health offers; referral rate to secondary care; proportion of CYP referred to a family support worker.

Methods Observational study using routinely collected data to evaluate activity and impact of the SCZ. SCZ weekly clinics, embedded in a partner primary care network, are located in Sparkbrook and Balsall Heath East, Birmingham's second most populous ward with a young population, high diversity and high infant mortality. The clinics provide preventive health, clinical care, mental health support and social support to CYP <16 years. UK Health Research Authority approval reference: 25/PR/0168.

Results From March 2022 to December 2024, 2265 CYP were booked into clinics (93.5% slots taken up); 89% of families were from the bottom Index of Multiple Deprivation quintile.

Preventive healthcare: immunisation advice increased from 10.7% in 2023 to 40.2% in 2024; oral health promotion from 29.2% to 46.8%; smoking cessation advice from 1.8% to 12.5%; 97% eligible children received Healthy Start vitamins; 83% had body mass index measured.

Clinical care: 73.8% of CYP discharged after seeing General Practitioner/paediatrician, 3.8% referred to secondary care, 14.7% patients were not brought to appointments.

Social support: 28.2% of CYP referred to a family support worker. Five top reasons for referral: feeding, behaviour, activities, special educational needs and disabilities, parenting skills.

Conclusion Initial data suggest preventive health and social support can be successfully integrated in a neighbourhood health offer for CYP living in deprivation, with low referral rates to secondary care.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Increased emergency department and outpatient visits by children and young people (CYP) strain the UK healthcare system against a backdrop of rising child poverty and attendant poor health outcomes.
- ⇒ Integrating care for CYP at a neighbourhood level could improve health outcomes while reducing demand on health and social care services but evidence is limited.

WHAT THIS STUDY ADDS

- ⇒ The service increased delivery of a range of preventive health measures to CYP and their families from marginalised populations, including immunisation advice and oral health promotion. Nearly a third of patients were successfully referred to a family support worker to address social determinants of health.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ The study provides early data on the impact of multidisciplinary neighbourhood care to support commissioners and healthcare providers planning/delivering similar offers.
- ⇒ The study identifies important data gaps and challenges around evaluating multidisciplinary neighbourhood health for consideration in future studies.

INTRODUCTION

Children and young people (CYP) and their families living in high-income countries face mounting challenges to their health and well-being, as the prevalence of long-term conditions, obesity and mental ill health continues to increase.¹ These challenges are exacerbated in minoritised and economically deprived communities by a range of socioeconomic and cultural pressures that inhibit access and utilisation of primary or



preventative healthcare services.^{2,3} This has led to a rise in children's attendances to emergency departments (ED), frequently due to conditions that could be more effectively treated in community settings.^{4,5}

In order to more effectively manage the health needs of CYP in underserved communities and reduce inappropriate ED attendance, a number of models of culturally sensitive and integrated care have emerged in North America, Europe and Australia.⁶ They share the broad aim of providing widely accessible health and social care or support for CYP that also mitigate the social determinants of ill-health such as poor housing, domestic violence or food poverty.^{6,7} It is crucial that the design and delivery of these complex interventions are evidence-based yet the accrual of evidence in support of their design has been hindered by fragmented data sets, imprecision over key indicators and the tension between aims of long-term improvement and the need to demonstrate short-term gains.⁸ The result is that evidence of the benefits of integrated care remains inconsistent, particularly among underserved CYP.^{6,9}

In the United Kingdom (UK), the potential of localised integrated health and social care has been recognised in the NHS Long Term Plan, which has seen the recent introduction of the national framework for integrated neighbourhood teams for CYP and in the UK government's 10-year plan for health.¹⁰ However, UK efforts at integrating health and social care to date have tended to focus on high-level processes such as integrated commissioning, strategic planning and there is a lack of guidance from the NHSE on how best to design and deliver place-based integrated care services along with practical support.^{11,12} This includes which combinations of medical and social care/support services are most effective at reaching underserved CYP; how to merge hard-pressed care organisations with differing agendas and funding mechanisms; and the practical support from a service perspective necessary to ensure delivery.

One NHS-funded pilot offers a useful early example of integrated neighbourhood care delivered by local health and social care providers for CYP in an underserved population in Birmingham.^{11,13} Called the 'Sparkbrook Children's Zone' (SCZ), the service has been used as an exemplar of integrated neighbourhood health in a 2025 report by NHS England.¹⁰ To help support the development of similar initiatives, the work presented here describes the details of the service offering and explores service utilisation from the first 34 months since it opened in March 2022 to understand how effectively the service is delivering its three key components, preventative care, clinical care and social support for CYP.

METHODS

Study design

An observational study, presenting early quantitative data of delivery and take-up of the SCZ service. The work presented here forms part of a mixed methods evaluation

funded by Birmingham Women's and Children's NHS Foundation Trust and led by the Department of Applied Health Sciences, University of Birmingham.^{11,13}

Setting/study population

Birmingham is a large, diverse city in the West Midlands, UK, with a population of over 1.1 million. The Sparkbrook and Balsall Heath East district is the second most populous ward with a young population (35% are <18 years compared with 20% nationally), high diversity and one of the highest rates of infant mortality in England, at 8/1000 deaths compared with 3.3/1,000 nationally.¹⁴

The ward was selected for a pilot integrated care service for CYP, based on high levels of both ED attendances from the district and of deprivation, meeting the NHS's priorities around tackling health inequalities.¹⁵ It was funded by NHS England's Integrated Models of Care and Early Years programmes, with Birmingham Women's and Children's NHS Foundation Trust acting as the lead organisation for the pilot.

Sparkbrook Children's Zone

The service is available to CYP <16 years old and led by three key organisations: GreenSquareAccord, a national housing and social care provider, which is currently the Voluntary Care Sector Early Help Lead in the locality (for CYP 0–19 years)¹⁶; healthcare professionals from Birmingham Women's and Children's NHS Foundation Trust; and general practitioners (GPs, or primary care doctors), drawn from the local Balsall Heath, Sparkhill and Moseley Primary Care Network (PCN). Service leads consulted local voluntary sector services, schools and communities (see online supplemental file 1 for summary of the findings of the community consultation). Ultimately, a localised clinic was developed that combines a colocated GP, paediatrician and early years (Early Help) family support worker that CYP access following referral from their usual GP (given the service's limited resource but also to ensure sharing of health information with families' GPs, the service leads decided on all CYP being referred by their GP). The service is summarised in [figure 1](#) (the supporting logic model is found in online supplemental file 2). The three key components being delivered are preventative health advice, clinical consultations and Early Help social support, and the key components of each of these service offers are summarised in [box 1](#).

Staffing the service

The clinic comprises colocated paediatricians, GPs and early years (Early Help) family support workers. Two paediatricians were provided by Birmingham Children's Hospital each able to offer a half-day a week to manage and run clinics. The initial aim was to work alongside GPs from the partner PCN, but after a few sessions, it became clear that they had limited capacity to commit to the clinic and so SCZ instead employed GPs from outside the PCN with an interest in child health to work alongside

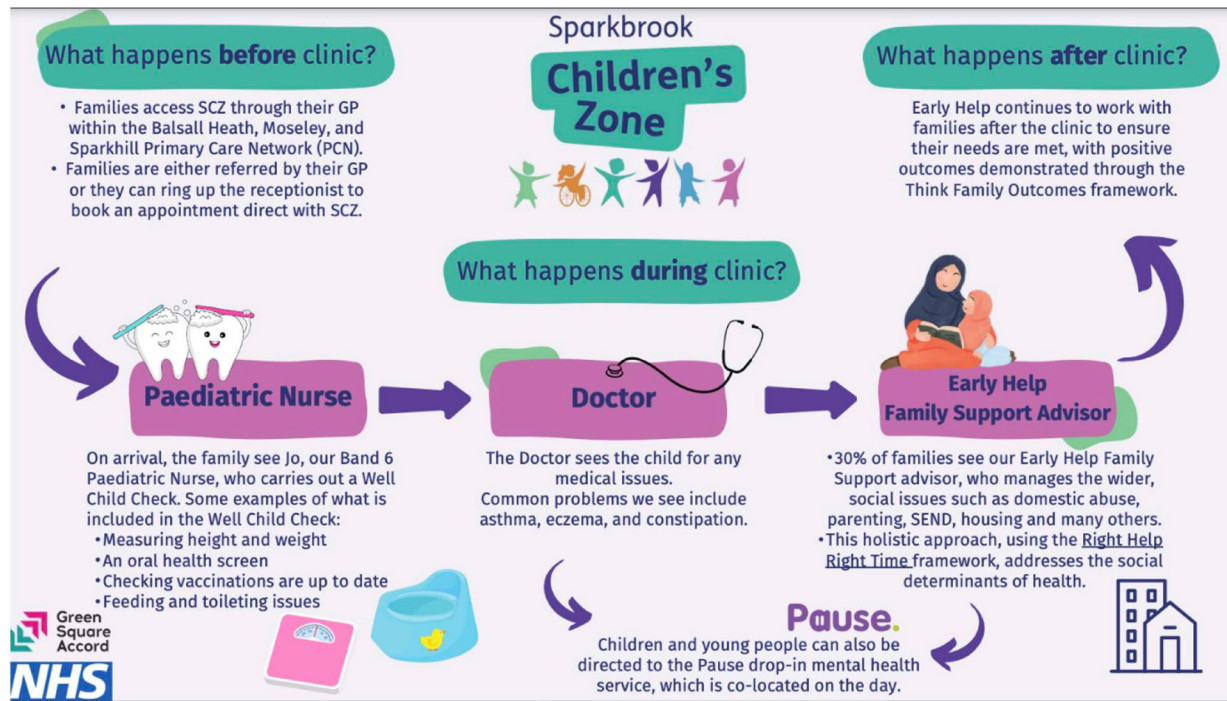


Figure 1 Sparkbrook Children's Zone (SCZ) clinic model. GP, general practitioner or primary care doctor

the clinic paediatricians. The family support worker was provided by GreenSquareAccord. In February 2024, a paediatric nurse (band 6) joined the team to help improve the preventive health offer embedded in clinics. She also worked alongside Early Help professionals to perform outreach work to bring the preventive health offer out to the community in schools, faith centres and other local settings. A drop-in mental health service for CYP (Pause clinic, Birmingham¹⁷) attends on a weekly basis. They see any person registered with a Birmingham GP, who is under 25 years and is not experiencing a mental health crisis.

Data collection/analysis

There were approximately 14 000 CYP (ie, <16 years old) registered to the PCN's eight practices. A template embedded in the EMIS IT system was used to record patient encounters. Data were collected from March 2022 when the SCZ consisted of 1 weekly half-day clinic at a single site, expanded in February 2023 to two half-day clinics a week and from October 2024, an additional two twilight clinics were added. Data from Early Help were collected on the team's Empowering Communities with Integrated Network Systems IT system beginning April 2024.

Aggregate data on demographics (including ethnicity and deprivation score) and total number of appointments offered and attended were collected. Further to this, data were collected on the three key components of the SCZ service offer:

1. Preventive health—consisting of a range of advice and healthy start vitamins.
2. Clinical healthcare—specifically diagnoses/conditions, the provision of care plans for three common

chronic conditions (asthma, constipation and eczema), alongside disposition, including referrals to secondary care, acute care and Early Help.

3. Social support—data were captured on the number of CYP referred, the reason for referral to Early Help and whether the family received light touch, intensive support or were escalated to Children's Social Care.

Descriptive statistics were used to analyse aggregated and anonymised data collected by clinical and Early Help staff for all three arms of the SCZ offer—clinical health, preventive health and social support.

Patient and public involvement

Alongside ongoing community engagement (see online supplemental file 2), our mixed methods study has two patient and public involvement and experience representatives from Sparkbrook. They reviewed both the study protocol and have contributed to continued review of the study at meetings held in 2023 and 2024.

RESULTS

The demographic profile of patients who attended SCZ clinics, the attendance/did-not-attend data, the numbers receiving preventive health, the number of CYP seen by clinical staff, family support and/or visited the drop-in mental-health service.

Patient demographics and attendance rates

Of the 2265 CYP who attended the SCZ between March 2022 and December 2024: 1042 (46%) were female; 314 (13.9%) were aged <12 months, 763 (33.7%) 12–59 months and 1332 (58.8%) >60 months. There were limited data on ethnicity but for the 312 patients where

**Box 1 Summary of the key components of each element of the Sparkbrook Children's Zone (SCZ) integrated care offers****Preventative healthcare**

- ⇒ Smoking cessation advice (if there is a smoker in the household).
- ⇒ Immunisation advice.
- ⇒ Body mass index calculated for children and young people (CYP) >2 years (and onward referral to a healthy eating/exercise programme when available/funded).
- ⇒ An oral health check and a toothbrush pack (children who were amber/red on the screening check had support accessing a dentist if the child was not registered with one).
- ⇒ Healthy start vitamins for CYP <4 years and mothers with an infant.
- ⇒ Directed via mobile phone text message postclinic to the NHS Healthier Together website (<https://www.what0-18.nhs.uk/>) to aid self-management of common conditions.

Clinical appointments

- ⇒ Clinic appointments are 25 min in length. General practitioners (GPs, or primary care doctors) and paediatricians see all presentations except acute injuries (which are better managed in minor injury units or emergency departments).
- ⇒ After taking time to discuss care plans with CYP and their families, clinicians were encouraged to provide written summaries of their care plans, which were sent via text message for all CYP attending with asthma, eczema or constipation (following guidance from the UK's National Institute for Health and Care Excellence).
- ⇒ Any child or family with social support needs are referred directly to the team's family support worker.
- ⇒ Electronic consultations offering remote clinical advice to GPs working for the partner primary care network.

Early Help

- ⇒ Usually referred directly after the clinical appointment but can be referred directly to Early Help by GP, school.
- ⇒ One-hour slots.
- ⇒ Early intervention to prevent social issues for families escalating.
- ⇒ Early Help workers navigate issues for families with schools, health, the voluntary sector, sexual health services and many others to enable families to thrive.
- ⇒ Early Help provides a broad range of services for CYP and their families including counselling.

this was recorded, the population was highly diverse and the largest proportion of patients were Pakistani (178, 57%).¹⁸ The Index of Multiple Deprivation (IMD) scores available for the total cohort (n=1710) were overwhelmingly in the most deprived quintile, that is, 1527, (89%), 115 (6.7%) in quintile 2 and 80 (4.7%) from quintile 3.

From opening the clinic from March 2022 to end December 2024, SCZ offered 2423 face-to-face (F2F) clinic slots, of which 2265 were taken up (93.5%). Of the clinic slots booked, 333 (14.7%) families did not attend (DNA).

Delivery of preventive health

Families received several health promotion interventions with the highest figures being body mass index measured—83%; Healthy Start vitamins (<4 years) —72%; oral health screening/promotion—39.7% and immunisation

advice—29% (compared with the PCN average of 1%). **Figure 2** plots the number of CYP who received a health promotion intervention against total clinic attendances for each quarter 2023–24, noting that the paediatric nurse now primarily responsible for delivering preventative care joined the clinic in Q4 2024.

Clinical care*Reason for referral*

The most common issues referred to the SCZ clinic were behavioural issues; mental health concerns; growth and development; picky eating and obesity; asthma and acute respiratory infections; rashes, including eczema; autism and Attention Deficit Hyperactivity Disorder (ADHD); speech delay; headache; abdominal pain, including constipation. For this period, we recorded 37 referrals to the collocated mental health drop-in service (Pause).

Provision of care plans

Following discussion of a patient's care plan in clinic, the SCZ aimed to provide written summaries of care plans, which were sent via text message to all CYP attending with asthma, eczema and/or constipation. Of the CYP attending with these conditions (March 2022 to December 2024), 91.5% of CYP with asthma received a care plan; 82% with eczema; 65.7% with constipation (see **figure 3**).

Patient disposition from clinical consultations

Nearly three quarters of CYP who attended a F2F clinic (73.8%) were discharged back to their GP, with 6.4% brought back to an SCZ clinic (see **table 1**), 3.8% of CYP were referred to secondary care and 1.1% required an emergency, same-day referral.

There were 10 weekly electronic consultation slots offering remote clinical advice to GPs working for the partner PCN, but the take-up was lower than expected and so this was discontinued after 2 years. Out of 390 slots taken, 149 (38%) of referrals were requests for an SCZ clinic appointment with 33 (8.5%), resulting in a secondary care referral.

Early Help*Reason for referrals*

Of the CYP attending clinics, 639 (28.2%) were referred to the collocated family support worker (Early Help). Full data on outcomes was only available from April 2023 until March 2025 following the appointment of our programme manager. During this 24-month period, 548 children and their families were seen in clinic, of whom 490 (89%) were in the lowest IMD quintile; 302 (53%) were under 5 years of age; 173 (31%) were aged 6–11 years and 83 (15%) were aged 12–16 years.

The issues with which families most frequently presented were helping to find activities (eg, stay-and-play groups, youth clubs) for CYP (134, 12%); behavioural issues (137, 12%); parenting skills (120, 11%); feeding issues (161, 15%); and special educational needs and

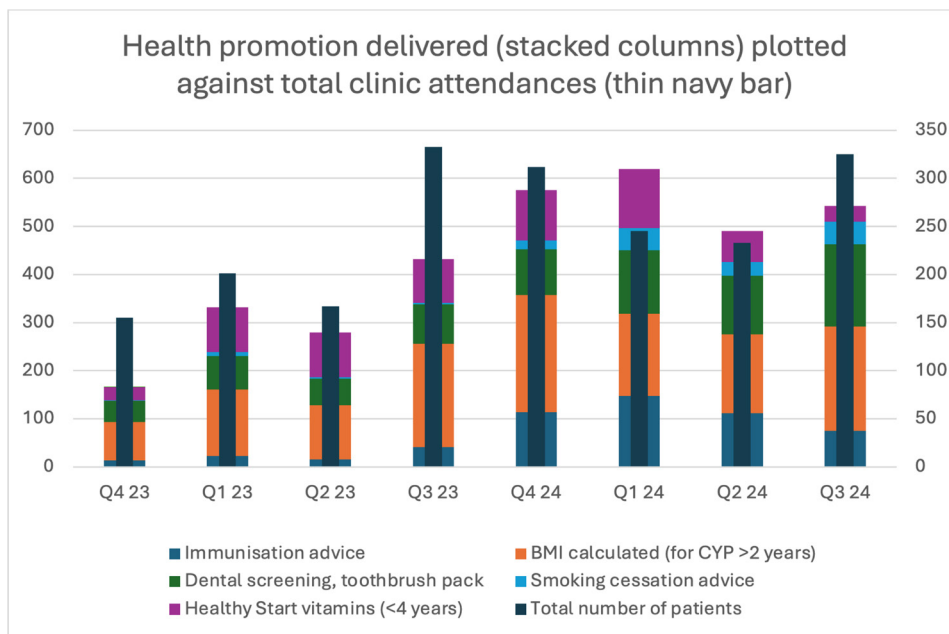


Figure 2 Health promotion work delivered by clinicians in F2F clinics. BMI, body mass index; CYP, children and young people; F2F, face-to-face.

disabilities support (121, 11%). These are summarised in [figure 4](#).

Referrals out from Early Help

Out of 548 of the total referred to Early Help from April 2023 to March 2025, 351 (64%) had 'light touch' navigation to local support services, for example, local voluntary support groups, SCZ's partner youth club or children's centres for stay-and-play sessions and parenting classes; 197 (36%) had more intensive, multidisciplinary support for multiple issues

(where a Family Connect Form was completed). The Family Connect Form is completed by the family support worker, who takes a detailed family and social history and in partnership with the family, identifies areas where CYP and their families need targeted early intervention to prevent the family's situation from worsening. This covers a wide range of issues, including finance, domestic violence, mental health and many other issues. Occasionally, CYP need more intensive social support and are escalated to children's services

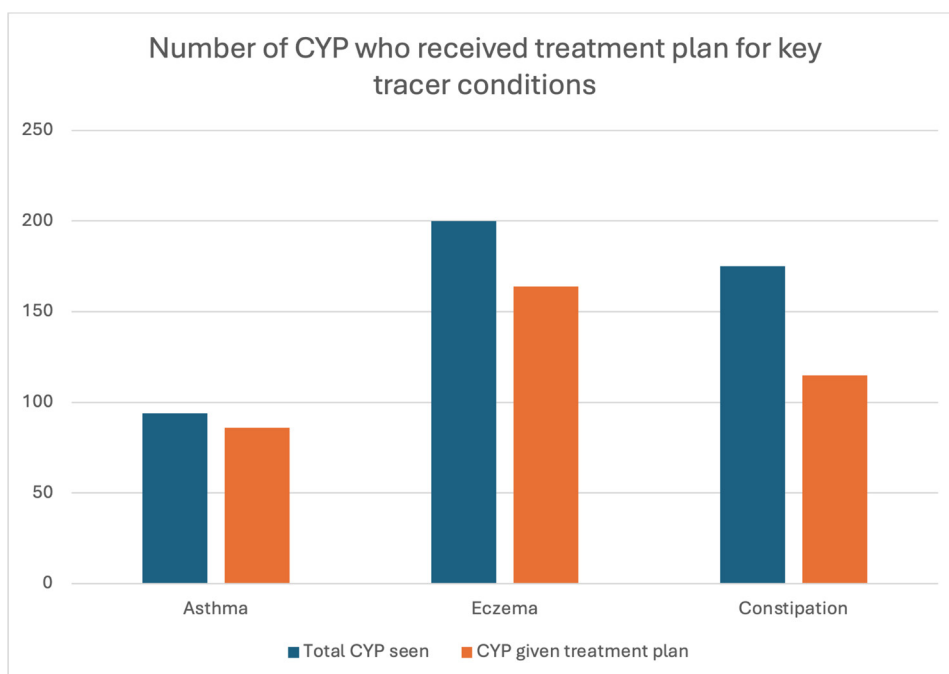


Figure 3 Number of CYP with asthma, eczema and/or constipation who received a written care plan via mobile text after F2F clinic. CYP, children and young people; F2F, face-to-face.

Table 1 Disposition outcomes for CYP attending Sparkbrook Children's Zone F2F clinics, March 2022–December 2024

Disposition	Total (out of 2265 F2F attendances—includes DNAs, n=333)	%
Discharged	1672	73.8
SCZ follow-up	146	6.4
Referred to secondary care	86	3.8
Emergency hospital admission	25	1.1
Referred for Early Help support	639	28.2
Did not attend (DNA)	333	14.7

CYP, children and young people; F2F, face-to-face; SCZ, Sparkbrook Children's Zone.

and of the CYP requiring MDT support in our cohort, one child was escalated to children's social care. [Table 3](#) provides data on the proportions of which key 10 issues ('Think Family outcomes') the family support workers addressed in our cohort who received more intensive multidisciplinary support, based on available data for 96 CYP, which started to be recorded across Birmingham from April 2024.

Table 2 Number and percentage of CYP for each of 10 key outcomes that family support workers provided support for, April 2024–March 2025 (note more than one issue for some of the 96 CYP included in this table)

Think family outcome	Number of CYP with issue (%)
Getting a good education	62 (22)
Good early years development	31 (11)
Improved mental and physical health	75 (26)
Reducing harm from substance abuse	0 (0)
Improved family relationships	42 (15)
Children safe from abuse and exploitation	3 (1)
Crime prevention, tackling crime	1 (0.4)
Safe from domestic abuse	6 (2)
Secure housing	22 (8)
Financial stability	43 (15)

CYP, children and young people.

DISCUSSION

Summary findings

The model of neighbourhood health for CYP demonstrated by the SCZ meets UK government and NHS aims

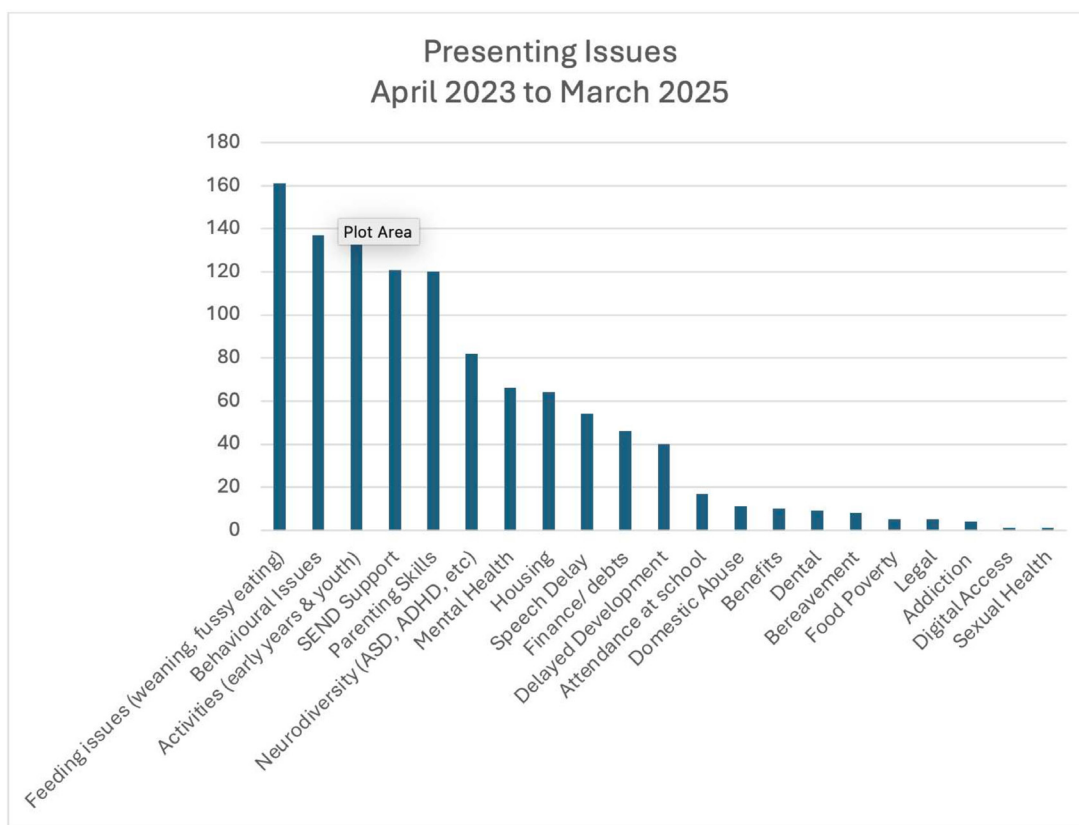


Figure 4 Issues presenting to SCZ's family support worker in clinic (families can present with more than one issue), April 2023–March 2025. SCZ, Sparkbrook Children's Zone; ASD, autistic spectrum disorder; ADHD, attention deficit hyperactivity disorder.

for the provision of multidisciplinary neighbourhood health.¹⁰ The SCZ experienced challenges in the practical delivery of the various elements of the service relating to the lack of interorganisational infrastructure and reliable funding as described elsewhere.¹¹ Despite this, the SCZ pilot data demonstrate significant take-up of preventive health, clinical health and social support. Below we place our findings in the context of the existing evidence exploring the localised delivery of care for underserved CYP in each of the three service domains.

Of the total number of CYP who attended clinic, nearly three quarters were discharged, a figure close to that reported in a similar integrated care offer delivered in London (Connecting Children 4 Care).¹⁹ We estimate that around 26% of clinic attendances were for acute medical conditions that could have been managed in routine primary care (although CYP benefited from the preventative and social support offers), and there was anecdotal evidence that partners in the PCN were filling consultation slots in the SCZ when their practice had exhausted capacity. Any future neighbourhood service must ensure primary care doctors continue to be the main point of care for CYP, managing both acute and long-term conditions,²⁰ and not replaced by secondary care teams who lack the context and place-specific knowledge in providing the holistic care that families want for their children.²¹

Attendance

The most recent figures indicate that some 15% of appointments are missed each year in general practice²² with the majority of these missed due to patient factors with several studies in the UK showing a strong association between DNAs and minority ethnic populations and lower socioeconomic status.²³ The levels of DNA in the SCZ were close to this national average, though it is worth observing that Sparkbrook has a super-diverse and socioeconomically challenged patient population.¹⁸

An increase in DNAs around school holidays was observed, perhaps due to additional child care pressures as observed in other localities.²³ The SCZ data also linked DNAs to appointments for acute problems (eg, a sore throat), which may have resolved prior to the appointment as also witnessed previously in primary care.²⁴

Delivery of preventive health

In the UK health policy advocates healthcare professionals 'make every contact count' by promoting preventive health in routine clinical consultations.²⁵ However, there are many barriers to delivering health prevention in standard primary care settings, including a lack of resource, adequate training and lasting commitment from commissioners (funders) needed to support its implementation.²⁶ The SCZ was able to deliver key preventative health messaging and interventions for CYP and their families with this success attributable at least in part to the longer standard appointment time, which allowed greater opportunity to understand the patient

and identify the preventive care which was most relevant and appropriate.²⁷

The delivery of preventive care was also boosted by the recruitment of a paediatric nurse, with extensive neonatal and health visitor experience (as shown in figure 4 from Q4, 2024: January–March). Their training and background meant they could confidently and independently advise on preventive health without recourse to a doctor or a family support worker. This reflects evidence elsewhere of the value of paediatric nurses in primary care environments in promoting healthy behaviours and offering a range of advice to families.²⁸

The reductions in vaccine uptake, particularly in ethnic minorities, are a continuing and widely recognised public health issue in the UK and beyond.²⁹ The SCZ's paediatric nurse increased the delivery of immunisation advice and the job role of the paediatric nurse appears well placed to address parental hesitancy towards vaccination.³⁰

Clinic delivery

The electronic consultation offering remote clinical advice to GPs working for the partner PCN appeared to be poorly communicated and understood by GPs with uptake lower than anticipated. A number of barriers to the use of e-consultations by primary care staff have been described, including concerns about increased workload, privacy, unsuitable infrastructure and lack of clinical quality.³¹ Though there are a number of known influences on GP referral rates including the characteristics of patients and GPs, the factors impacting teleconsultations on referral rates are not fully understood, nor is their impact on patient outcomes.³²

The lack of suitable referrals to e-consultations by clinicians in other areas of the PCN raises an issue previously explored in other models of integrated care that not only does awareness need raising in patients but also among other parts of the health service.³³ For new care offers such as e-consultations to succeed, clear communication of the offer to ensure understanding and trust in the service needs to be established among professional partners early.³⁴

UK's National Institute for Health and Care Excellence recommends written treatment plans to support more effective service utilisation and self-management³⁵ and the SCZ was able to deliver treatment plans to 91% of CYP with asthma. This compares favourably with the findings of a Global Asthma Network study, which reported that these plans were typically provided for only 62.8% of patients³⁶ and the SCZ also extended the concept to eczema and constipation.

Around one in five CYP in the UK is thought to have a mental disorder with impacts on individuals, their families and for service utilisation.³⁷ To meet this need, the SCZ embedded a weekly drop-in mental health service, which was greeted favourably by staff and anecdotally by patients.¹¹ However, there were difficulties in precisely recording referral rates into the service with some being made by GPs and others by the SCZ's family support

workers. This highlights the challenges of sharing information across health and social care sectors, which the SCZ shares with similar multiagency care offers due to issues of governance and data interoperability.^{38 39}

It is worth noting that a related qualitative exploration of staff experiences of delivering the SCZ described multiple benefits of collocating health workers with family support workers, including reduced stigma for families needing to access social support, improved clinicians' own awareness of multidisciplinary offers (and so improving their own practice) and streamlined referral between clinical and social support elements of the service.^{40 41}

Social support

Although there are multiple examples of integrated care for CYP in high-income countries, few have adopted SCZ's model of incorporating social support.^{6 39} The SCZ's collocation of Family Support Workers is one of the first examples in the UK of combining (and collocating) these services. While 28.2% of CYP who attended clinics were referred to a family support worker, it is feasible that the actual number of CYP impacted by the subsequent intervention might be triple that (our estimate based on the recorded number of siblings in the cohort), as an intervention that might improve an aspect of their domestic circumstances would also benefit their siblings.

The collocation of health and social support has been shown to improve the financial security of families⁹ and is cost-effective for service providers.¹³ However, a previous qualitative exploration of the SCZ reported difficulties in securing funding for the social support element,¹¹ reflecting previous evidence of how funding restrictions, organisational barriers and the undervaluing of social support in health have hindered previous attempts of such integration.⁴²

Strengths and limitations

The study is limited by the lack of comparative figures from other models of integrated care because its novel approach to collocating social support has not been evaluated anywhere else in the UK.¹⁹ There are also acknowledged data gaps around the collection of prospective data on referral into social support, or the take-up of the mental health support offer. Similar gaps in routinely collected data have prevented a more detailed breakdown of the performance of primary care-based services, and their impact on ED attendances has been recognised previously.⁴³ There are recommendations for future research to establish more robust indicators, based on the data available, with evaluations carried out over the longer term to ensure the true impact of neighbourhood health for CYP.^{6 43}

There was a lack of detailed data on the ethnicity of patients and the SCZ service has since modified its data collection template to include this. However, local authority data on ethnicity for the Sparkbrook and Balsall Heath East ward confirm that the area covered by

the SCZ is highly diverse including those of South Asian ethnicity (61.8%), White British (12.1%), Black African-Caribbean (9.2%) and a range of other ethnic groups (8.5%).¹⁸

Although it might be assumed that previously recognised barriers to attending appointments might be acting on the patient population of the SCZ,²³ the next phase of the study will gather qualitative data from CYP and their families to explore these challenges and how they might be mitigated. More broadly, there have been calls for future research on this specific topic.⁴⁴

CONCLUSION

Initial data suggest preventive health and social support can be successfully integrated in a neighbourhood health offer for CYP living in deprivation, with low referral rates to secondary care, making the SCZ a scalable and likely cost-effective intervention. Understanding the nature of the shortcomings of the routinely collected data sets also provides important learning for future evaluation of multidisciplinary neighbourhood health.

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