# Knowledge Mobilisation Fellow

*Prevention in social care role profile: hosted by North East London Integrated Care Board*

**Location:** North East London Integrated Care Board
**Duration:** Part-time, approximately 2.5 years (Early 2025 to September 2027)
**Funding:** National Institute for Health and Care Research (NIHR) Applied Research Collaboration North Thames
**Eligibility:** Only academic researchers from North Thames partner university institutions are eligible to apply
**Salary/reimbursement:** Applicants will need confirmation from their employer that they are able to be released for 2.5 days to undertake the role. We will provide the funding required to compensate for their time (ie, 2.5 days of their salary)

**Role Overview:**

We are seeking a Knowledge Mobilisation (KM) Fellow to support the analysis and identification of actionable insights of linked health and social care data in improving population health outcomes.

This role will be instrumental in facilitating the exchange of knowledge between analysts, healthcare providers, social care teams, supporting data insights to be effectively translated into practice across North East London bridging health and social care together and providing evaluation for these projects.

**Key Responsibilities:**

**Analytics and Data Support**

- Work with NEL Population Health Team, data service and insights team to support research and analyse linked health and social care data sets
- Conduct data quality checks, identify gaps, and provide recommendations for data enhancements to improve the validity and usefulness of data and analytics.
- Partner with local authorities and public health analysts to identify key priorities, perform analyses, and share findings that support quality improvement and service redesign with a focus on prevention in Social Care. This could include working on key uses cases to identify findings with a focus on areas such as reducing costs, optimising resource, keeping people out of hospital, timely hospital discharge, reducing A&E attendances, understanding wider determinants of health, and ultimately improving outcomes for all residents of London.

**Facilitate Knowledge Exchange**

- Act as a bridge between the ICB, local authorities, providers, and other partners to share linked health and social care insights and promote evidence-informed decision-making. This will include creating reports, presentations, and contributing to workshops and events.
- Be the driving force into turning insights into actionable projects that form part of the Joint Forward Plan
- Enable Research Collaboration - Coordinate with academic partners to support research activities and dissemination of findings.
- Develop academic links with North Thames ARC to support collaboration and wider policy development.

**Evaluate Impact**

- Contribute to evaluating the impact of data-driven initiatives and support continuous learning and improvement.

**Skills, qualifications and Experience:**

- Background in data science / analytics ideally with experience applying to health, social sciences, public health or a related field
- Strong communication and stakeholder engagement skills.
- Analytic skills and the ability to translate complex data into simple terms
- Familiarity with data governance and ethical considerations in health and social care. (Basic IG training can be given)
- Technical skills – ability to query complex data using SQL or python and use Power BI for analysis and report creation (training can be given)

**Examples of data driven projects the fellow may support:**

- For avoidable A&E attendances, developing a predictive model using linked dataset. This could identify high-risk individuals and trigger proactive interventions by community health and social care teams
- Avoidable emergency admissions - support the design of integrated care pathways to identify causes of admissions and create targeted prevention strategies
- Timely hospital discharge - create a discharge pattern analysis to understand what causes delays, using this to indicate who would likely be delayed in discharge, and more proactively addressing it

- Outpatient redesign - pilot virtual ward model. This would use integrated data to determine which patients could benefit from particular remote consultations, potentially involving both health and social care professionals
- Prescribing costs - implement a community-based medication review program. This would use our linked data to identify opportunities for optimisation, considering both health and social factors.