6.0 Phase 2: The Second WG Meeting

6.1 Introduction

6.1.1. Purpose and Context

The second WG meeting took place three months after our initial meeting (see Section 3). It built directly on meeting 1, moving from the initial presentation of administrative data evidence towards reflection on evidence engagement, interpretation, and application. The first meeting had introduced the Working Group, explored stakeholders' current data and evidence-use practices, and presented early evidence on the WHO, WHAT, WHERE, and WHEN of ADHD among young people in NI. Stakeholders responded positively to the value of NI-specific evidence, but also identified limitations, particularly the absence of diagnostic data, the need for contextual explanation, the risk of misinterpretation, and the importance of linking statistics with lived experience and service realities.

The purpose of Meeting 2 was therefore to return to the group after a period of reflection and potential use. It was designed to ask whether stakeholders had engaged with the evidence, how they had understood its relevance, whether they had shared it within or beyond their organisations, what had prevented or enabled use, and what new evidence would make the findings more useful. In this sense, Meeting 2 functioned as a bridge between evidence generation and evidence mobilisation.

6.1.2. Objectives of the meeting

- Re-orientate members to the overall mission of the SET WG and the key findings from Meeting 1.
- Review how stakeholders had engaged with, interpreted, shared or used the evidence during the previous three months.
- Identify barriers and facilitators to evidence use across individual, organisational and system levels.
- Reflect on the relevance, accessibility, clarity and usability of the evidence for different roles and organisations
- Situate the WG within wider questions about administrative data evidence, dissemination and impact.
- Present new ADHD evidence generated in response to stakeholder feedback, including analyses involving deprivation, settlement band and medication trajectories.
- Gather stakeholder responses to the new evidence and its presentation.
- Identify potential uses of the evidence over the next four months and prepare for the final WG meeting and UK-wide engagement activity.

6.2 Methods

6.2.1. Procedures

The event was held on the Belfast Campus of UU (room BC-05-320) from 10am to 4pm on Friday 8th May 2026. Morning refreshments and lunch were provided, and dietary and accessibility needs were canvased during registration.

All WG members received a save-the-date notice in early April, followed by the finalised event agenda the week before the event. Most members confirmed their intention to attend; however, five members were unable to attend, and another three members were unable to attend on the day due to extenuating circumstances. However, three members who were unable to attend the first meeting, including our public co-chair member, were able to attend this meeting.

The meeting was audio recorded to support production of the summary report and associated outputs. Participants were reminded that the discussion would be treated confidentially and that any material included in outputs would be anonymised.

6.2.2. Presentations & Activities

The second meeting was designed to focus more heavily on group discussion and reflection, with small emphasis on presentations.

The second meeting was designed to focus more heavily on group discussion and reflection, with small emphasis on presentations. In total, three brief presentations were prepared by the academic members. The first presentation was prepared for the morning session and involved an overview of Meeting 1, including the WG's mission, key insights from the first discussion, and a recap of the evidence previously presented. Following the first presentation, the group moved into discussion of the past three months, focusing on evidence use, relevance, sharing, barriers and facilitators.

The afternoon included the second presentation on a scoping review of ADR UK impact case studies, designed to help the group think about who uses administrative data evidence, how that evidence is used, and what project features are associated with impact. A further presentation introduced new ADHD analyses developed in response to WG feedback, including deprivation, urban/rural settlement and longitudinal prescribing trajectory analyses. The day ended with a discussion of the newly presented evidence, how members might use the evidence over the next four months and what support or further analysis might be useful.

6.2.3. Evaluation

Due to the poor response to the previous post-event evaluation (< 20% response rate), it was determined that a post-event evaluation would not be circulated after the second meeting.

6.3. Results

6.3.1. Attendees

In total, 10 WG members attended, including three academic researchers from ADRC-NI and UU, an independent public engagement consultant, representatives from a range of organisations and sectors, including RCPSYCH, Neurodiversity Spark, and ADDNI, and our public co-chair member.

6.3.2 Review of Meeting 1: what had already been learned

The first substantive part of the day reviewed the content and key insights from Meeting 1. Members were reminded that Meeting 1 had explored the potential of sensitive data, stakeholders' current evidence-use practices, the initial WHO/WHAT/WHERE/WHEN evidence on ADHD among young people in NI, feedback on the usability and presentation of that evidence, and potential future uses.

Several themes from Meeting 1 were revisited. First, the group had identified a lack of clear feedback loops between research and practice. Researchers often assume they know what evidence users need, but stakeholders' real-world priorities may differ substantially from academic assumptions.

Second, the group had discussed funding pressures and reactive evidence use. Evidence was often mobilised to meet funder requirements, justify services, support business cases, or respond to key reporting points. This reactive pattern was linked to limited time, staffing and analytical capacity, as well as the recurring need for organisations to "reinvent" themselves in funding applications. However, the meeting also recognised that some organisations have embedded evidence more deeply into their core operations.

Third, accessibility remained central. Members had discussed the difficulty of navigating the administrative data landscape in NI, uncertainty around available data sources and access routes, and the impact of departmental siloes on data linkage. They also noted that research outputs are often written primarily for academic audiences, with technical or legalistic language that limits usability for frontline staff, practitioners and communities. The lack of locally comparable NI evidence was also highlighted, leading organisations to rely on evidence from England and Wales despite contextual differences.

Fourth, the 4 Ws framework was recalled as a practical and resonant structure. It aligned with how organisations think about targeting services, identifying pressure points and communicating need to decision-makers. However, stakeholders had repeatedly emphasised that the framework is a starting point rather than a complete account. The data can show patterns, but users still need explanation, interpretation and lived experience context, essentially the "why" behind the observed patterns.

The initial ADHD evidence presented at Meeting 1 was then revisited (see Section 2 for full overview).

6.3.3. Discussion of evidence use over the past three months

The next section invited members to reflect on whether and how they had used the evidence since Meeting 1. The intended focus was to collect concrete examples of evidence use, including use in policy, practice, service planning, funding applications, strategic work, internal discussions or external sharing. The chair of the WG explicitly reassured members that there was no expectation that they must have used the evidence during the three months between meetings. Non-use was framed as valuable learning because it could help identify barriers to evidence mobilisation.

The discussion produced fewer straightforward examples of completed evidence use than the prompt may have anticipated. However, one member did report using the evidence from Meeting 1 to inform multiple research and funding proposals.

This example also prompted discussion about the unusual nature of the WG process. An academic member noted that, in conventional academic pathways, findings are normally analysed, peer-reviewed and published before being widely discussed or used. In this project, stakeholders were invited to engage with, interpret and consider the usefulness of findings before publication.

Members discussed how this although this created some uncertainty about how far the evidence could be used externally in the immediate term, it also allowed stakeholders to shape interpretation, identify missing context, and surface practical implications before the evidence was finalized.
The discussion also showed that the evidence contributed to broader thinking about future projects, engagement activities and accessibility-focused work. Members discussed how the evidence relating to later identification of ADHD among girls and women could form the basis for future research, including doctoral work or further evidence-building activity. This was linked to discussion of DfE-funded studentships, where proposed doctoral projects in NI must now align with Programme for Government priorities and may involve collaboration with external partners, including agencies and VCSE organisations. In this way, the evidence was not only discussed as something to be used immediately, but also as a basis for future research questions and collaborative funding opportunities.

Members also used the evidence to highlight groups not captured by medication-based administrative data, including children and young people who are undiagnosed, diagnosed but not medicated, on waiting lists, or supported through non-pharmacological routes. These omissions were especially important because they are groups that stakeholder organisations are actively trying to reach. The evidence therefore generated questions about what is visible in administrative data, what remains outside it, and what additional sources of information are needed to understand need more fully.

6.3.4. Barriers to evidence use

As few concrete examples were identified, the discussion did not proceed in depth through the planned individual, organisational and system-level framework. Instead, members focused more broadly on the potential uses of the evidence and the factors that may enable or constrain its mobilisation in future.

As previously highlighted, members discussed the publication status of the findings as one barrier to immediate external use. Because the findings had not yet been published, members, particularly the academic researchers, reflected on uncertainty about how confidently the evidence could be used beyond the WG. Academic members initially assumed that academic articles may not be accessible or useful to stakeholder members based on feedback from Meeting 1 and thus queried what formats should they provide the evidence in. However, stakeholder members challenged this assumption, noting that academic articles are often a primary source of information because they are perceived as validated evidence. When the issue of paywalls was re-raised from Meeting 1, members noted that, for those present, university connections or other routes often enabled access to academic literature. This point was therefore treated as specific to the members in the room, rather than as evidence that paywalls are not a barrier for all stakeholder groups.

The short timeframe between meetings was also discussed as a practical constraint, as three months was not necessarily enough time for evidence to move into organisational decision-making, funding cycles or policy conversations. Members discussed funding and cost as central factors shaping whether evidence can lead to action. Some members reflected that even where the right people are involved and evidence is relevant, local and compelling, change may not follow if there is no funding available, relationships with influential advocates haven’t yet been developed, there is no established mechanism through which services, departments or organisations can respond, or there is no clear route for dissemination.

This created a broader discussion about the limits of evidence in a constrained system: evidence may identify need, support arguments and strengthen the case for action, but its practical influence is limited where resources are not available. Wider financial pressures also formed part of the discussion. Members referred to cuts and constrained resources across sectors, including universities and public/third-sector organisations. While academic members highlighted their desire to collaborate with different sectors in research processes, this is generally not possible without funding being in place.

6.3.5. Relevance, accessibility, clarity, and usability of the evidence for diff

Discussions surrounding the relevance, accessibility, clarity, and usability of the evidence remained important. First, members emphasised that NI-specific evidence has value precisely because it is locally generated. Even where members were uncertain about whether government or services would act on the evidence, home-grown evidence was viewed as important because it reduces reliance on evidence from England, Wales or elsewhere.

Second, members repeatedly highlighted the importance of understanding what the evidence does and does not show. A key issue was the use of ADHD medication as a proxy for ADHD, which is currently the only available route to examining ADHD using administrative data in NI. Members highlighted that prescribing data captures only those who receive medication and therefore excludes several relevant groups, including people who are undiagnosed, diagnosed but not medicated, waiting for assessment, receiving non-pharmacological support, or experiencing need without service contact. These are often the groups that organisations seek to support, meaning that administrative data may miss important groups.

Third, a substantive part of the discussion focused on the need to interpret administrative data within its wider context. In discussing improving the administrative data infrastructure, one member cautioned that better linkage or more data does not automatically produce better evidence or better policy. Members highlighted the importance of asking why data are collected, who they are used by and for, what is included, and what remains absent. This was linked directly to the ADHD evidence, which captures medication receipt but not diagnosis, waiting lists, non-pharmacological support or unmet need. Members asked why the available data do not provide access to those diagnosed but not medicated, and why children from lower-income families appear more likely to receive medication. These questions reinforced the importance of examining systems, service access, family context, school environments and lived experience alongside administrative data.

Fourth, the discussion moved into wider questions about diagnostic systems, gendered presentation of ADHD, school environments, educational support, the broader contexts that shape ADHD-related outcomes, and lived experiences of ADHD. Much of this discussion echoed Meeting 1, where administrative data evidence had been understood as an important starting point, particularly because of the questions it generates. Members repeatedly returned to the need for further stories and contextual evidence to sit alongside the administrative data. The data were viewed as useful because they identified patterns and prompted questions, but members emphasised that there were many stories to drill into before the patterns could be fully understood. This included questions about diagnosis, medication, gender, school readiness, educational environments, parental support, deprivation, rurality and wider socioecological factors.

Finally, accessibility was also discussed in practical terms. Members noted that evidence is less accessible when it is text-heavy, particularly for audiences with lived experience, neurodivergent people, families or communities who may not engage with dense written reports. This did not mean that detailed evidence was not valued; rather, members highlighted the need for outputs that preserve rigour while also being usable, readable and meaningful to different audiences.

6.3.6. Situate the WG within wider questions about administrative data evidence, dissemination and impact

The meeting included a presentation on a scoping review of ADR UK impact case studies. The intended purpose was to use these case studies to consider who engages with administrative data evidence, how evidence is used, and what project features are linked to impact.

The discussion focused strongly on how impact is recognised and valued. Members reflected that academic and research impact systems tend to privilege policy impact, particularly evidence being cited in government or policy documents. This was discussed in relation to Research Excellence Framework (REF) expectations and the way researchers are incentivized to describe impact. Thus, the ADR UK case studies were described as examples selected to highlight impact, but stakeholder members were cautioned that what is visible in such case studies depends on how impact is defined, recorded, and rewarded.

The discussion also highlighted the visibility of VCSE impact. One member described the VCSE sector as “self-sufficient because we have to be,” while academic members noted that formal impact systems are not well set up to capture how evidence changes organisational thinking, service delivery, advocacy, or community understanding. Members discussed how impact case studies and academic reporting structures may privilege policy-facing examples, particularly where evidence is cited in strategies, committees or government documents. This was linked to a wider concern about selectivity in policy uptake: evidence may gain visibility when it aligns with policy priorities or when an influential policy actor is willing to take it forward, while other forms of evidence use remain less visible or less valued.

Members also discussed whether evidence mobilisation could be made more reciprocal and responsive. Examples were given of rapid, needs-led approaches in which organisations gather contextual information from service users or stakeholders, combine this with existing research evidence, and translate it quickly into tailored workshops, recommendations or practical supports. This raised the possibility of developing more structured hubs of expertise or rapid-response models that could bring academic, sectoral and lived-experience knowledge together around specific issues and produce evidence that is timely enough to inform practice and policy conversations. This point was framed as an emerging idea rather than a fully developed proposal.

The discussion therefore raised the issue of whether current cultures of impact measurement adequately capture the value of evidence outside formal policy change. Members did not suggest that policy impact lacks value; rather, they questioned whether policy citations alone are sufficient for understanding how evidence travels, who uses it, and what kinds of change it enables.

6.3.7. New evidence generated since Meeting 1

The afternoon session was intended to respond to evidence requests from Meeting 1 and present additional analysis where possible. Requested areas included mortality, female health conditions, lived-experience narratives and deprivation data. The session also introduced new analyses using deprivation, settlement band and trajectory modelling.

Academic members explained that some requested analyses could not be completed within the available data and project scope. Mortality, including death by misadventure, was not possible because of the young demographic, low numbers and disclosure issues. Female-specific health conditions were not feasible because the relevant data were limited or not available in a form suitable for analysis. Supplementary lived-experience narratives were also not possible within the administrative data itself, although the need for such narratives had been recognised. Deprivation and settlement band analyses were possible and were therefore presented to the group. These included summary and inferential statistics relating to deprivation deciles and settlement bands as predictors of ADHD medication receipt, as well as annual ADHD medication prevalence stratified by deprivation decile and settlement band.

Academic members also noted that, although there had been no further specific evidence requests from members, they had undertaken additional analyses that they would typically consider when working with similar longitudinal administrative data. Specifically, they highlighted that the longitudinal nature of administrative data enables powerful analytic approaches, such as latent class growth analysis, which can identify distinct groups of people who follow similar patterns over time rather than treating the population as a single average. Using LCGA, academic members presented evidence on four distinct ADHD medication trajectories identified within the data. They also presented associations between these trajectories and demographic and household-level variables, as well as longer-term outcomes including education, employment, health and later psychotropic prescribing.

It was acknowledged that, in conducting these additional analyses, the researchers were again operating partly on assumptions about what might be useful to stakeholders, rather than responding only to evidence that had been directly requested. However, this was considered important for demonstrating the kinds of evidence that researchers would typically generate from longitudinal administrative data and for inviting stakeholder reflections on whether such analyses were useful, understandable and relevant.

6.3.8. Stakeholder responses to the new evidence and its presentation

Following the new evidence presentation, participants were asked to reflect on how understandable and useful the evidence was, and whether there were other ways it could be presented. This discussion returned the group to the central questions of the SET project: what makes administrative data evidence meaningful to those who might use it, and what forms of explanation are needed for responsible interpretation?

Stakeholder members highlighted that the new evidence and its presentation were useful, particularly because the deprivation and settlement band analyses responded to previously identified evidence needs. However, academic members also noted that the trajectory analysis could be interpreted in several ways and that further research would be needed to understand whether the identified trajectories reflected developmental patterns, service-related factors, treatment pathways or other contextual influences.

In response to the new evidence, the discussion also returned to ADHD among girls and young women. Members highlighted adolescence as a particularly important period and raised questions about hormonal issues, female-specific health conditions, and how these may intersect with ADHD symptoms, medication, support needs and service transitions. The discussion included reference to conditions and issues such as PMDD, endometriosis, adenomyosis and hormonal contraceptive use.

This discussion did not provide definitive conclusions, but it showed how the new evidence generated further questions about gender, development and health that could not be answered using the current administrative data alone.

6.3.9. Potential future uses of the evidence

The final part of the day was intended to look ahead to the next phase of the Working Group and consider how the learning from Meeting 2 should inform future work.

In terms of future evidence needs, stakeholder members highlighted the need for adjusted analyses exploring the education outcomes associated with ADHD medication status. Specifically, members were interested to know whether the association between specific ADHD medication trajectories and lower educational qualifications remained after accounting for other key demographic and contextual factors.

In terms of potential uses of the evidence, members asked for time to consider how they could potentially use this evidence over the coming four months.

6.4. Discussion

6.4.1. General discussion

The second WG meeting aimed to understand how members had engaged with, interpreted, shared, or used the ADHD evidence during the three months following Meeting 1. It also sought to identify barriers and facilitators to evidence use, reflect on the relevance and usability of the evidence, present new analyses, and consider how the evidence might be used over the next phase of the project.

Overall, while there were relatively few examples of direct evidence use within the three-month period, the meeting showed that evidence had nonetheless begun to shape stakeholder thinking, generate new questions, support emerging research and funding ideas, and clarify the conditions needed for evidence mobilisation. The meeting therefore generated important insight into the realities of evidence use across stakeholder groups.

The first key theme was the relatively short period between the initial and second meeting. It is widely recognised that there is a "17-year gap" between research generation and implementation in practice (Rubin, 2023). Against that backdrop, expecting substantial evidence use within three months is likely unrealistic. Therefore, the use of the evidence in funding/research proposals by one member was encouraging. This was an important example of early evidence mobilisation, particularly given the short timeframe between meetings and the fact that the findings had not yet been formally published. It suggests that pre-publication evidence can still have practical value for stakeholders when it is locally grounded, relevant to their work, and able to strengthen the rationale for further activity.

A second key theme was the unusual structure of the WG process itself. Stakeholders were invited to engage with and interpret findings before they hagone through the usual academic publication and peer-review process. This created a valuable opportunity for stakeholder interpretation to shape how the evidence is understood and presented. However, it also raised practical questions about whether this model could be adopted routinely. The process allowed stakeholders to identify issues that may not have been visible from an academic perspective alone, strengthening the case for involving stakeholders earlier in the research cycle, particularly when working with sensitive administrative data. At the same time, the discussion suggests that this model has limits. Bringing stakeholders together around emerging evidence before publication is time-intensive, may create uncertainty about how findings can be used externally, and may not be feasible for every study. The implication is not that all sensitive data research should follow this exact structure, but that mechanisms are needed to bring stakeholder insight into evidence generation and interpretation earlier, more systematically and more reciprocally than traditional dissemination models often allow.

A third theme was the value of NI-specific evidence. Stakeholders are often required to rely on evidence from other jurisdictions, particularly England and Wales, despite differences in policy, service structures, geography, population context and political history. Locally generated evidence therefore has a value beyond the specific findings it produces. It provides a more legitimate basis for local advocacy, planning and further enquiry. This "home-grown" quality may make the evidence more persuasive in local conversations about services, funding, education, health and support needs.

However, stakeholders noted that administrative data evidence should be presented not only in terms of what it shows, but also in terms of who it cannot show. This is especially important when medication receipt is used as a proxy for ADHD. Such evidence can show who receives medication, where prescribing is concentrated, and how medication patterns vary over time. However, it cannot capture everyone with ADHD, including those who are undiagnosed, diagnosed but not medicated, waiting for assessment, receiving non-pharmacological support, or experiencing need without service contact. For many stakeholders, these missing groups are central to the realities they encounter in practice.

A fourth theme was that more data does not automatically mean better evidence. The discussion around improving administrative data infrastructure raised an important caution: more data, or better data linkage, does not automatically produce better evidence or better policy. Evidence must be interpreted within systems of power, governance and use. This is a crucial point for administrative data research. Data are not neutral simply because they are large, linked or population based. They are collected for specific administrative purposes, shaped by service structures, and made available through particular governance systems. As members noted, it matters why data are collected, who uses them, who they are used for, what is included, and what remains absent. For this project, that means the absence of diagnostic data is not just a technical limitation. It shapes the kinds of questions that can be asked and the populations that can be seen. Similarly, findings showing higher medication receipt among certain groups should not be read simplistically. They require careful interpretation alongside knowledge of service access, family context, schools, diagnostic pathways and wider social conditions. The wider implication is that administrative data evidence should be accompanied by critical reflection on the data infrastructure that produced it. Better data systems may be necessary, but they are not sufficient. Responsible evidence use also requires transparency, contextual interpretation and attention to whose experiences remain outside the data.

Another major learning point was that evidence use is constrained by cost, funding, and system responsiveness. Evidence may identify a problem, strengthen an argument or support a proposal, but it cannot produce change by itself.

A third theme was the value of NI-specific evidence. Stakeholders are often required to rely on evidence from other jurisdictions, particularly England and Wales, despite differences in policy, service structures, geography, population context and political history. Locally generated evidence therefore has a value beyond the specific findings it produces. It provides a more legitimate basis for local advocacy, planning and further enquiry. This "home-grown" quality may make the evidence more persuasive in local conversations about services, funding, education, health and support needs.

However, stakeholders noted that administrative data evidence should be presented not only in terms of what it shows, but also in terms of who it cannot show. This is especially important when medication receipt is used as a proxy for ADHD. Such evidence can show who receives medication, where prescribing is concentrated, and how medication patterns vary over time. However, it cannot capture everyone with ADHD, including those who are undiagnosed, diagnosed but not medicated, waiting for assessment, receiving non-pharmacological support, or experiencing need without service contact. For many stakeholders, these missing groups are central to the realities they encounter in practice.

A fourth theme was that more data does not automatically mean better evidence. The discussion around improving administrative data infrastructure raised an important caution: more data, or better data linkage, does not automatically produce better evidence or better policy. Evidence must be interpreted within systems of power, governance and use. This is a crucial point for administrative data research. Data are not neutral simply because they are large, linked or population based. They are collected for specific administrative purposes, shaped by service structures, and made available through particular governance systems. As members noted, it matters why data are collected, who uses them, who they are used for, what is included, and what remains absent. For this project, that means the absence of diagnostic data is not just a technical limitation. It shapes the kinds of questions that can be asked and the populations that can be seen. Similarly, findings showing higher medication receipt among certain groups should not be read simplistically. They require careful interpretation alongside knowledge of service access, family context, schools, diagnostic pathways and wider social conditions. The wider implication is that administrative data evidence should be accompanied by critical reflection on the data infrastructure that produced it. Better data systems may be necessary, but they are not sufficient. Responsible evidence use also requires transparency, contextual interpretation and attention to whose experiences remain outside the data.

Another major learning point was that evidence use is constrained by cost, funding, and system responsiveness. Evidence may identify a problem, strengthen an argument or support a proposal, but it cannot produce change by itself.

Members’ reflections pointed to a difficult but important reality: even strong, locally relevant evidence may have limited practical effect if there are no resources, mechanisms or receptive decision-makers able to act on it. This complicates simple models of evidence-based policy or evidence-informed practice. The barrier is not always that stakeholders lack evidence, misunderstand evidence or fail to value evidence. In many cases, stakeholders may already recognise the need, but operate in systems where funding, service capacity, departmental structures or political priorities limit what can be done. This has important implications for how the project evaluates evidence use. If evidence does not lead quickly to policy or service change, this should not automatically be interpreted as failure. It may reflect wider constraints rather than limited evidence quality or stakeholder engagement. It means that producing evidence is not enough; evidence must be actively mobilised through relationships, networks, timing and translation. Members’ reflections suggest that evidence is more likely to be useful when there are trusted routes between researchers, stakeholders, policymakers, practitioners and communities.

A final learning point was that impact must be understood beyond policy uptake. The discussion of ADR UK impact case studies raised a broader question about how evidence impact is recognized. Academic systems often privilege policy-facing impact, particularly citation in government documents, strategies or committees. While these forms of impact are important, they do not capture the full range of ways evidence can matter. For stakeholders, evidence may have value when it supports advocacy, helps an organisation understand need, strengthens a funding application, shapes service thinking, builds confidence, or helps communities make sense of their experiences. These effects may not appear in formal policy documents, but they can still be meaningful. This point is especially relevant to the VCSE sector.

Members described the sector as self-sufficient out of necessity, often working adaptively and responsively with limited resources. Evidence may be used in this context in ways that are practical, relational and community-facing, but not easily captured by academic impact frameworks. If impact is defined too narrowly, important forms of evidence use may remain invisible. The implication is that this project should adopt a broad view of impact. In addition to tracking policy or strategic uptake, it should attend to changes in understanding, confidence, relationships, advocacy capacity, research ideas and organisational thinking. These may be early or indirect forms of impact, but they are central to how evidence travels in real-world settings.

Members' reflections pointed to a difficult but important reality: even strong, locally relevant evidence may have limited practical effect if there are no resources, mechanisms or receptive decision-makers able to act on it. This complicates simple models of evidence-based policy or evidence-informed practice. The barrier is not always that stakeholders lack evidence, misunderstand evidence or fail to value evidence. In many cases, stakeholders may already recognise the need, but operate in systems where funding, service capacity, departmental structures or political priorities limit what can be done. This has important implications for how the project evaluates evidence use. If evidence does not lead quickly to policy or service change, this should not automatically be interpreted as failure. It may reflect wider constraints rather than limited evidence quality or stakeholder engagement. It means that producing evidence is not enough; evidence must be actively mobilised through relationships, networks, timing and translation. Members' reflections suggest that evidence is more likely to be useful when there are trusted routes between researchers, stakeholders, policymakers, practitioners and communities.

A final learning point was that impact must be understood beyond policy uptake. The discussion of ADR UK impact case studies raised a broader question about how evidence impact is recognized. Academic systems often privilege policy-facing impact, particularly citation in government documents, strategies or committees.

While these forms of impact are important, they do not capture the full range of ways evidence can matter. For stakeholders, evidence may have value when it supports advocacy, helps an organisation understand need, strengthens a funding application, shapes service thinking, builds confidence, or helps communities make sense of their experiences. These effects may not appear in formal policy documents, but they can still be meaningful. This point is especially relevant to the VCSE sector.

Members described the sector as self-sufficient out of necessity, often working adaptively and responsively with limited resources. Evidence may be used in this context in ways that are practical, relational and community-facing, but not easily captured by academic impact frameworks. If impact is defined too narrowly, important forms of evidence use may remain invisible. The implication is that this project should adopt a broad view of impact. In addition to tracking policy or strategic uptake, it should attend to changes in understanding, confidence, relationships, advocacy capacity, research ideas and organisational thinking. These may be early or indirect forms of impact, but they are central to how evidence travels in real-world settings.

6.4.2. Next steps

Although immediate evidence use was limited, the meeting generated several future research and evidence priorities. This is an important outcome in itself. Evidence can contribute to impact by shaping what is asked next, not only by answering existing questions.

Therefore, academic members will conduct further adjusted analyses, particularly in relation to education outcomes. This reflects a desire to move beyond descriptive findings towards analyses that help clarify whether observed associations remain after accounting for demographic, household and contextual factors. Such work may be important for producing evidence that is more useful for service planning, advocacy and policy conversations. The broader implication is that the WG should treat question-generation as a key output. For administrative data research, especially in under-evidenced areas, identifying the next set of questions may be as important as producing initial findings.

Learning from Meeting 2 provide several directions for the next phase of the WG. Specifically, evidence use should be evaluated realistically. Given the short timeframe and pre-publication status of the findings, future evaluation should capture both direct use and earlier forms of engagement, such as changes in thinking, development of proposals, identification of gaps, stakeholder confidence and new research questions.

Moreover, evidence mobilisation should be supported beyond publication. This may include developing accessible outputs for different audiences, identifying key decision-making routes, supporting stakeholders to use findings in proposals or advocacy, and exploring reciprocal models of evidence support. The idea of hubs of expertise or rapid-response collaborations may be worth developing further, particularly if they can bring together academic, sectoral and lived-experience knowledge around specific questions.

Finally, the meeting reinforced the core value of the WG: stakeholders are not simply end users of evidence, but co-interpreters of its meaning. Their expertise helps identify what administrative data can show, what it misses, how it might be misread, and what further evidence is needed. This reciprocal role is essential if sensitive data evidence is to support meaningful, ethical and contextually grounded change.

6.4.4. Acknowledgements

The help provided by the staff of the Northern Ireland Longitudinal Study (NILS/NIMS) and the NILS Research Support Unit is acknowledged. The NILS is funded by the Health and Social Care Research and Development Division of the Public Health Agency (HSC R&D Division) and NISRA. The NILS-RSU is funded by the ESRC and the Northern Ireland Government. The authors alone are responsible for the interpretation of the data and any views or opinions presented are solely those of the author and do not necessarily represent those of NISRA/NILS. The Honest Broker Service data has been supplied for the sole purpose of this project.

6.4.3. References

Rubin R. (2023). It Takes an Average of 17 Years for Evidence to Change Practice-the Burgeoning Field of Implementation Science Seeks to Speed Things Up. JAMA, 329(16), 1333-1336. https://doi.org/10.1001/jama.2023.4387