Foundations
What Works Centre for Children & Families

KINSHIP CONNECTED: PILOT RANDOMISED CONTROLLED TRIAL

Evaluation protocol

External project title	Pilot randomised controlled trial and implementation and process evaluation of Kinship Connected
Intervention developer	Kinship
Delivery organisations	Kinship
Evaluator	Centre for Evidence and Implementation (CEI) and Ipsos UK
Principal investigator	Katherine Young
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Type of trial	Pilot two-arm randomised controlled trial, waiting list design
Age or status of participants	Kinship carers
Number of participating local authorities	Four

Number of children and families	200 kinship carers
Primary outcome(s)	Feasibility of a full-scale RCT: LA site recruitment (target: four sites); carer recruitment (target: 50 per LA); retention at endline (target: 80%); outcome measure face validity and completion rates (target: above 90%)
Secondary outcome(s)	Carer level: Kinship carer self-efficacy (measured by the Brief Parental Self-Efficacy Scale) Carer level: Carer wellbeing (measured by the Short Warwick–Edinburgh Mental Wellbeing Scale) Child level: Unrelated care placement (measured by LA administrative data)
Contextual factors	LA characteristics (population size, urban/rural classification, indices of deprivation); existing kinship support provision (current services, staffing levels, specialist roles); demographic composition (ethnic diversity, age distribution of kinship carers); financial support available (special guardianship allowances, discretionary payments, average amounts); and organisational context

SUMMARY

Approximately 141,000 children in care in the UK are living in a 'kinship care' arrangement, where they are looked after by relatives or family friends as an alternative to foster care (House of Commons Library, 2025). Research shows that kinship carers face a range of challenges, including economic vulnerability and impacts on health and wellbeing, alongside limited awareness of and access to available resources and support (Ott et al., 2024).

Kinship Connected is a navigator and support programme designed to support kinship carers to navigate complex statutory, voluntary, and community support systems. Delivered by the charity Kinship, the programme provides tailored one-to-one practical and emotional support, advocacy with services, and opportunities for peer connection. Support is flexible and kinship carer-led, combining home- and community-based contact with remote support, and is grounded in trauma-informed and strengths-based practice. The programme also includes system-level work to improve local awareness and coordination of support for kinship families.

This protocol sets out a pilot two-arm randomised controlled trial (RCT) with an embedded implementation and process evaluation (IPE) and a cost evaluation, designed to assess the feasibility of a future full-scale effectiveness trial and to generate early indications of promise. The pilot will recruit 200 kinship carers across four local authorities (Newham, Blackpool, Rochdale, and Oxfordshire). Participants will be individually randomised (using a ratio of 1:1) either to receive Kinship Connected immediately or to a 6-month waitlist control group receiving local authority (LA) business-as-usual support, with access to Kinship Connected after endline data collection.

The primary aim of the evaluation is to assess the feasibility of conducting a full-scale trial, LA site recruitment, kinship carer recruitment, retention over the six-month intervention or waitlist period, and completion and validity of outcome measures.

Secondary aims are exploratory and focus on estimating the potential effects of Kinship Connected on kinship carer parental self-efficacy (measured using the Brief Parental Self-Efficacy Scale; Woolgar et al., 2023), carer wellbeing (measured using the Short Warwick–Edinburgh Mental Wellbeing Scale; Stewart-Brown et al., 2009), and the probability of a child entering unrelated foster care[1] during the 6-month intervention period.

Quantitative impact analysis will follow an intention-to-treat approach, using regression models appropriate to each outcome, with effect estimates reported alongside confidence intervals to reflect uncertainty. The IPE is guided by Proctor et al.'s implementation outcomes framework (Proctor et al., 2011), and will use mixed methods, including programme monitoring data, administrative data, surveys, and qualitative interviews with kinship carers, LA practitioners, and delivery staff, to examine fidelity, reach, acceptability, appropriateness, mechanisms of change,

[1] Unrelated foster care is when a child is placed with approved foster carers who have no prior biological, familial, or social connection to the child.

perceived impacts, and unintended consequences. A cost analysis will estimate the resources required to deliver the programme from an LA perspective, focusing on staff, delivery, and infrastructure costs.

Key points in the study timeline include trial set-up, ethics, and data protection approvals during early 2026; recruitment, baseline data collection, and randomisation from June to September 2026; delivery of the intervention for immediate referral participants (June 2026 to March 2027); and delivery of the intervention for waitlist participants (November 2026 to September 2027).

Findings from this pilot will inform decisions about programme refinement, scalability, and progression to a full-scale RCT of kinship navigator support in England.

CONTENTS

BACKGROUND AND PROBLEM STATEMENT

Kinship care refers to arrangements in which children who are unable to live with their birth parents are cared for by relatives or family friends (Department for Education, 2024a). Kinship care can be informal or formal. Informal kinship care is where a relative or family friend cares for a child through a private, interpersonal agreement without the involvement of the local authority (LA) or court. Formal kinship care is where a child is placed with a relative or family friend through a legal route, such as by an LA or court order. While it is difficult to estimate the total number of children in kinship care due to variation in definitions and the inclusion of informal arrangements, Census 2021 identified approximately 121,000 children living in kinship care households in England and Wales (Office for National Statistics, 2023), with broader policy estimates suggesting around 141,000 children in England (House of Commons Library, 2025). There are more precise figures available for specific types of formal kinship care arrangements: for example, 13,360 children were placed with kinship foster carers in England as of 31 March 2025 (Department for Education, 2026), and 48,020 children in England left care to live under a Special Guardianship Order between 2006 and 2023 (Selwyn & Gardiner, 2025).

Evidence suggests that children in kinship placements[2] have better outcomes than their peers in unrelated foster care. Specifically, kinship care has been associated with better behavioural and mental health outcomes and greater placement stability compared with unrelated foster care (Winokur et al., 2014; Winokur et al., 2018; Selwyn & Gardiner, 2025). Drawing from children's and young people's self-reported experiences, UK evidence further indicates that children in kinship foster care report higher levels of wellbeing, greater trust in their carers, and a stronger sense of stability and belonging than children in unrelated foster care (Coram Voice & Rees Centre, 2023). These strengths are commonly understood to stem from pre-existing relationships, emotional attachment, and long-term commitment between children and carers, which may support children's sense of belonging and wellbeing. However, these relative advantages do not eliminate broader inequalities faced by children in kinship care and kinship carers.

These positive outcomes are observed despite the fact that kinship carers face additional and different challenges compared with other foster carers (Winokur et al., 2014). On average, kinship carers are older, less educated, less financially stable, and more likely to be disabled than their non-kinship foster carer counterparts (McGrath & Ashley, 2021; Cuddeback, 2004). These challenges are often compounded by the circumstances that precipitate kinship care arrangements, including parental mental ill health, substance use, domestic abuse, incarceration, or bereavement (Kinship, 2024).

[2] We use the term 'placement' throughout this protocol because it is the label used in the administrative data on which our analysis relies. We recognise, however, that these are children's homes, and our use of the term is not intended to diminish that.

In addition, data shows that children in kinship care are disproportionately Black or of mixed heritage compared with children living with a parent (Nuffield Family Justice Observatory, 2025). This disproportionality is particularly pronounced in informal arrangements that are less likely to involve statutory services, which again are more commonly reported among Black and Asian families (Tah & Selwyn, 2025). Hence, informal kinship carers are the least supported group, typically having limited access to financial, practical, and therapeutic support from children's social care and LAs, in contrast with kinship carers in formal arrangements (Department for Education, 2024a; Foundations, 2023).

Common challenges facing kinship carers include:

1. **Economic vulnerability and financial strain:** Kinship carers and children in their care are disproportionately economically vulnerable, with many households experiencing financial stress and living below the poverty level. Grandparent kinship carers, a common demographic in kinship care, are particularly susceptible to poverty, typically being out of the workforce.
2. **Lack of knowledge, access to resources, and advocacy:** Limited awareness of kinship care and available resources results in kinship carers being unaware of the support available to them, including peer support. This is compounded by significant gaps and variation in support provided by local authorities for kinship families, leaving kinship carers struggling to identify and access the support available for their unique circumstances, needing tailored guidance.
3. **Legal support and information:** Kinship carers often require legal services and information concerning obtaining legal guardianship, or contact or custody disputes, as they must navigate complex relationships with the birth parents of the children they care for.
4. **Health and wellbeing of kinship carers and children:** Kinship carers can experience high levels of stress, which can negatively impact their physical and mental wellbeing. Children in kinship care may present with behavioural problems or special educational needs and disabilities (SEND), contributing to caregiver distress. Declining health is particularly pertinent for older kinship carers. Additionally, kinship care households are more likely to include an adult whose long-term physical or mental health condition substantially limit daily activities (Office for National Statistics, 2023).
5. **Loss and isolation:** Kinship carers may also experience profound feelings of loss and identity change, often linked to the bereavement or loss of a family member's ability to care for a child that precipitated the kinship arrangement. These experiences can contribute to social isolation and a heightened need for emotional and peer support.
6. **Child welfare system involvement and instability:** Children in kinship care often have a history of involvement with children's social care services and may face placement instability, with a risk of entering or re-entering formal foster or residential care if the kinship arrangement breaks down.
7. **Addressing parental issues:** Kinship care arrangements are often precipitated by challenges faced by birth parents, such as mental health difficulties, incarceration, financial instability, or substance misuse. These circumstances can disrupt and reconfigure existing family relationships, as kinship carers assume primary caregiving roles, which may strain

relationships with birth parents and require mediation, particularly where contact or co-parenting arrangements are in place.

Together, these challenges mean that kinship families need targeted and consistent support, including accessing financial help, engaging with statutory services, connecting with others facing similar challenges, and navigating additional support according to their individual needs (Waddell et al., 2022). Kinship navigator programmes are designed to address these challenges directly. Typically, they provide tailored one-to-one guidance to help carers understand their rights, access services, navigate legal and welfare systems, and connect with peer and community support. Navigator models aim to reduce informational barriers, build trust in services, and strengthen carers' capacity to secure appropriate support, thereby improving carer wellbeing and contributing to greater placement stability for children (Steinmetz & Fox, 2024; Fowler et al., 2026).

Kinship navigator programmes show promise in addressing the rising, and often overlooked, needs of kinship families, as identified in our recent review of interventions to support kinship families (Ott et al., 2024); for example, Colorado's Kinship Navigator Program (Forehand et al., 2024). There is also some new evidence from an evaluation of the Washington Case Management Navigator Programme reporting child-level outcomes, showing that navigator programmes may also be associated with improvements in children's health and educational engagement, facilitated by increased preventative care use, fewer emergency department visits, and reduced absences from school and early years provision (Fowler et al., 2026). However, evidence to understand the effectiveness and implementation of kinship navigator programmes within the UK children's social care context is currently limited, and further exploration is required to understand how to best support kinship families to thrive and provide safe, consistent homes to children who cannot live with their birth parents.

Policy context

Kinship care has received increasing national policy attention in England in recent years. The Independent Review of Children's Social Care (MacAlister, 2022) highlighted kinship care as a critical part of a family-first system and identified navigator-style support as a promising approach. This was followed by the publication of the first Kinship Care Strategy for England (Department for Education, 2023), which committed to strengthening identification, recognition, and support for kinship families. More recent policy developments include legislative and programme-level reforms aimed at improving consistency and transparency of support, such as requirements for local authorities to publish a kinship local offer, increased emphasis on family group decision making, and targeted investment in training, information, advice, and peer support for kinship carers (Department for Education, 2024b). The UK government is also piloting a financial allowance for kinship carers in selected areas of England through designated Kinship Zones, reflecting growing recognition of the financial pressures faced by kinship families and building on evidence that financial allowances can support placement permanency, reduce the likelihood of placement disruption, and increase the likelihood of permanent guardianship (Department for Education, 2025a; 2026; Ott et al., 2024). Recent announcements also include the appointment of a National Kinship Care Ambassador, Dr Jahnine Davis, to advocate for kinship children and carers across government and work directly with local authorities to improve services.

Within this evolving policy and programme context, there is growing interest in models that can help kinship carers navigate complex and evolving support systems and access services that meet their needs. Kinship Connected, a navigator and support programme designed and delivered by the organisation Kinship, is one such model that seeks to fill this gap by providing tailored guidance and support for kinship families.

This pilot randomised controlled trial (RCT) and implementation and process evaluation (IPE) seeks to test the feasibility, acceptability, and implementation of Kinship Connected, while exploring its potential to improve outcomes for kinship carers and children in kinship care. Generating high-quality evidence on the promise of kinship navigator programmes within the UK children's social care system is essential to inform future policy decisions about scaling, commissioning, and sustaining navigator models within LA systems.

Intervention and theory of change

Intervention

Kinship Connected is a navigator and support programme designed to help kinship carers to 'navigate' the services available to them. Kinship Connected is delivered by Kinship, the leading kinship care charity in England and Wales. The programme was originally adapted from a programme called Relative Experience, developed in the north-east of England in a partnership between Grandparents Plus (now Kinship), Family Lives, and the Family and Childcare Trust. Independent evaluations (Starks & Whitley, 2020; Whitley et al., 2023) and consultation with kinship carers and LA teams informed refinements to the intervention, including a greater emphasis on peer support and partnership working with local services. The programme was refined and relaunched as Kinship Connected in 2018 and has continued to evolve in response to feedback, evaluation findings, and the changing needs of kinship carers (Starks & Whitley, 2020).

A core principle of Kinship Connected is adaptability. The programme is designed to provide responsive, individualised support that reflects the differing circumstances, strengths, and levels of need among kinship families. While the frequency, duration, and mode of support vary across participants, the programme includes several core components that all kinship carers experience during the six-month intervention period. These core components are:

1. Initial contact and engagement
2. Registration, including a structured needs assessment and collaborative goal-setting process
3. A three-month review
4. A six-month review.

These stages provide a consistent framework for programme delivery, review, and monitoring across all participants. Beyond these core elements, support is flexible and tailored according to individual needs and circumstances.

Following referral to the programme, kinship carers are supported by a Navigator through the registration process. This involves a comprehensive needs assessment, incorporating validated self-

efficacy and wellbeing measures, as well as a collaborative goal-setting exercise. Together, these inform an individualised support plan. Navigators use this assessment to determine the appropriate level and type of support, which is reviewed and adjusted throughout the intervention, including formally at the three-month review point.

Navigators offer one-to-one practical and emotional support, delivered either in person (in the home or in community settings) or by phone, depending on the preferences and accessibility needs of the kinship carer. This support may include advocacy with educational, statutory, and voluntary services; emotional support; practical assistance such as information and advice; help to access financial entitlements and grants; priority access to Kinship's advice line; and referrals to relevant internal or external services. The approach is described by Kinship as relationship-based, strengths-based, and trauma-informed, drawing on active listening, empathy, confidence building, skills development, and, where appropriate (and applicable), the lived experience of the Navigator or team.

In addition to one-to-one support, Kinship Connected facilitates group-based activities. These include Navigator-led in-person and virtual support groups (typically hosted once a month) and ad-hoc family events. Navigators will also provide signposting to peer-led support groups held in community venues such as church halls or cafes, and in-person or online workshops and training events delivered as part of Kinship's free national services to all kinship carers, regardless of arrangement type. Workshop topics span all areas of kinship family life – for example, introduction to kinship care, managing contact, raising a child of a different cultural or ethnic identity, understanding trauma and attachment, and working with children's services.

At a community and systems level, Navigators play a key role in understanding and responding to local need. They work to map existing kinship support provision and identify gaps in services, areas of high or unmet demand, and opportunities for effective signposting. This work facilitates referrals into the programme and creates opportunities for professionals to join a local Community of Practice, supporting shared learning and coordination across services. Navigators engage actively with local kinship communities through outreach, awareness-raising activities, and the delivery of Kinship Connected launch events. These activities are designed to increase visibility of support, reach less-well-served carers and reduce barriers to engagement. They also embed themselves within the wider local service landscape by building relationships with local authorities and partner organisations. Through these partnerships they promote an improved understanding of kinship care and encourage more consistent identification, signposting, and referrals across agencies. Through this combination of individualised support, peer connection, awareness raising, and local systems engagement, Kinship Connected aims to strengthen outcomes for kinship carers, children, families, and local support systems.

The programme's flexible components vary considerably according to the level of need identified. At the higher end of need, support may involve weekly in-person home visits, regular telephone check-ins, and active advocacy at statutory meetings. At lower levels of need, support may consist of fortnightly or monthly contact focused on reviewing goals, facilitating service access, and encouraging participation in peer support activities. There is no fixed formula governing the frequency or intensity of support, and some families may require more intensive input during periods of crisis or at the early stages of a kinship arrangement. Participation in the programme is

voluntary throughout, and the pace, focus, and mode of support are co-produced with kinship carers to ensure responsiveness and appropriateness.

Navigators are employed and supported by Kinship within LAs to deliver high-quality practice through a structured programme of training, induction, and supervision. This includes training on the Kinship Connected model, trauma-informed practice, and safeguarding, alongside regular supervision and reflective practice sessions.

For more information about Kinship Connected, see the intervention protocol.[3]

Table 1. Template for Intervention Description and Replication (TIDieR[4])

Brief name	Kinship Connected
Why	Kinship Connected is a navigator and support programme designed to support kinship carers to navigate complex systems of statutory, voluntary, and community-based support. Kinship carers often assume caring responsibilities during periods of crisis and face substantial informational, emotional, financial, and practical challenges, while receiving limited and inconsistent support. Navigator programmes show promise in addressing the often overlooked needs of kinship families by reducing informational barriers, strengthening access to services, and providing relational, strengths-based support. Kinship Connected has been developed specifically for the UK context and aims to support kinship carers at key points in their caring journeys, including at the start of a placement and during significant life events, with the aim of helping reduce stress, strengthen carers' capacity, and mitigate risks of placement breakdown. The programme also aims to support kinship carers to develop longer-term informal, peer, and professional support networks, contributing to more stable and supportive environments in which children can thrive.

[3] See: https://foundations.org.uk/wp-content/uploads/2026/08/kinship-connected-intervention-protocol.pdf

[4] The Template for Intervention Description and Replication (TIDieR) is a 12-item checklist and guide used to improve the reporting quality and replication of research interventions. It ensures essential details – such as the "what", "who", "how", and "where" of an intervention – are included in published studies, ultimately enabling better implementation.

What	Navigators support kinship carers to engage with systems and access appropriate support through: • Individualised one-to-one support delivered by specialist Navigators • Advocacy and support with statutory and non-statutory services • Practical information, guidance, and signposting aligned to carers' goals. Specific support offered by Kinship carers includes: • Specialist free advice (Kinship Advice Service) • Access and signposting to the National Training and Support Service (delivered by Kinship and funded by the Department for Education) • Support groups (facilitated by Kinship Navigator) and peer support groups (facilitated by kinship carers as part of the National Peer Support Service funded by Department for Education) • Access and signposting to advice and information (both locally and at a national level) through Kinship Compass, an online interactive digital tool • Support and information to access grants • Free MaxCard and access to food bank vouchers • Access to Someone Like Me (a one-to-one peer listening service) • Effective partnerships among the statutory, voluntary, and community sector; for example, virtual schools, Book Trust, Place2Be and food banks • Celebratory events including the annual Kinship Care Week • Membership of Kinship Community (tailored emails, Facebook page and other social media channels). Participants receive a welcome pack, including: • A goal-setting template • The *Kinship Care Guide for England* (practical tools, resources, and checklists) • Access, where appropriate, to therapeutic parenting support toolkits.
Who	Support is delivered by specialist practitioners known as Navigators. Navigators are experts in kinship care, with diverse professional backgrounds including social work, welfare benefits, education, legal services, and therapeutic support. Some Navigators have lived experience as kinship carers.
How	The programme is delivered through a hybrid model, combining in-person support and remote contact. Delivery is flexible and led by kinship carer preference. Navigators also facilitate group-based support and community events.

Where	Support takes place in: • Kinship carers' homes • Community settings (e.g. cafes, gardens, schools, community venues) • Remote environments (phone, video, text).
When and how much	Kinship Connected follows a structured, milestone-based model delivered over 6 months: **Referral verification** (within 3 working days): Referrals are verified by a Kinship Navigator to confirm eligibility, willingness to engage, and any safeguarding considerations. This step supports safe and appropriate progression prior to first contact. **First contact** (within 5 working days): The Navigator contacts the kinship carer to explain the programme, confirm consent, assess accessibility and safety for meeting (including home visits), and book the registration meeting. **Registration and needs assessment** (within 10 days of referral): The registration meeting takes place (preferably in the carer's home) and includes a structured needs assessment (low/medium/high), collaborative goal setting, and provision of programme materials. **One-to-one navigator support** (months 0–6): Navigators provide personalised one-to-one support, which may include home visits, phone or text check-ins, advocacy, and liaison with services. Support is carer-led in terms of frequency, setting, and focus. **Mid-point review** (approximately 3 months): Progress against goals is reviewed and the support plan is adapted to reflect changing needs. **Final review and closure** (6 months): A final in-person review (up to 2 hours) closes support goals, completes post-intervention outcome measures, and provides tailored signposting to ongoing supports. Programme completion is confirmed in writing, and carers are invited to provide feedback. **Post-intervention feedback:** A separate satisfaction survey is sent electronically following programme completion. Kinship Connected is delivered over 6 months. Carers are expected to receive approximately: • 3–4 in-person sessions • 4–6 remote contacts. Frequency, duration, and type of contact vary according to individual needs and circumstances.

Tailoring (adaptation)	The intervention is tailored through: • An initial needs assessment and personalised 3-month support plan • Ongoing flexibility in delivery mode and focus • Formal review and adaptation of the support plan at 3-month mid-point review. All adaptations are made collaboratively with the kinship carer in response to changing needs.

Theory of change

The full theory of change (ToC) diagram is in Appendix A. For more information on the ToC, see the intervention protocol.[5]

Expected causal pathways

The ToC comprises three interrelated causal pathways, each involving specific mechanisms of change that contribute to short-, intermediate-, and long-term outcomes.

Socio-emotional support pathway

Kinship carers often experience high levels of stress, isolation, and emotional burden due to the sudden assumption of caregiving responsibility, limited formal recognition, and challenges navigating complex systems. Kinship Connected's socio-emotional support activities are designed to address these challenges by providing consistent, relational, and trauma-informed support through a trusted Navigator and opportunities for peer connection.

This pathway highlights how emotional support leads to increased wellbeing for kinship carers and how peer support leads to kinship families experiencing increased social connectedness and stronger community support. These outcomes are expected to occur through several mechanisms of change (defined as the changes happening within the kinship carers). These include psychological mechanisms, such as:

- Kinship carers feel heard, understood, and emotionally supported
- Kinship carers feel a sense of agency and empowerment over their interactions and circumstances
- Kinship carers have increased confidence to navigate support systems
- Kinship carers build connections with other people like them.

As a result, the expected short- and intermediate-term outcomes are that kinship carers:

[5] See: https://foundations.org.uk/wp-content/uploads/2026/08/kinship-connected-intervention-protocol.pdf

- Experience reduced stress and strain
- Have improved parental self-efficacy and belief in their ability as a caregiver
- Experience increased social connectedness
- Experience improved wellbeing
- Provide more responsive and consistent care
- Sustain peer networks and positive relationships
- Experience reduced feelings of isolation and loneliness
- Have more stable family relationships alongside children in their care.

One-to-one Navigator support creates a safe and reliable relationship in which carers feel listened to, validated, and understood. This relational consistency is expected to reduce emotional distress and increase carers' sense of confidence and control over their circumstances. Evidence from social work practices, specifically those using strengths-based approaches to carer-focused interventions, suggests that trusted, non-judgemental relationships are a mechanism for improving caregiver wellbeing, engagement with support, and resilience, particularly for families experiencing stress or adversity (Social Care Institute for Excellence, 2018; Caiels et al., 2023).

The quality and consistency of this relational support are underpinned by Kinship's workforce development activities, including the recruitment of Navigators with relevant prior skills and experience, structured training on the Kinship Connected model and trauma-informed practice, regular weekly discussion meetings, and ongoing supervision and reflective practice. These activities are intended to strengthen Navigators' ability to build trusting relationships, respond empathetically to carers' experiences, maintain professional boundaries, and provide emotionally attuned support. Within the ToC, the implementation of these workforce support activities forms an important part of this pathway, as they increase the consistency, confidence, and relational quality of support delivered to kinship carers.

Peer-based activities, including support groups and family events, provide opportunities for carers to connect with others who share similar experiences. These activities reduce feelings of isolation and stigma, strengthen informal networks of support, and enable shared learning and mutual encouragement. Research on peer support interventions indicates that social connection and shared experience can play a significant role in improving emotional wellbeing and sustaining caregiving roles over time, particularly where formal support is limited (Joo et al., 2022).

Together, these activities are expected to lead to the identified mechanisms of change: kinship carers feeling emotionally supported, understood, and empowered. This in turn contributes to improved wellbeing, reduced stress, increased social connectedness, and stronger peer networks. Improved emotional wellbeing and confidence enable kinship carers to provide more consistent, responsive care to children, supporting placement stability and positive family relationships. This pathway aligns with findings from several evaluations of Kinship Navigator programmes (Starks & Whitley, 2020; Gómez et al., 2024) which show that socio-emotional support is a critical foundation for sustaining kinship arrangements and preventing escalation to statutory interventions.

Practical support pathway

Kinship carers face significant practical challenges when they assume caregiving responsibilities, often in emergency circumstances with little to no notice, limited financial support, and a lack of clear information about available services. Navigating complex systems of support can be overwhelming, particularly when carers are simultaneously managing children's immediate needs. This can lead to financial insecurity, increased strain, and difficulty accessing timely and relevant support. Kinship Connected's practical support pathway is designed to reduce these pressures by providing personalised one-to-one support, advocacy, and navigation to resources, enabling carers to experience greater stability and build longer-term capacity.

This pathway focuses on ensuring kinship carers can access the practical resources, financial support, advice, and services required to meet their needs and the needs of their kinship children, and manage day-to-day challenges. These outcomes are expected to occur through several mechanisms of change. These include behavioural and structural mechanisms, such as:

- Kinship carers have a better understanding of their own strengths, needs, and goals
- Kinship carers feel more informed about available support and how to access it
- Kinship carers are more willing to seek appropriate support from formal and community services
- Navigators reduce the bureaucratic and emotional barriers to kinship carers accessing support.

As a result, the expected short- and intermediate-term outcomes are that kinship carers and kinship families:

- Experience reduced strain as their immediate practical needs are being met
- Have improved access to immediate support services that align with their goals
- Are more likely to access appropriate services before reaching crisis
- Seek and use support independently and advocate for themselves and the children in their care
- Have their immediate practical needs met
- Have the needs of children better understood and met
- Have reduced practical and financial concerns.

One-to-one Navigator support plays a central role in helping kinship carers to identify and prioritise their practical needs. The needs assessment and goal setting at the start of the programme provide the foundation for this pathway. Through structured conversations, kinship carers develop a clearer understanding of their own support needs and priorities, as well as those of the children in their care. This helps kinship carers to articulate their needs, which leads to accessing appropriate support. Evidence from strengths-based approaches suggests structured reflection and goal setting can improve engagement with services and support more effective problem-solving in the face of complex or intersecting challenges (Scerra, 2011; Ford, 2019).

Navigators provide tailored information, advice, and signposting to relevant services, including financial entitlements or grants support, legal advice, free training and workshops, and specialist provision. Where needed, Navigators provide advocacy and hands-on assistance to overcome

administrative or systemic barriers. This advocacy may include helping carers prepare for and attend meetings with schools, children's services, or health professionals; supporting carers to understand and challenge decisions; assisting with applications for financial support, benefits, or legal orders; facilitating communication between agencies; or helping carers articulate their needs and rights within complex systems.

The unique role of the Navigator as an independent professional working across multiple services means they complement statutory provision by focusing on coordination, advocacy, and confidence-building rather than case management or statutory decision making. This is expected to increase carers' knowledge of what support is available and how to access it, while also improving the timeliness and appropriateness of service access. Evidence from navigator and advocacy-based interventions indicates that reducing informational and practical barriers can significantly improve service uptake and help prevent needs from escalating into crisis, particularly for populations who may be less familiar with formal support (Saluja et al., 2025; McCartan, 2025; National Institute for Health and Care Excellence, 2022).

As carers begin to access appropriate resources and services, their immediate practical needs, such as financial pressures, access to equipment, or support for a child's education or wellbeing, are more effectively addressed. This is expected to reduce day-to-day strain, enabling carers to focus more fully on their caregiving role. At the same time, ongoing support from Navigators aims to build carers' confidence and skills in navigating systems independently. Through confidence and skills building carers develop greater self-efficacy in seeking out information and engaging with services without ongoing support.

Peer learning and informal sharing of practical advice are integrated throughout Kinship Connected's group-based activities, including peer support groups, family events, and workshops and training sessions. These activities provide opportunities for kinship carers to exchange experiences, discuss challenges, and learn practical strategies from others in similar situations. Evidence from peer-supported and community-based interventions suggests that practical knowledge exchange, alongside formal advice, can enhance problem-solving skills and increase confidence in managing complex systems (Joo et al., 2022).

Together, these activities are expected to activate the identified mechanisms of change: kinship carers becoming more informed, better able to understand their needs, and more confident in navigating support systems. This, in turn, leads to improved access to timely and appropriate services, reduced financial and practical strain, and increased capacity to respond to the individual needs of children. As carers gain confidence and independence, there is also an increased likelihood that they will seek support proactively, resulting in more referrals to appropriate services before challenges escalate into crisis.

Systems change pathway

Kinship carers often interact with a fragmented system of support where there is great local variation in entitlements, support, and awareness of kinship-specific needs across agencies. This can result in inconsistent identification of kinship carers, uneven access to support, and missed opportunities for early support and intervention. The Systems Change pathway within Kinship Connected is designed to address these structural challenges by strengthening coordination,

improving shared understanding of kinship care, and embedding Navigators within local service ecosystems to improve responsiveness and integration.

This pathway focuses on improving the local support and service environment for kinship families by strengthening coordination, awareness, and responsiveness across the system. The mechanisms of change here support the Navigators' work to embed Kinship Connected within a local area's statutory kinship offer. These comprise systems mechanisms such as:

- Navigators supporting LA staff to identify and understand the needs of kinship families, and how to meet them
- Navigators supporting the LA to identify gaps and opportunities for better practice and processes
- Navigators improving the trust between the LA and kinship carers.

As a result, the expected short- and intermediate-term outcomes are:

- Referral pathways into Kinship Connected are better understood
- LA staff see the benefits of navigation support
- Higher take-up of support services by kinship families
- Better communication between services
- Services are more joined up and less fragmented
- Support for kinship families is prioritised
- The system is better able to support kinship families effectively
- Navigation support is embedded in the local kinship offer
- Sustained take-up of local and national services by kinship families.

A key mechanism of change in this pathway is the co-location and active embedding of Navigators within kinship service teams or Family Hubs. By working alongside local services in person Navigators become a visible and accessible point of connection for both practitioners and kinship families. This embedded presence helps to promote referral pathways into Kinship Connected and increases familiarity with the service across agencies. Evidence from integrated family support and multi-agency "hub" models suggests that co-location and shared working environments improve cross-agency communication, increase referral rates, and support more coordinated responses to family needs (Department for Education, 2025b).

Another important mechanism is the Navigator's relational role as an independent, trusted professional working across statutory and voluntary services. Through their position outside formal decision making structures, Navigators can act as neutral brokers between kinship carers and local authorities. This helps to improve communication, build trust, and reduce perceived power imbalances between families and statutory services. Evidence from advocacy and family navigation models suggests that trusted intermediary roles can improve engagement with services, increase transparency, and strengthen relationships between families and statutory systems, particularly in contexts where trust may be limited (Burke et al., 2023).

In addition, systems-level change is supported through activities that build shared understanding of local need and strengthen community and organisational engagement. This includes systematic mapping of local kinship support provision to identify existing services, gaps in provision, and

areas of high or unmet demand. Insights from this mapping are used to inform service coordination and improve alignment between need and provision.

Kinship Connected launch events also raise awareness of the programme, building relationships with key stakeholders and strengthening referral pathways at the point of implementation. Alongside this, Navigators engage in ongoing community engagement with local organisations, including voluntary and community sector partners, schools, and other frontline services, to improve awareness of kinship care and embed the programme within local support ecosystems. These activities collectively enhance visibility of kinship carers' needs, improve shared intelligence across services, and support more consistent identification and referral practices.

Together, these activities are expected to lead to the identified mechanisms of change: as Navigators become embedded within local networks, local authorities gain increased knowledge of referral pathways into Kinship Connected and a clearer understanding of the benefits of uptake for families. At the same time, their ongoing engagement work increases awareness of kinship carers' needs and how these can be better met through coordinated responses. This contributes to increased use and take-up of both local and national services, as referral pathways become clearer and more consistently applied.

Over time, these changes support more joined-up service delivery, with agencies working more collaboratively and effectively to respond to kinship families' needs. This includes improved coordination between statutory and voluntary services, more consistent identification of kinship carers, and earlier intervention before issues escalate. Ultimately, through sustained embedding within the kinship local offer, Kinship Connected becomes an integrated part of the local support ecosystem, contributing to a more coherent, responsive, and kinship-aware system.

This aligns with evidence from evaluations of system navigation and integrated family support approaches, which show that embedded navigator roles, combined with strong relational practice and system feedback loops, can improve cross-agency coordination, increase service uptake, and strengthen overall system responsiveness to vulnerable families (Teggart et al., 2023; Wijekulasuriya et al., 2025).

Impacts

Over time, through the three casual pathways, the intervention is expected to contribute to:

- Improved quality of life for kinship carers
- More children whose parents are unable to care for them are in safe, stable kinship placements and fewer children grow up in the care system
- Children in kinship families have greater likelihood of health, happiness, and opportunities to thrive
- Improved and more accessible local services for kinship families
- Kinship carer community is more resilient and less reliant on children's social care services, which contributes to potential long-term cost savings for the wider system.

Assumptions

To enable these outcomes and impacts to occur, the programme is operating with these key assumptions:

1. **The Navigator role is understood and accepted by the LA:** The LA recognises the value of the Navigator role, supports its integration, and enables access to relevant systems and staff.
2. **Referral pathways are clear, functional, and consistently used:** Referral routes into the programme operate smoothly, are well communicated, and reach the kinship carers who most need support.
3. **Navigators have the interpersonal skills and cultural competence needed to build trust with kinship carers:** Navigators are able to engage sensitively and effectively with diverse family situations and needs.
4. **The Navigator role is acceptable and trusted by kinship carers:** Kinship carers perceive the role as supportive, non-judgemental, and beneficial, enabling strong engagement.
5. **Kinship carers have the capacity and willingness to engage with the programme:** Participants have enough time, emotional bandwidth, and stability to take part meaningfully in support activities.
6. **In-person support is logistically feasible across the local area, including rural settings:** Navigators can reach kinship carers face to face where needed, and carers can reasonably access in-person sessions.
7. **Kinship carers complete the core six months of the programme:** Most carers remain engaged for the minimum period required for the model to have impact.
8. **The needs assessment process is reliable and appropriate, and captures the right information:** The assessment tools and process accurately identify carers' and children's needs and inform appropriate support plans.
9. **Statutory services can respond to any increase in referrals or service uptake prompted by the programme:** Children's social care and related services have the capacity to act on identified needs and do not create bottlenecks.
10. **Navigators receive adequate training, supervision, and ongoing support:** Navigators are equipped with the knowledge, skills, and guidance required to deliver the programme safely and effectively.

Business as usual

Participants in the control condition will receive business-as-usual (BAU) services available in their local area during the waiting list period. The nature and availability of LA support for kinship families varies considerably across sites, meaning BAU services will vary. Support for kinship carers varies depending on the type of arrangement, the child's care history, and the LA area.

BAU for kinship carers can usually be described as a combination of the following three main service routes, each of which is described in more detail below:

- Local area services for kinship carers as developed by the LA and described in its kinship local offer
- National services delivered by Kinship (the charity), as noted below. These are available to all local areas (regardless of whether they have commissioned Kinship to deliver in their area)
- Other voluntary and community sector (VCS) services.

Local authority services

Local authorities' kinship local offer should set out, in clear and practical terms, the support that kinship families can expect to access locally. In each area, this will comprise, though to different extents, LA-run services such as training and peer support groups, advice and information, financial and practical support where relevant, help to access and navigate health and education services, and signposting to third-sector and community-based support. This sits alongside LAs' general duty to safeguard and promote the welfare of children within their area who are in need and to promote the upbringing of these children by their families by providing a range and level of services that is appropriate to those children's needs (Children Act 1989, section 17).

Kinship national services

There are a number of services that Kinship provides to kinship carers nationally for free, regardless of the local area and kinship arrangement type (i.e. of any legal order or none).

1. **Kinship Advice Service:** The service is freely available for all kinship carers regardless of their legal order and provides specialist advice regarding welfare benefits/social work, education, and finance.
2. **Kinship Training and Support Service:** Includes a comprehensive portfolio of in-person and online training workshops and roadshows; information and signposting to resources and support.
3. **Kinship Peer Support Service:** Kinship provides kinship carers in England with the support they need to set up and sustain their own peer support group, including guidance, support, resources, and training to help groups start and sustain. Alongside their peer support service, Kinships run a peer listening service called Someone Like Me.
4. **Kinship Compass:** A free interactive online navigation tool that provides local and national independent information, support, and advice for kinship carers who enter their postcode or location. It is a gateway to all of Kinship's support and advice to guide kinship carers in their caring role.
5. **Kinship Care Guide for England:** This is a practical companion guide for kinship carers to understand kinship care, from becoming a kinship carer to living as a kinship family. It includes practical tools, resources, checklists, and signposting to help them navigate complex systems.
6. **Kinship Community:** While not a service, the Kinship Community of 12,000+ kinship carers offer up-to-date news, events, campaigning, research, and participation opportunities and tailored content for kinship carers.

Other voluntary community services

Kinship carers and their families can also access support from other public services, national charities, and local voluntary and charitable sector.

These include:

- Advice services provided by the Family Rights Group, Coram Legal Centre, and Grandparents Legal Centre
- Peer-to-peer in-person and online groups, including on Facebook
- Charities working in specific geographic areas
- Charities working with specific groups of kinship carers, such as Families in Harmony and Adfam.

PILOT IMPACT EVALUATION

Research questions

This pilot evaluation is designed to assess the feasibility of a future full-scale RCT, while exploring early indications of promise. The research questions reflect this dual purpose. Feasibility is the primary focus, given that Foundations confirmed in December 2025 that the intervention model is stable, and the pilot is intended to test RCT mechanisms and procedures required for a future larger-scale trial.

The pilot is designed to address the following primary research question:

RQ1: Is it feasible to conduct a full-scale randomised controlled trial of Kinship Connected? Specifically:

- Were sufficient LA sites recruited and engaged to participate in the trial (target: four sites)?
- Were sufficient numbers of eligible kinship carers identified and recruited within the evaluation timeframe (target: 50 per LA)?
- Were sufficient numbers of kinship carers retained through the 6-month intervention or waitlist period (target: 80% retention; 40 per LA)?
- Do the selected outcome measures show face validity against the intervention aims, and do they achieve acceptable completion rates at baseline and follow-up (target: above 90%)? Face validity will be assessed through qualitative interviews, which will explore whether carers and delivery staff identify parental self-efficacy and carer wellbeing as primary perceived impacts of the programme.

The pilot will also address three secondary research questions on the estimated effects of Kinship Connected. These are exploratory, given that the trial is not powered to detect meaningful effects.

Estimates will be reported with 95% confidence intervals to convey uncertainty, and are intended to generate hypotheses for a future full-scale trial rather than to provide confirmatory evidence of effectiveness.

RQ2: What is the estimated effect of Kinship Connected on kinship carers' parental self-efficacy at 6 months post-randomisation, compared with LA business-as-usual support? Parental self-efficacy will be measured using the Brief Parental Self-Efficacy Scale (short form).

RQ3: What is the estimated effect of Kinship Connected on kinship carer wellbeing at 6 months post-randomisation, compared with LA business-as-usual support? Wellbeing will be measured using the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS).

RQ4: What is the estimated effect of Kinship Connected on the probability of a child entering unrelated foster care during the 6-month trial period, compared with LA business-as-usual support? This outcome captures whether a child leaves the kinship

placement and enters an unrelated foster care arrangement. It does not include cases where kinship carers become approved foster carers, as the child remains within the same family.

Design

The impact evaluation of Kinship Connected will be a pilot two-arm parallel randomised controlled trial with 200 kinship carers across four LA sites using a waitlist design. The design allows for concurrent recruitment and delivery across all sites, with participants individually randomised to compare outcomes between those receiving Kinship Connected and those receiving LA business-as-usual support.

Randomisation will occur at the individual family level, with each kinship carer (and the children in their care) allocated to either the intervention or control condition using a 1:1 allocation ratio. The decision to randomise individually (instead of at an LA cluster level) enables inclusion of informal kinship carers who are not systematically recorded in LA databases, avoids the sample size inflation required for cluster-level designs, and aligns with the Kinship Connected referral model, which operates through multiple channels including self-referral and community organisations. While cluster randomisation was initially considered as it would have reduced operational complexity, it was ultimately ruled out due to the limitations it would place on inclusivity, buy-in from participating LAs (including access to relevant data to measure outcomes), and statistical power.

A single treatment arm has been designated for this study, through which 100 kinship carers (25 per site) will be randomised to receive the Kinship Connected programme. Kinship Connected is a six-month intensive navigator intervention delivered by specialist Navigators. The programme provides individualised one-to-one support including practical and emotional support, assistance navigating systems and services, and connection to peer support networks. For full details of the intervention components, please see the intervention protocol.

A total of 100 kinship carers (25 per site) will be randomised to the control arm. This is the randomisation target and is fixed by design. The expected analytic sample at endline is 80 per arm, after allowing for 20% attrition. Further detail is provided in the sample size section.

Control participants will receive LA business-as-usual (BAU) support during the six-month waitlist trial period. They will be offered access to Kinship Connected after endline data collection is complete.

The documented variation in BAU informs interpretation in two ways. First, site profiles of BAU provision will be reported alongside the impact estimates. This will show readers the counterfactual against which Kinship Connected is compared. Second, qualitative findings from the IPE on how BAU shapes carer experience will be integrated with the quantitative findings. BAU is the comparator the trial tests against, so the variation contextualises rather than adjusts the estimates.

Given this heterogeneity, the evaluation will systematically document what control participants receive. Three sources will be used. First, LA administrative data where available. Second,

participant self-report at endline on services accessed during the trial period. Third, a mapping of BAU provision across sites, conducted during the set-up phase as part of the IPE.

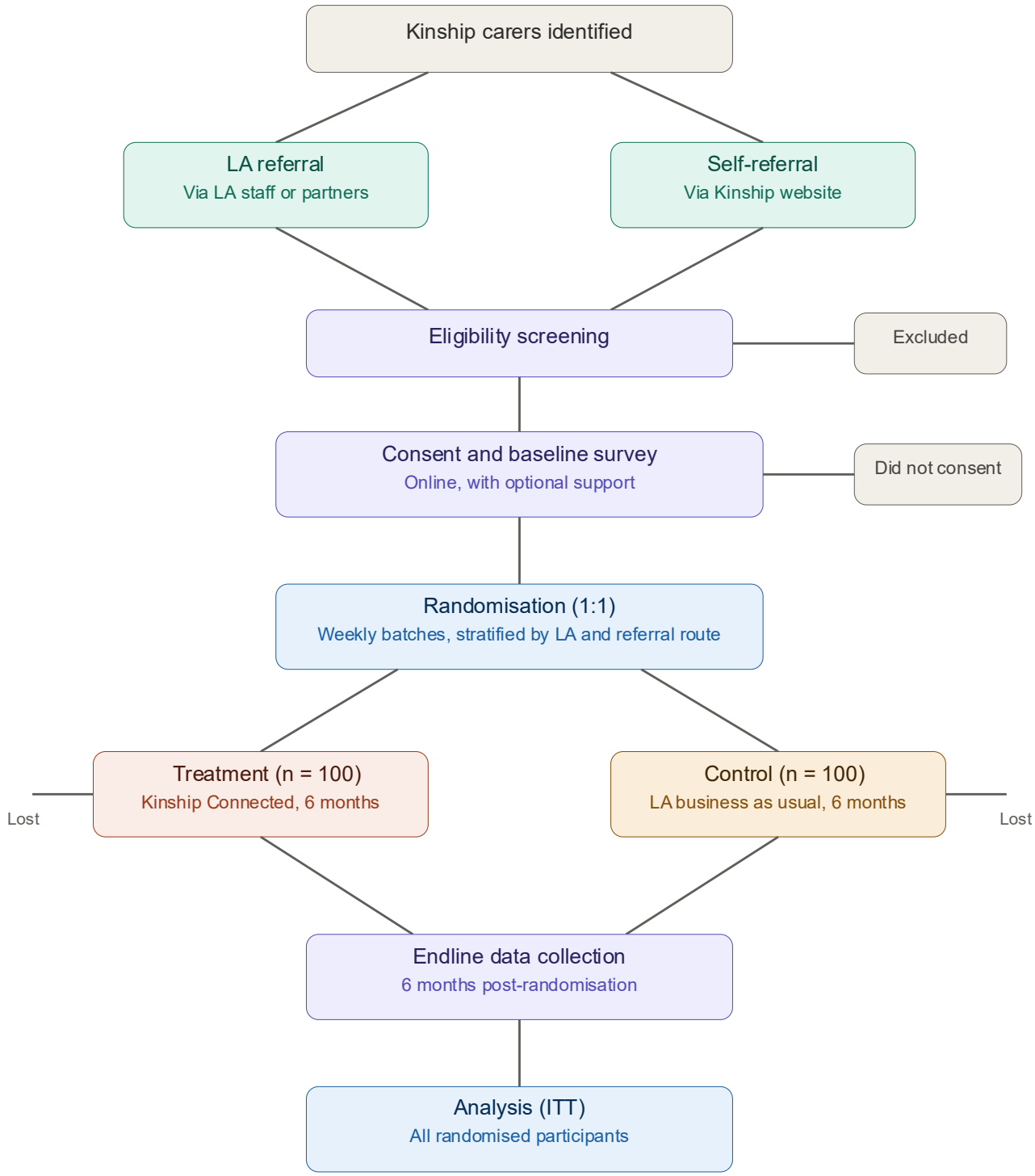
Table 2. Design overview

Trial type and number of arms		Pilot two-arm randomised controlled trial, waiting list design
Unit of randomisation		Kinship carer (individual level)
Stratification variables (if applicable)		LA & referral type (LA vs self-referral)
Primary outcome	**Variable**	Feasibility of a full-scale RCT
	Measure (instrument, scale)	LA site recruitment (target: 4 sites); carer recruitment (target: 50 per LA); retention at endline (target: 80%); outcome measure face validity and completion rates (target: above 90%)
Secondary outcome(s)	**Variable(s)**	Kinship carer parental self-efficacy; kinship carer wellbeing; child entry into unrelated foster care
	Measure(s) (instrument, scale)	Brief Parental Self-Efficacy Scale (short form); Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS); administrative data on unrelated care placement (binary)

The CONSORT[6] diagram in figure 1 sets out the participant journey through the trial. It shows how kinship carers will enter the study, how eligibility and consent will be confirmed, how randomisation will be conducted, and how outcomes will be collected and analysed at endline. The randomisation box shows the target of 100 carers per arm. The analytic sample at endline is expected to be smaller after attrition. See the sample size section for details.

[6] The CONSORT (Consolidated Standards of Reporting Trials) flow diagram provides the reader with information about how the trial was conducted, reporting enrolment, allocation, follow-up and analysis of patients involved in the RCT (Falci & Marques, 2015; Hopewell et al., 2025).

Figure 1. CONSORT diagram



Randomisation

Randomisation will be conducted centrally by Ipsos UK using stratified block randomisation with a 1:1 allocation ratio between intervention and control arms. The full randomisation sequence will be generated before any participants are recruited, using computer-generated random number sequences in Stata with a fixed seed for reproducibility.

The randomisation list will be stratified by two variables: LA (Newham, Blackpool, Rochdale, Oxfordshire) and referral pathway (LA referral versus self-referral). This creates eight strata. The inclusion of referral pathway as a stratification variable recognises that these two pathways likely identify different populations. They may differ in baseline characteristics, prior engagement with support, and levels of motivation for engaging with support. Stratification ensures balanced representation of these characteristics across trial arms.

Other variables known to influence baseline outcomes, such as carer age, ethnicity, and time in the caring role, will not be used for stratification. Stratifying on more than two variables risks producing empty cells within strata, which would undermine the balance that stratification is designed to achieve. These variables will instead be included as covariates in the analysis, where sample size constraints do not apply in the same way.

Within each stratum, randomisation will use permuted blocks of size two. Each block will contain exactly one treatment allocation and one control allocation in random order. This should guarantee that the maximum imbalance between arms within any stratum is one participant at any point during the trial. The block size of two was chosen to maintain tight balance given the small expected sample size per stratum. Minimisation was considered as an alternative but was not adopted. With only two stratification variables and eight strata, stratified block randomisation achieves comparable balance. It also allows the full sequence to be generated in advance, removing the need for live software during the trial.

The pre-generated list will contain 50 allocation slots per stratum (400 in total). This provides a generous buffer above expected recruitment. As each participant completes consent and baseline data collection, they will be assigned to the next available slot in their stratum. This approach removes any dependency on batch size (i.e. batch-based randomisation requires a minimum number of participants before randomising, which could delay treatment access if referrals are slower or lower than expected). Using the current approach, a single participant arriving in a quiet week receives their allocation in the same way as one arriving alongside several others. There is no minimum batch size requirement and no need to defer randomisation to accumulate a larger group.

Allocations will be processed on a weekly cycle. Each week, the Ipsos UK analyst will receive from Kinship a list of newly consented participants, identified by a unique trial ID, LA, and referral pathway. The analyst will look up the next available slot in the relevant stratum, record the participant's ID and date of assignment, and communicate the allocation result. The randomisation list will not be shared outside Ipsos UK. An operating manual accompanies the randomisation list. It provides step-by-step instructions for the weekly allocation process. This ensures continuity if the responsible analyst changes during the trial.

Baseline data collection will be completed for all participants prior to randomisation. This prevents any influence of group allocation on baseline responses. Following each weekly allocation, participants will be informed of their group assignment promptly. This ensures no unnecessary delay in accessing support for those allocated to the intervention arm. Participants allocated to the control group will be offered the Kinship Connected programme after completing endline data collection.

Given the pilot nature and scale of this trial, maintaining complete blinding of analysts to group allocation presents practical challenges. The aspiration is for analysts conducting the statistical estimation of treatment effects on carer self-efficacy, wellbeing, and foster care placement to remain blinded to allocation until database lock. The reality of a small research team and the need for ongoing monitoring may make full blinding impractical. Analyst awareness of allocation is not expected to bias outcome measurement. Outcomes are either self-reported by participants or drawn from independently maintained administrative records. The analysis plan will not be modified on the basis of unblinded interim information. The pre-specified analysis plan, and the commitment not to modify it on the basis of interim information, is the main safeguard against analytical bias.

The randomisation process will be documented through the pre-generated randomisation list, which will record each allocation, the participant assigned, the date of assignment, and the initials of the analyst who processed the allocation. The Stata do-file used to generate the list, the random seed, and a log of the generation process will be stored securely as part of the audit trail. A CONSORT flow diagram will track the flow of participants through recruitment, randomisation, and follow-up. Any deviations from the randomisation protocol will be documented and reported in the final report.

Managing urgent need

Kinship does not offer crisis or emergency support services. As outlined in the eligibility criteria and participant information materials, this trial is not appropriate for kinship carers who require urgent support at the point of referral, or who are anticipated to require such support within the six-month waiting period. If a kinship carer who is allocated to the control group contacts Kinship or the evaluation team during the waiting period to request urgent assistance, they will be signposted to relevant support services available through their LA or other appropriate providers. This approach is consistent with usual care arrangements, as control group participants continue to have access to BAU support from their LA. This process is not considered to raise ethical concerns, as no participant is denied access to existing statutory or community-based support. All instances of kinship carers seeking urgent support during the trial will be systematically recorded and monitored.

Participants

A kinship carer is defined as a relative or close family friend (a “connected person”) who has primary day-to-day responsibility for the care of a child who cannot live with their birth parent(s). The trial will randomise 200 kinship carers, 50 per LA across four sites. Assuming 20% attrition

between randomisation and endline, the analytic sample is expected to be 160, or 40 per site. Further detail on sample size and the minimum detectable effect size (MDES) is provided in the sample size section.

Inclusion criteria

Participants must meet all of the following criteria.

Role and care arrangement

- Be a kinship carer as defined above, with at least one kinship child aged 0–18 currently living in their care.
- Fall within one of the following arrangements: informal kinship care (no legal order), Special Guardianship Order (SGO), Child Arrangements Order (CAO) or Residence Order (RO), or Connected Foster Carer formally transitioning to an SGO.

Practical and geographic

- The kinship carer must be residing in the LA area covered by this agreement at the point of referral.
- The kinship carer must have sufficient understanding of written English to read, understand, and provide true informed consent to the participant information sheet provided by Kinship's evaluation partners.[7] Reasonable adjustments to programme delivery (including interpreter support) may be available and will be considered on a case-by-case basis with the research team.

Clinical and safeguarding

- Be assessed as not requiring urgent or immediate support that would make a six-month waiting period inappropriate. This assessment is made by LA staff for LA referrals, and by self-report for self-referrals.

Exclusion criteria

Participants will be excluded if any of the following apply.

- They are unrelated or unconnected foster carers.
- They are connected foster carers who are not transitioning to an SGO.
- They are adoptive parents or prospective adopter households only.
- They are birth parents or other carers without primary caring responsibility for the child.

[7] Where a kinship carer's first language is not English, the referring worker must contact the Charity Project Lead before referral to discuss whether translated consent materials are available and approved for use in the trial. A carer should not be excluded on language grounds alone without this conversation. Interpreter support cost should be covered by the LA if they have referred the kinship carer.

Identification and recruitment

Kinship carers will enter the trial through two pathways: LA referral and self-referral. The pathways share a common framework, with different routes of identification and referral.

The pathway is determined by the kinship carer themselves. In practice, this decision is circumstantial and shaped by the carer's context and how they first encounter the programme. Some carers will come via the LA referral pathway because they are already engaged with statutory services, while others will access the programme through the self-referral pathway because they are not known to the LA, prefer not to engage with it, or encounter Kinship Connected through community routes.

Common framework: Each LA has an embedded Navigator who supports recruitment, maps the local support for kinship care offer and areas of high demand and need, and engages with local community and voluntary sector organisations. All interested carers receive an easy-read information sheet to support informed decision making.

After a referral is submitted, Kinship sends the carer an automated email. This contains the full participant information sheet, FAQs, a data privacy notice, and a link to a consent form and the baseline questionnaire. Participation only proceeds once informed consent has been given.

LA referral pathway: This pathway enables LA teams to refer eligible kinship carers to the trial. LA staff receive detailed information about the study, including inclusion and exclusion criteria. The Navigator works with LA teams (for example, early help or equivalent family support services) and is co-located where feasible.

When a kinship carer approaches the LA for support, LA staff provide the easy-read information sheet. If the carer is eligible and interested, LA staff complete the LA referral form and submit it to Kinship.

Self-referral pathway: This pathway provides an accessible route for carers who may not wish to engage with their LA, are unaware of available support, or are not known to the LA (for example, informal kinship carers).

The Navigator hosts a launch event for the trial and engages with local community organisations. The launch event is held during the beginning of the delivery phase and will provide information to kinship carers on what the programme is, impacts from kinship carers who have been through the programme, and time for Q&A. There will also be time to support kinship carers to complete self-referral forms if appropriate.

Information on Kinship Connected and the trial is available on a dedicated page on Kinship's website. The page sets out eligibility criteria, what participation involves, and the purpose of the study. The easy-read information sheet is available to download. Interested carers will complete an expression of interest form on Kinship's website.

Sample size/MDES calculations

This pilot study is designed primarily as a feasibility trial. Sample size is determined by practical constraints, including delivery capacity and expected referral flows, rather than formal power calculations.

The randomisation target is 200 kinship carers, 100 per arm, with 25 per arm in each of the four participating LAs. Actual recruitment distribution may vary by site based on referral patterns and capacity. The analysis follows an intention-to-treat principle, so participant data will be analysed according to their randomised group.

Assuming 20% attrition between randomisation and endline, the expected analytic sample is 160 carers, or 80 per arm. Attrition rates will be monitored throughout the pilot as a key feasibility parameter. The MDES is calculated on the expected analytic sample, because participants without an endline outcome cannot contribute to the effect estimate.

With 80 per arm, 80% power, alpha of 0.05, and a two-sided test, the MDES is 0.446 standard deviations. This assumes no clustering and no baseline adjustment. Baseline–endline correlations are unknown and will be estimated from the pilot data. Baseline adjustment is expected to reduce the MDES, but the magnitude of the reduction cannot be quantified in advance. The pilot will estimate the outcome standard deviation, the baseline–endline correlation, attrition, and any clustering. These parameters will size a future definitive trial, which would be powered to detect a smaller, policy-relevant effect.

This pilot is not powered to detect meaningful intervention effects. Underpowered studies face increased risks of Type M (magnitude) and Type S (sign) errors. Type M refers to overestimation of effect sizes when significant effects are detected. Type S refers to detecting effects in the wrong direction. Effect estimates from this pilot must not be interpreted as definitive evidence of effectiveness or lack thereof. They should be viewed as indicative, providing early signals to inform decisions about a full-scale trial.

All power calculations and related analyses will be conducted in Stata. Syntax will be documented and made available to support transparency and reproducibility in an appendix to the final report.

Table 3. Sample size considerations

Parameter		Assumptions
MDES		0.446
Baseline/endline correlations	**Child**	N/A
	Family	N/A
	Social worker	Unknown
Intracluster correlations (ICCs)	**Family**	N/A
	Social worker	Unknown
	Team	N/A
Alpha		0.05
Power		0.8
One-sided or two-sided?		Two-sided
Level of intervention clustering		N/A
Average cluster size		N/A

Parameter		Assumptions
Sample size (children)	Intervention	N/A
	Control	N/A
	Total	N/A
Sample size (families)	Intervention	80
	Control	80
	Total	160

Outcome measures

The primary outcomes address the feasibility of a full-scale RCT. Four indicators will be assessed:

1. Recruitment of LA sites (target: four).
2. Recruitment of eligible kinship carers per site (target: 50).
3. Retention through the 6-month intervention or waitlist period (target: 80%).[8]
4. Completion rates for each outcome measure at baseline and follow-up (target: above 90%).[3]

Face validity of the outcome measures will be assessed through qualitative interviews with carers and delivery staff, as part of the implementation and process evaluation. Full details of the feasibility analysis are set out in the analysis plan.

[8] These targets are consistent with expectations for pilot RCTs, where the primary aims are to assess feasibility, acceptability, and study procedures rather than to determine effectiveness. Retention rates of around 80% are commonly considered acceptable for pilot studies over short follow-up periods, while higher completion rates (≥90%) for outcome measures are desirable to assess the acceptability and burden of data collection and to minimise missing data. Achieving these thresholds would support progression to a fully powered trial with acceptable levels of attrition and data completeness (National Institute for Health Research, 2019; Medical Research Council, 2006; Eldridge et al., 2016).

Three secondary outcomes will be measured. All are aligned with the Kinship Connected theory of change (see Appendix A).

The first secondary outcome is kinship carer self-efficacy, measured using the Brief Parental Self-Efficacy Scale (BPSES; short form; Woolgar et al., 2023). The BPSES is a self-report measure completed by kinship carers. It will be administered at baseline (prior to randomisation) and at six months, at the end of the intervention for treatment participants, and at the end of the waitlist period for control participants. BPSES was selected over a general self-efficacy scale because parental self-efficacy maps more directly onto the intended impact of the Navigator Programme. Strengthened parental confidence is theorised to support more consistent caregiving, which in turn contributes to placement stability and child wellbeing. BPSES also aligns with Kinship's existing data collection processes, reducing burden on carers.

The second secondary outcome is kinship carer wellbeing, measured using the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown et al., 2009). SWEMWBS will be administered at baseline and at six months. Control participants will receive a £20 voucher for completing the baseline survey and a £20 voucher for completing the follow-up survey. Treatment participants will not receive survey incentives, given that they are receiving the Kinship Connected programme.

The third secondary outcome is unrelated care placement status at six months, obtained from LA or Kinship administrative data. This is a binary outcome. It captures whether a child leaves a kinship placement and enters an unrelated foster care arrangement during the trial period. The outcome serves as a proxy for fewer children growing up in the care system.

As noted in the randomisation section, the analyst will be blinded to randomisation condition where feasible.

While the intervention is designed to support kinship carers, the evaluation must monitor for potential harms, adverse effects, or unintended consequences. For participants randomised to the control condition, potential harms include delayed access to needed support during the six-month trial waitlist period, which could result in placement instability or carer stress. For treatment group participants, the intensive nature of the Navigator support could surface difficult emotions, highlight unmet needs that cannot be immediately addressed, or create dependency on support that will end after six months.

One additional potential unintended consequence of the intervention is identification of significant safeguarding needs that could result in a Child Protection Plan or a child moving into social care. All potential harms will be monitored throughout, reported to the evaluation team in regular progress meetings, and captured in Kinship's administrative data. These will be explored in detail in the implementation and process evaluation.

Data collection plan

Kinship will be responsible for all data collection activities required for the impact evaluation, from the point of first contact with carers through to preparation of datasets for Ipsos UK. As agreed with CEI, the BPSES and SWEMWBS measures will be embedded within Kinship's standard

self-referral form (sent to carers following an expression of interest) and within a shorter, equivalent version for LA-referred carers.

This means that completion of these outcome measures will be integrated into Kinship's routine referral and onboarding processes, rather than administered separately by the evaluator. All responses, including BPSES and SWEMWBS scores, will be captured directly by Kinship and stored in its Salesforce system, in line with agreed data protection and information governance requirements. Kinship will then extract and transfer the relevant de-identified data securely to Ipsos UK for monitoring and statistical analysis. Table 4 outlines the key responsibilities.

Table 4. Data collection roles and responsibilities

	Kinship	Ipsos UK
Participant ID	Create a unique ID for each participant	–
Randomisation	Provide IDs to Ipsos UK and any agreed stratification variables needed for randomisation	Conduct randomisation and return allocation to Kinship
Baseline data collection	Collect BPSES and SWEMWBS via referral forms; record in Salesforce	–
Follow-up data collection	Collect BPSES and SWEMWBS via referral forms; record in Salesforce	–
Quality assurance/data monitoring	Export data from Salesforce on a weekly basis in the form of standardised CSV files	Run checks (completeness, plausibility, duplicates) and feedback issues to Kinship and support rectification

Participant ID and data linkage

As outlined in previous sections, Kinship will generate a unique participant ID for every carer who enters the trial. This ID will be the only identifier shared with Ipsos UK for the purposes of randomisation and subsequent analysis. Because all evaluation data (including BPSES and SWEMWBS responses) will be collected directly through Kinship's Salesforce system, the unique ID will be automatically and consistently linked to each participant's records from the point of first data entry.

In practice, this means that when data are exported from Salesforce and transferred to Ipsos UK, each row of de-identified data already carries the correct participant ID, removing the need for any separate matching process and reducing the risk of linkage errors.

Quality assurance

Before data collection begins, Ipsos UK and Kinship will review the referral form and planned Salesforce export specification together to confirm that all variables required for the evaluation (including IDs, outcome measures, trial arm indicators, site information, and key covariates) are present, correctly coded, and clearly defined.

Kinship will export data from Salesforce on a weekly basis in the form of standardised CSV files, using a fixed set of variable names and a consistent column order to minimise formatting errors. On receipt of each file, Ipsos UK will run a set of routine quality checks, including basic counts by site and trial arm, checks for missing or implausible values, and identification of any duplicate records or internal inconsistencies. Findings from these checks will be fed back promptly to Kinship so that any systematic issues (e.g. fields not being completed, coding errors, or anomalies at particular local authorities) can be identified and corrected at source.

Analysis plan

A detailed statistical analysis plan will be developed as a separate document following the Foundations SAP guidance template. The SAP will complement this protocol and will be finalised and published on Foundations' website before endline data collection begins.

Data collection independence

Kinship, the delivery organisation, will collect outcome data for this trial. This departs from standard trial practice, where data collection is independent of delivery. The arrangement is necessary for three practical reasons. First, Kinship holds the relationship with carers through referral, baseline, and follow-up. Second, embedding outcome measures in Kinship's existing forms reduces participant burden. Third, independent data collection would require additional budget that is not available.

This arrangement creates risks to internal validity. The protocol sets out these risks and the mitigations in place. The mitigations reduce these risks but cannot eliminate them. Some residual bias is expected and is accepted as a trade-off given the pilot nature of the trial and the practical constraints set out above. The full independence protocol is implemented across the trial period.

Table 5. Identified risks and mitigations for data collection

Risk	Description	Mitigation
Positive responsive bias	Treatment carers may give more favourable answers to the organisation that supported them. Control carers do not have this relationship, so the bias is asymmetric.	Online self-completion is the default mode, to reduce interpersonal pressure.
Demand characteristics	Carers who know the survey comes from Kinship may infer what a 'good' answer looks like. This affects the treatment arm more than the control arm.	Information sheets are branded as coming from the evaluation team, not the Kinship Connected programme. A standard instruction states there are no right or wrong answers.
Data collectors not blinded	Full blinding is not feasible. Kinship must know allocation to deliver the correct condition. Knowledge of allocation can influence how staff chase responses or interact with carers.	Structural separation between delivery staff and survey staff. Survey staff do not attend case meetings. Survey staff do not see progress notes. Follow-up procedures are standardised across arms. Reminders, timing, mode, and wording are identical. The protocol acknowledges openly that data collectors are not blinded.
Differential attrition	Kinship has an ongoing relationship with treatment carers, making them easier to reach at endline. Control carers may be harder to follow up. Response rates may differ by arm.	Identical follow-up procedures for both arms. Real-time monitoring of response rates by arm. Incentives will be offered for endline completion for those in the control group. Escalation if a response rate gap emerges.

The analysis plan reports endline response rates by arm. Sensitivity analysis for differential attrition is conducted using Lee bounds, as set out in the feasibility analysis.

Analysis plan

Feasibility analysis

The feasibility analysis will address RQ1, the primary research question. It will assess whether a full-scale RCT of Kinship Connected is feasible. This analysis will be descriptive rather than inferential, given that feasibility indicators are counts and proportions, not treatment effects.

Four indicators will be reported. First, the number of LA sites recruited and engaged, against the target of four. Second, the number of eligible carers recruited per LA, against the target of 50.

Third, the proportion of carers retained through the 6-month intervention or waitlist period, against the target of 80%. Fourth, completion rates for each outcome measure at baseline and endline, against the target of above 90%. Face validity of the outcome measures will be assessed through qualitative interviews with carers and delivery staff, as part of the IPE.

Each indicator will be reported with a 95% confidence interval where relevant. Variation across LAs will be described. The qualitative component will be drawn from the IPE and integrated into the feasibility assessment. Full details are set out in the IPE section.

Endline response rates will be reported separately by trial arm. This will test whether Kinship's ongoing relationship with treatment carers produces higher response rates in the treatment arm. Sensitivity analysis for differential attrition will be conducted using Lee bounds. Methods will be specified in the SAP.

Analysis of secondary outcomes

The analysis of secondary outcomes will address RQ2 to RQ4. It will estimate the effect of Kinship Connected on three outcomes: kinship carer parental self-efficacy, kinship carer wellbeing, and the probability of a child entering unrelated foster care during the trial period.

These analyses will be exploratory. The pilot is not powered to detect meaningful effects, as set out in the sample size section. Estimates will be reported to inform a future full-scale trial. They should not be interpreted as confirmatory evidence of effectiveness.

The secondary outcomes will be analysed at the same tier. No outcome will be ranked as primary, because the trial is not powered for outcome estimation. The primary research question is feasibility (RQ1). The secondary outcomes are self-efficacy, wellbeing, and foster care placement.

Self-efficacy

The analysis of self-efficacy will use ordinary least squares (OLS) regression. The endline score on the Brief Parental Self-Efficacy Scale is regressed on treatment assignment, controlling for baseline covariates. The analysis follows an intention-to-treat (ITT) principle. All randomised participants are analysed according to their assigned group, regardless of actual receipt of or engagement with Kinship Connected. This preserves the benefits of randomisation.

The regression equation is:

$$Y_{ij} = \beta_0 + \beta_1 Treat_i + X_{ij} + \varepsilon_{i,j}$$

In this equation, j represents the LA, i represents the individual carer, β_0 is a constant term, Y_{ij} represents the outcome score for participant i at LA j. $Treat_i$ is the treatment indicator for participant i. X_{ij} represents various individual characteristics of participant i at LA j, and $\varepsilon_{i,j}$ is the error term for participant i at provider j.

The regression model includes the following covariates. First, the baseline value of the outcome, where available. Second, LA fixed effects, to account for site-level differences. Third, a set of baseline carer and arrangement characteristics: referral pathway, carer age, ethnicity, gender, time

in the caring role, type of kinship care arrangement, relationship to the child(ren) in their care, and number of kinship children in the carer's care. The final covariate list will be confirmed in the SAP, based on baseline data availability and balance checks.

Treatment effects will be reported as Glass's Delta, calculated using the unadjusted standard deviation of the control group at endline, in line with Foundations' guidance. Estimates will be reported with 95% confidence intervals and p-values. Standard errors use robust variance estimation to allow for heteroscedasticity. LA fixed effects are the main approach to site-level differences. As a sensitivity check, we will re-estimate the model with standard errors clustered at LA level.

The pilot is not powered to detect meaningful effects. Estimates should be treated as exploratory and interpreted with caution.

Wellbeing

The analysis of wellbeing will follow the same approach as self-efficacy. The endline SWEMWBS score is the outcome. Baseline SWEMWBS is the baseline covariate. The model specification, covariates, effect size convention, and sensitivity checks are identical to those described for self-efficacy.

Unrelated care placement

Placement change is a binary outcome. It takes the value 1 if a child moves from kinship care into an unrelated foster care placement during the trial period, and 0 otherwise. An unrelated placement is defined as a placement with a carer who is not a relative or connected person of the child. This includes placements with unrelated foster carers, residential care settings, unrelated adoptive carers, or other non-kinship placements. The outcome takes the value 0 where the child returns to their birth parent(s), moves to another kinship placement, remains with the same carer who becomes an approved foster carer, or remains with the same carer under a Special Guardianship Order (SGO) or other legal status change.

Because the outcome is binary, the analysis uses logistic regression rather than OLS:

$$\Pr(Y_{ij} = 1) = \Lambda\left(\beta_0 + \beta_1 Treat_i + X_{ij}\right)$$

Here, $\Lambda(\cdot)$ is the logistic function. The other notation follows the self-efficacy model.

The covariates are the same as for self-efficacy, with one exception: no baseline value of the outcome is included. By design, all children are in kinship care at baseline, so the baseline value is constant and cannot be adjusted for.

Treatment effects will be reported as odds ratios with 95% confidence intervals. As a sensitivity check, we will re-estimate the model with standard errors clustered at LA level.

Two points should be noted. First, the base rate of foster care entry over six months is expected to be low. This will produce wide confidence intervals and unstable estimates. Second, the pilot is not powered to detect effects on this outcome. Findings will be indicative only.

A complier average causal effect (CACE) analysis will be employed to estimate the effect of actually receiving the intervention among those who comply with their assignment. This is particularly relevant given anticipated variation in engagement: some treatment group carers may not engage with their assigned Navigator, while some control group carers may independently access Kinship services. Compliance will be defined as attending a minimum number of sessions (to be agreed with Kinship and Foundations during development of the SAP) with a Navigator for the treatment group, with instrumental variable analysis used to estimate CACE. As a sensitivity check, the CACE analysis will be repeated using an alternative compliance threshold of at least double the minimum number of sessions. This will test whether the estimated effect among compliers is sensitive to the chosen definition of engagement.

Analysis of harms

Potential harms will be monitored through multiple channels. Quantitative indicators will include any deterioration in outcome measures between baseline and follow-up, reports of placement breakdowns or child welfare concerns, and participant withdrawal citing negative experiences. Qualitative data from the implementation and process evaluation (described in detail below) will systematically explore participants' experiences of any negative consequences or unmet expectations.

Analysis to inform a future trial

Several further analyses will inform the design of a full-scale RCT. These are descriptive and hypothesis-generating.

First, service uptake will be compared between arms. This will draw on programme monitoring and administrative data collected across the trial period. The analysis will examine whether Kinship Connected supplements or substitutes for existing services, and whether control participants independently seek Navigator-type support.

Second, dosage-response patterns will be explored within the treatment group. The analysis will examine associations between engagement intensity and outcomes. Engagement will be measured by the number of contacts, hours of support, and breadth of topics covered.

Third, variance parameters will be estimated to support sample size calculations for a future trial. These will include standard deviations of outcome measures, baseline–endline correlations, attrition rates by arm and participant characteristics, and any evidence of clustering within LAs.

Fourth, theory of change pathways will be examined descriptively. Formal mediation analysis is not feasible given the sample size. Instead, the analysis will use correlations and graphical displays to check whether participants accessing specific intervention components show expected patterns of intermediate outcomes. This will complement the qualitative analysis in the IPE.

Fifth, the inclusion of pilot LAs in a future RCT will be assessed. Criteria will include intervention stability, evaluation procedure consistency, contamination between arms, and remaining eligible participant pools.

Finally, this is designed as an external pilot. Pilot data will inform the design of a future trial, but pooling pilot participant data into a full trial is not planned. Whether the pilot LAs are included in a future trial is a decision for the end of the pilot. It depends on the intervention and evaluation design remaining stable across phases, and on the contextual and feasibility findings from this study.

Progression criteria

The pilot will inform a clear decision about whether to proceed to a full trial. Progression will be assessed against the four feasibility targets, using a traffic-light (RAG) framework. Each indicator is rated green, amber, or red.

Table 6. Progression criteria

Indicator	Green: proceed	Amber: proceed with revisions	Red: do not proceed without major revisions
LA site recruitment	All 4 sites recruited and engaged	3 sites recruited	Fewer than 3 sites
Carer recruitment	40–50 per LA	30–39 per LA	Fewer than 30 per LA
Retention at endline	80% or above	65–79%	Below 65%
Outcome completion[9]	Above 90%	80–90%	Below 80%

Progression will be a judgement across all four indicators, not a mechanical sum of the ratings. A single amber or red rating would not automatically halt progression. The decision draws on the feasibility indicators together with qualitative evidence from the IPE. This evidence may help explain why a target was missed, and whether the cause is fixable. The evaluation team will make a recommendation to Foundations, who hold the final decision on progression.

[9] Outcome completion refers to participants having provided consent and initiated completion of the measures.

Contextual factors analysis

This study is not powered for quantitative contextual analysis given the limited number of participating local authorities (n=4). However, documenting and understanding contextual variation across sites is essential for interpreting findings and assessing generalisability to other settings.

Key contextual factors at the LA level will be systematically documented through a mapping exercise conducted during the set-up phase. This mapping exercise will also inform interpretation of findings through the implementation and process evaluation. These factors include:

- LA characteristics (population size, urban/rural, coastal or non-coastal, indices of deprivation)
- Existing kinship support provision (current services, staffing levels, specialist roles)
- Demographic composition (ethnic diversity, age distribution of kinship carers)
- Financial support available (special guardianship allowances, discretionary payments, average amounts)
- Organisational context (recent Ofsted rating, children's services improvement journey, strategic priorities for kinship care).

Given the small number of sites, formal quantitative analysis of contextual moderators is not feasible. Instead, we will use descriptive approaches to characterise variation across the four local authorities and explore potential patterns. This will involve creating site profiles summarising key contextual features, examining whether outcomes vary systematically with LA characteristics, and using qualitative data from the implementation and process evaluation to understand how local context shapes intervention delivery and reception.

IMPLEMENTATION AND PROCESS EVALUATION

Aims

The IPE aims to complement the pilot impact evaluation by generating detailed evidence on how Kinship Connected is delivered within the context of a RCT, how it is experienced by kinship carers and practitioners, and how and for whom it appears to work within the context of the UK children's social care system. The IPE will be guided by Proctor et al.'s implementation outcomes (Proctor et al., 2011), with a focus on understanding key implementation domains such as acceptability, fidelity, reach, and appropriateness. Specifically, the IPE will:

- Assess fidelity and adaptation of Kinship Connected during delivery in the pilot trial, examining the extent to which the intervention is delivered as intended, the nature and rationale for any adaptations made in practice, and the implications of these adaptations for future delivery at scale.
- Examine programme reach, engagement, and acceptability, including which kinship carers are reached by the programme (with attention to informal kinship carers and other underserved groups), patterns of engagement and dosage, and carers' and Navigators' perceptions of the relevance, accessibility, and value of the support provided.
- Describe and compare usual practice for supporting kinship carers across participating sites, in order to assess programme differentiation and understand what Kinship Connected adds relative to existing LA and voluntary sector support.
- Explore mechanisms of change, investigating whether the intermediate changes anticipated in the theory of change (such as increased knowledge of rights and services, improved confidence in navigating systems, and strengthened trust in statutory and voluntary support) are observed, and how these may contribute to carer wellbeing and placement stability.
- Identify contextual enablers, barriers, and unintended consequences of implementation, including organisational-, workforce-, and system-level factors that influence delivery and outcomes, and any unanticipated positive or negative effects experienced by carers or delivery staff.

Together, these aims will provide critical evidence on the acceptability and implementability of Kinship Connected within the context of an RCT, informing interpretation of pilot impact findings and supporting decisions about refinement, scaling, and future evaluation of kinship navigator models in England.

Research questions

As noted above, the IPE is informed by Proctor et al.'s implementation outcomes framework. The research questions below operationalise this framework by focusing on key aspects of delivery, experience, and integration of Kinship Connected across participating sites.

RQ5: Are recruitment strategies effective at reaching, engaging, and retaining the intended intervention recipients, including those who are less well served?

RQ6: What support and services are accessed by participants in the intervention group, what support and services are accessed by control group participants during the waiting period, and how do these differ?

RQ7: Is the Kinship Connected model acceptable and appropriate for kinship carers (including minoritised ethnic families), delivery professionals, and local authorities?

RQ8: Is the evaluation design acceptable and appropriate for kinship carers (including minoritised ethnic families), Kinship Family Workers, and LA staff?

RQ9: What impacts for carers are perceived by the carers and professionals delivering the intervention as a consequence of Kinship Connected?

RQ10: Which of the proposed mechanisms of change are supported by the evidence, and how do these mechanisms operate in practice within the Kinship Connected model?

RQ11: Are there any unintended consequences or other negative effects of Kinship Connected?

RQ12: Is the delivery model ready to be implemented at a larger scale?

RQ13: Are any changes to the programme theory of change, recruitment, training, or management needed for progression to a larger-scale trial?

How each research question will be addressed is set out in Table 7 below, which maps individual questions to the relevant data sources, methods of data collection, and analytic approaches. This table demonstrates how qualitative and quantitative evidence will be used, and how findings will be triangulated across sources to generate robust insights into implementation, delivery, and experience of the programme.

Table 7. IPE methods and related research questions overview

Research methods	Data collection methods	Participants/ data sources	Data analysis methods	Research questions addressed	Implementation outcome
Administrative data	Collected by Kinship staff	All kinship carers in the trial (both intervention and control groups)	Descriptive quantitative analysis	6	Differentiation
Programme monitoring data	Collected by Navigators	All kinship carers in the intervention group	Descriptive quantitative analysis	5 and 6	Reach, differentiation, reported impact
Kinship carer baseline and follow-up survey	Online survey (as part of outcome survey)	All kinship carers in the trial (both intervention and control groups)	Descriptive quantitative analysis	7 and 8	Acceptability, appropriateness, fidelity
Semi-structured discussions with kinship carers, LA practitioners, and Kinship delivery team	Qualitative interview	28 discussions in total purposively selected at mid and end timepoints	Qualitative thematic analysis	5, 6, 7, 8, 9, 10, 11, 12, and 13	Reach, acceptability, appropriateness, perceived impacts and mechanisms of change, unintended consequences, progression

Design

This implementation and process evaluation (IPE) will be embedded in, and run in parallel alongside, the pilot impact evaluation. The IPE will use a mixed-methods design to assess each of the research questions using qualitative and descriptive quantitative data. Quantitative data will be administrative and programme monitoring data collected and provided by the LAs and Kinship. Qualitative data will be generated through semi-structured discussions with kinship carers, local staff involved in recruitment and referrals, and Kinship delivery staff.

Data collection methods

The IPE will involve the following data collection activities.

Administrative data

LA administrative data: We will explore the feasibility of collecting administrative data from local authorities to examine uptake of LA services among control group participants during the six-month waiting period, as well as the potential to capture outcomes related to placement stability. Data-sharing agreements will be in place with each LA, and we will work with key contacts and data managers as needed to identify relevant data. If data is available, the evaluation team will request it at two time points: within three months of the start of delivery, and at the end of the delivery period. LAs will send the data in a password-protected file over encrypted email to the evaluation team.

Administrative and programme monitoring data: Administrative and programme monitoring data will be collected by Kinship staff across the full trial delivery period, from May 2026 to September 2027, covering all intervention and waitlist control participants once they start the intervention. This timeline reflects the operational delivery period of Kinship Connected, as the final control cohort will complete the intervention in September 2027. However, for the purposes of the evaluation, only administrative data collected between May 2026 and April 2027 will be shared with the evaluation team for analysis. This timeframe aligns with the funded evaluation period and the point at which the final cohort completes follow-up data collection within the evaluation window. Administrative and programme monitoring data collected after April 2027 will therefore support programme monitoring and delivery but will not be included in the formal evaluation analyses. Kinship will export this data from its Salesforce system, and send the data in a password-protected file over encrypted email to the evaluation team.

Administrative data will be collected to monitor engagement with other Kinship services among both the intervention group during the period of programme delivery, and the control group during the waitlist period. The data will be used to assess potential contamination of the control group by identifying whether participants allocated to the waitlist condition have accessed Kinship's national services during the waiting period, and to inform interpretation of trial findings. Although not an exhaustive list, administrative data will include:

- Use of advice and information services (e.g. advice line enquiries; email/webform queries; information packs/resources shared; signposting)
- Engagement with peer and community support (e.g. attendance at peer support groups, community drop-ins, online forums/sessions; number of sessions attended; where available, duration)
- Engagement with Kinship's community and membership offer (e.g. membership registration/status; event attendance; engagement with member communications or community activities)
- Participation in training and structured support programmes (e.g. enrolment onto training; modules/sessions attended; completion status; certificates issued; mode: online/in-person).

Programme data will be collected to monitor engagement with the intervention, what activities have been delivered as part of the intervention, and indicators relevant to the trial outcomes (such as service access, advocacy activity, and progress against support goals). This data will be used to understand which services participants receive, fidelity to the delivery model, and how Kinship

Connected is different from BAU between the intervention and control conditions by examining the nature, intensity, and timing of support received. It will also be used to describe patterns of participation over time, as recorded through programme monitoring data, supporting interpretation of engagement, delivery, and how the intervention is experienced by participants. Although not an exhaustive list, the programme data will include:

- Type, frequency, and mode of contact with the Kinship Navigator
- Participation in assessment, planning, and review activities
- Use of advice, information, and signposting support
- Engagement with peer support and community-based support
- Engagement with Kinship community and membership offer
- Receipt of advocacy and representational support
- Receipt of practical and financial support
- Completion of intervention milestones and outcomes documentation.

Qualitative interviews

Semi-structured discussions with kinship carers: CEI will lead 12 one-to-one discussions with kinship carers who have taken part in the intervention. Discussions will take place from November 2026 to April 2027. These discussions will focus on the carers' experience of Kinship Connected and trial procedures, and will explore reach, acceptability, appropriateness, perceived kinship carer- and child-level impacts and mechanisms of change, and unintended consequences. Discussions will take place with kinship carers who have completed the programme to ensure that participation does not interfere with the delivery process or affect carers' access to services. Each carer will take part in one discussion. The inclusion criteria for kinship carers are noted above under 'Participants'.

Kinship carers will be given the option to provide their email address and indicate their willingness to be contacted for a discussion as part of the follow-up questionnaire they complete at the end of the programme. From those who express interest, the evaluation team will purposively sample kinship carers and contact them to invite participation and arrange a discussion. Kinship carers will be purposively sampled where possible to ensure diversity across key characteristics, including LA, caregiver relationship to the child (e.g. grandparent, aunt, sibling), length of time in the kinship caregiving role, ethnicity, gender, age, and type of care arrangement. Due to the small number of discussions, sampling will be approached pragmatically and we expect limited scope for rigorous sampling.

Kinship carers who take part in qualitative discussions will receive a £25 voucher as a token of appreciation for their time.

Semi-structured discussions with LA practitioners: CEI will lead eight one-to-one discussions with LA staff who recruited carers to the programme. These will take place from November 2026 to April 2027. These discussions will focus on the fit of Kinship Connected within LA systems and trial-related procedures, and will explore reach, feasibility, acceptability, appropriateness, perceived impacts and mechanisms of change, unintended consequences, and progression. The inclusion criteria for LA staff are that they are employed by a participating LA and were involved in referring kinship carers to the Kinship Connected pilot trial.

Kinship will provide LA staff with the information sheet and gather consent to be contacted by the CEI and Ipsos. From those who consent, LA staff will be purposively sampled where possible to ensure diversity across key characteristics, including LA and role. Due to the small number of discussions, sampling will be approached pragmatically and we expect limited scope for rigorous sampling.

LA staff who take part in qualitative discussions will receive a £25 voucher as a token of appreciation for their time.

Semi-structured discussions with Kinship Connected delivery team: CEI will lead eight one-to-one or group discussions with Kinship staff (four Navigators and four core members of the programme team). These will take place from November 2026 to April 2027. These discussions will focus on delivery and trial procedures, and will explore reach, feasibility, acceptability, appropriateness, perceived impacts and mechanisms of change, unintended consequences, and progression. The inclusion criteria for Kinship staff are that they are employed by Kinship and were involved in delivering the Kinship Connected programme during the trial period.

Members of the programme team will be known to the evaluation team as we work collaboratively to design and implement the evaluation. The evaluation team will contact members of the programme team to invite participation and arrange a discussion. Programme team staff will provide Navigators with the information sheet and gather consent to be contacted by the evaluation team. From those who consent, the evaluation team will contact them to invite participation and arrange a discussion.

All participants will receive tailored information sheets that provide information about their rights as a research participant, including data protection. Written consent will be gathered ahead of time, with verbal consent obtained at the start of the discussion. The discussions will be led by trained researchers from CEI using bespoke discussion guides to cover key topics, while allowing for flexibility to focus on participants' priorities. Where possible, discussion guides will be piloted with appropriate populations to ensure suitability. Discussions will last up to 60 minutes (45 minutes for kinship carers) and will take place either online or over the phone. They will be audio-recorded with the participant's permission.

Appropriate accessibility options for all the discussions will be explored and offered in line with the specific needs of the participant, including reasonable adjustments such as the provision of interpreters, holding discussions outside the typical workday, or alternative communication formats where needed. Where possible, we will offer choice in interviewer identity (e.g. gender, ethnicity). We recognise that this choice will be informed and limited by the size and demographic composition of the research team.

Analysis

Data from each element of the IPE will be analysed separately. Findings will then be triangulated and integrated initially across the different strands of the IPE, identifying areas of difference and reinforcement. Subsequently, this integrated analysis will be further triangulated with the impact findings, using multiple data sources to substantiate and explain the results.

Quantitative analysis

Quantitative data derived from administrative and programme records will be analysed using Excel, with descriptive statistics used to summarise patterns of participation and service use. These analyses will inform assessment of reach and differentiation across sites and contribute to understanding perceived impacts of the intervention.

Qualitative analysis

Qualitative data from the discussions will be digitally recorded and transcribed verbatim. Analysis will be thematic analysis (Braun & Clarke, 2006) operationalised through the Framework Approach (Gale et al., 2013) to structure, synthesise, and interpret qualitative data from interviews, records, and observation. The analytical framework will be developed deductively from the IPE research questions, the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2022), and the programme's theory of change, alongside inductive coding to capture emergent themes, including unexpected, unintended, and negative consequences. Selected constructs from CFIR may be drawn on where relevant as sensitising concepts to help interpret implementation determinants such as organisational context, implementation processes, and barriers and enablers to delivery.

The analysis will examine intervention and trial procedures, including reach, feasibility, acceptability, appropriateness, perceived impacts, and mechanisms of change, as well as unintended consequences and progression. Particular attention will be paid to how contextual factors, implementation processes, and stakeholder experiences shape variation across sites and influence the feasibility of implementation.

Mapping of business as usual

Kinship will undertake a structured mapping exercise of BAU provision for each participating LA.[10] This will capture the range and nature of services and supports available to kinship families, with explicit consideration of variation by legal arrangement (e.g. special guardianship, child arrangements orders, informal care). This local mapping will be complemented by an overview of nationally commissioned or delivered services to provide a comprehensive picture of the wider support landscape. Key contextual factors at the LA level will be systematically documented during the study set-up phase through a standardised mapping exercise.

These data will be used to characterise variation in BAU and inform interpretation of the IPE and impact outcomes.

[10] Local authorities involved in related pilot activity have been excluded from participation to minimise contamination. See intervention protocol for more details.

Quality assurance

To ensure analytical rigour, transparency, and integrity throughout the implementation and process evaluation, a range of quality assurance procedures will be applied. Analysis will be conducted by a multidisciplinary evaluation team, with multiple researchers involved in qualitative coding and interpretation to support consistency and credibility. Coding frameworks will be developed collaboratively and iteratively reviewed to ensure they remain grounded in the data and aligned with the evaluation aims.

Regular internal analytic meetings will be held to review emerging findings, test interpretations, and support systematic triangulation across qualitative and quantitative data sources. These meetings will be used to explore areas of convergence and divergence, assess the coherence of findings across participant groups and sites, and reflect on how implementation evidence informs interpretation of impact findings. Delivery partners will also be invited at key points to engage with early interpretations of the findings, in order to sense-check emerging conclusions, surface alternative explanations, and help ensure that interpretations are grounded in delivery context.

Key analytic decisions, including revisions to coding frameworks and interpretation of complex or ambiguous findings, will be documented in a structured decision log, creating a clear audit trail from raw data to reported findings. This will support transparency and facilitate replication or further analysis.

An external advisory group will be engaged at key stages of the evaluation to provide critical challenge and independent perspective, including support with interpretation of findings and consideration of implications for practice and progression to a future full-scale trial.

Members of the external advisory group include:

- Dr Ellie Ott, Associate Director (Research and Data) at the Nuffield Family Justice Observatory. She has been a foster carer for over 10 years, and is an adoptive parent. She led CEI's review of interventions for kinship families and has overseen major evaluations of interventions in children's social care, including the Department for Education evaluation of the Mockingbird Programme.
- Dr Marc Winokur, Director of the Social Work Research Centre at Colorado State University. He has conducted pivotal reviews of kinship care, including the Foundations review of interventions to support kinship carers, and evaluated the Colorado Kinnected Kinship Navigator Program through an RCT design.
- A kinship carer from Foundations' Experts by Experience panel.
- A kinship carer from Kinship's network.
- LA representative – practitioner involved in programme referral.
- LA representative – practitioner involved in programme referral.*

* Currently being recruited from participating LAs.

Appropriateness for progression to a full trial

For the IPE, we will assess the appropriateness of Kinship Connected for progression to a full impact trial by drawing on evidence across both trial feasibility and delivery feasibility.

In relation to trial elements, this assessment will consider the practicality of recruitment and randomisation procedures, achieved recruitment and retention rates, the completeness and quality of baseline and follow-up outcome data, and the availability, quality, and consistency of administrative and programme data needed to support a future trial (including data on service use, intervention delivery, contamination, and child placement outcomes).

In relation to delivery elements, the assessment will consider the acceptability and appropriateness of Kinship Connected among kinship carers (including the extent to which carers regard the support as relevant, accessible, and sufficiently responsive to their needs), alongside the views of delivery staff and LA practitioners on the fit, feasibility, and implementability of the model.

We will also consider evidence on fidelity and adaptation, implementation barriers and enablers, potential harms or unintended consequences, and the extent to which the intervention can be delivered consistently while retaining appropriate flexibility.

Progression will not be determined by any single indicator in isolation. Rather, we will triangulate findings from the IPE with the pilot impact data, using qualitative evidence to help explain quantitative patterns in recruitment, retention, data completeness, service use, and exploratory outcome estimates, and using the quantitative findings to test the plausibility and significance of issues identified through the implementation evidence.

Drawing on this integrated assessment, we will apply evaluative judgement to determine whether the intervention and evaluation design appear sufficiently feasible and robust for testing at a larger scale, whether progression would be appropriate only with modifications, or whether more substantial refinement would be needed before a full trial could be recommended. Where changes are indicated, we will specify their implications for the delivery model, trial design, and any preparatory work required prior to progression.

COST ANALYSIS

The cost analysis will estimate the resources required to deliver Kinship Connected across the four participating local authorities. As this is a pilot study and effect estimates are not suitable for causal interpretation, the cost analysis will focus on a financial analysis rather than a full value for money assessment. The financial analysis will estimate the cost of delivering the intervention from the perspective of the LA, assuming no external subsidy from Foundations.

Costs will be estimated for the intervention as delivered during the pilot, using local prices rather than national averages. The analysis will cover three categories of cost: staff costs (including Navigators, programme management, and any in-kind contributions from LA staff), facilities and equipment, and other intervention costs such as training, materials, and travel. Staff costs will be reported with particular granularity given that the intervention is labour-intensive.

Costs will be separated into prerequisites (resources the LA already has access to), start-up costs (incurred to begin delivery, such as Navigator recruitment and training), and recurring costs (incurred for each year of delivery). This separation will allow decision makers in other local authorities to adjust estimates to their own circumstances.

The cost analysis will report the average cost per family per year and the total cost per LA year. Development costs for the intervention and evaluation costs will not be included, following Foundations guidance.

Cost data will be collected from Kinship's financial records and delivery data held in Salesforce, supplemented by interviews with delivery staff where necessary to capture in-kind contributions and staff time. Data collection will take place towards the end of the delivery period to ensure costs reflect the intervention as actually implemented.

In addition to the financial analysis, the evaluation will identify the data and methodological requirements for conducting a full value for money analysis in a future trial. This will include identifying the relevant benefits and disbenefits that would need to be monetised, the data sources required to estimate them, and any gaps in current data collection that would need to be addressed.

The detailed costing templates used to capture pre-delivery, delivery, and local authority costs (Tables 10 to 12) are provided in Appendix B. These templates itemise each cost line by category, unit cost, and rationale, and provide the structure through which the financial analysis described above will be populated once delivery is under way.

ETHICS AND PARTICIPATION

We have sought ethical appraisal from Foundations' Research Ethics Committee. The evaluation team members from CEI and Ipsos UK developed accompanying application materials, including participant information sheets and consent forms, LA and self-referral forms, indicative questionnaires, and indicative topic guides.

The ethics appraisal process followed an iterative review timeline. An initial draft application was developed and internally reviewed in March 2026, followed by submission to Foundations' Research Ethics Panel in late March 2026. Feedback was received mid-April, with a follow-up resubmission undertaken by the evaluation team. Final ethical approval was granted following second resubmission at the end of April 2026, prior to the commencement of the data collection.

The procedure for obtaining consent to participate in the trial involves a two-step process and is consistent across both LA referrals and self-referrals. Kinship carers are first provided with information on the trial (including an easy-read information sheet) and, where interested and eligible, are referred or self-refer into the study. Following this, they receive the full participant information materials and are invited to provide informed consent and complete baseline measures via an online system. Participation in the trial proceeds only once informed consent has been obtained.

For qualitative components of the evaluation (e.g. one-to-one or group discussions), participants will receive a separate information sheet and provide explicit consent prior to taking part. This ensures that consent is informed, relevant, and specific to each element of participation.

Participation in the evaluation is voluntary, and participants will be informed of their right to withdraw at any time. Participants may withdraw at two levels: (1) they may request that their data be withdrawn from the evaluation while continuing to receive support through Kinship Connected, or (2) they may withdraw from the trial entirely. In the latter case, the implications depend on their allocation. Participants in the intervention group will continue to the programme where appropriate, but will no longer contribute data to the evaluation, whereas participants in the control group who withdraw from the trial will not receive the programme. These options will be clearly explained in participant information materials, and participants will be reminded that choosing not to participate or withdrawing their data will not affect the support they receive from Kinship or their LA. Participants may withdraw the majority of their data from the evaluation up until May 2027. Qualitative data collected from discussions may be withdrawn up until January 2027, after which analysis of that data will have begun.

Registration

We will register this trial protocol on the Open Science Framework in July 2026, and will update with outcomes at the end of the project.

Data protection

CEI has given this project an internal Data Protection Identifier (DPID) as part of our robust approach to identify risks posed to the people whose data is being used within the Kinship Connected evaluation. CEI screened this project with our Data Protection Officer (DPO) whom we employ to oversee all data usage activities.

From the risk screening, our DPO identified a requirement for a Data Protection Impact Assessment (DPIA) to be conducted for the Kinship Connected evaluation, which we have done.

Risks that have been identified include data leakage or personal data breach due to multiple points of transfer of personal data requiring diligence and oversight by individuals in multiple different organisations, made more confusing with a split between a waitlist and a treatment group list where the waitlist will also receive the intervention after the research data collection is over. The risk to a kinship carer would be they are targeted by biological parents for physical or verbal abuse and on extremely rare occasions lead someone to find (and possibly cause harm to) the children in their care. Where Kinship staff data were to be breached it may have a consequence on their job security if they have expressed an opinion their employer feels is contentious.

All CEI employees have to take data protection training to understand the risks involved and are briefed on identified best practices by our DPO from conducting the DPIA. CEI writes and distributes data privacy notices for any people we are collecting data about, and has written a data-sharing agreement in accordance with the UK regulator's code of conduct for data sharing, which we will have in place with the LAs who are sharing data with us about young people.

We will maintain data protection by design in the way we set up the Kinship Connected evaluation by conducting checks of system settings to keep data at the highest level of security available and configured to only allow specific named researchers access to only the data they need to access.

For this project CEI will use personal data under UK GDPR article 6.1(a) "consent" as the lawful basis for processing activities involved to organise and review the data in the analysis of information for the Kinship Connected evaluation. Ethical consent under the Data Use and Access Act 2025 (s.68(3)) is compatible with consent as the lawful basis for data use under UK GDPR articles 6.1(a) and 9.2(a) for special categories of personal data.

Other processing activities or uses of personal data will include using data to request informed ethical consent for participation in the evaluation, in interviews and surveys, to transcribe audio-recorded interviews, and to send a survey is under UK GDPR article 6.1(f) "legitimate interest". The use of personal data to identify a person's data to be able to respond to any data subject rights requests or complaints they may have, or to manage any breaches, is under UK GDPR article 6.1(c) "legal obligation", with the legal text being the UK GDPR. Where personal data will be added to the Foundations Data Archive this is under the UK GDPR article 6.1(e) "Public Interest" in alignment with the Digital Economy Act 2017.

This is not an exhaustive list and the data privacy notice we produce for each collection of data clearly indicates the uses of data which are relevant to each participant and the associated lawful basis for processing.

Ethical informed consent will be sought from kinship carers, LA staff, and Kinship staff prior to taking part in an interview or survey. Should a data subject withdraw their ethical informed consent before any analysis has begun, CEI will delete that personal data and not include it in the project, with the goal of meeting data privacy legislative obligations to the data subject.

CEI demonstrates UK GDPR compliance externally through its comprehensive website-based Data Privacy Policy.[11] Where a data subject interacts with CEI, where the processing of their personal data is different to that specified on our website we produce a relevant data privacy notice in accordance with the information required of such a fair processing notice pertaining to either article 13 of the GDPR, if we are collecting personal data about a data subject directly from a data subject, or article 14 of the GDPR, if we are collecting personal data about a data subject from another party.

These notices are provided at the point of collecting that personal data, or, where collection is indirect, if we have identified there is a disproportionate effort to provide a data subject with a privacy notice we will make a record of this with the reason why we believe this to be so.

Each data privacy notice holds a copy of a data subject's data protection rights and a contact email address for such requests to be made (dpo@ceiglobal.org).

Compliance for data processing is demonstrated for each project we conduct through our internal data protection review procedures. The first step in our data protection review procedures is for our project managers to complete a data protection risk screening (Privacy Impact Assessment) form that is sent to our DPO. The DPO assesses the requirement for a DPIA and assists us in the completion of the DPIA where required.

The DPIA outlines all purposes for processing personal data alongside the lawful basis for doing so, the retention periods for any data collected, specifying points of minimisation throughout any project, and who the personal data will be transferred to, which could include other controllers or processers and the technical, organisational, and/or contractual measures which need to be in place to make such processing compliant.

There are a number of points of collection of personal data that are relevant to the Kinship Connected evaluation and will be used by CEI. Understanding the points of collection of data is important to understand the data processing roles of the organisations processing/using the personal data.

Data being used in the project by CEI includes: name, contact details, reason for referral, location, a legal order or context for a kinship child, financial circumstances or support network, if they're vulnerable to harm or at risk, information such as sex, gender identity, ethnicity, and if they have been discriminated against within Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation), participant characteristics (age, gender, race/ethnicity, placement duration, children in their care etc.), delivery (start and end dates), support goals, attendance etc., answers in surveys,

[11] See: https://www.ceiglobal.org/privacy-policy.

workshops, and interviews about their experiences and opinions of the relevant Kinship services, and any further personal information volunteered in any interactions.

The questionnaires and discussions: CEI and Kinship will be Joint Data Controllers for the personal data of all individuals that complete a survey or attend an interview. CEI uses third-party suppliers to support its work in conducting and often recording interviews, which will also be transcribed, as well as digital survey platform providers. Each of these suppliers is a data processor on behalf of CEI and CEI maintains up-to-date Data Processing Agreements with all suppliers in accordance with the requirements of article 28 of the GDPR.

Personnel

Evaluation team

The evaluation is being delivered in partnership between the Centre for Evidence and Implementation (CEI) and Ipsos UK. CEI is responsible for overall project management and leads the implementation and process evaluation (IPE), while Ipsos UK leads the impact and cost evaluation. The two organisations will work collaboratively across all components of the evaluation to ensure coherence in design, delivery, analysis, and interpretation.

- India Thompson (CEI, Advisor) – Project lead; responsible for leading the day-to-day project activities and leading on the IPE.
- Dr Katherine Young (CEI, Director) – Project manager; holds overall responsibility for the project and provides quality assurance throughout.
- Amy Hall (CEI, Principal Advisor) – Project researcher; overseeing trial implementation, data collection, and analysis for the IPE.
- Ssanyu Kayser (CEI, Research Assistant) – Researcher; supporting data collection and analysis and providing administrative and research support throughout the IPE.
- Dr Jessica Ozan (Ipsos UK, Head of Education) – Ipsos UK lead; responsible for inputs from Ipsos UK team and overseeing the impact study.
- Jemuwem Eno-Amooquaye (Ipsos UK, Senior Consultant) – Analyst; responsible for data management.
- Facundo Herrera (Ipsos UK, Associate Director) – Analyst; responsible for quality assurance as trial adviser.
- Akshay Choudhary (Ipsos UK, Senior Consultant) – Analyst; responsible for data analysis.
- Sara Laabid (Ipsos UK, Senior Consultant) – Analyst; responsible for randomisation process
- Ellie Keeble (Ipsos UK, Associate Consultant) – Analyst; responsible for supporting quantitative data collection and analysis.

Delivery team

The intervention is being delivered by Kinship. Kinship is responsible for programme delivery across participating sites and will work collaboratively with the evaluation team to support

alignment between delivery and evaluation activities, while maintaining appropriate independence in the conduct of the evaluation.

- Fiona Summers (Kinship, Head of Programmes) – Delivery oversight; quality assurance, monitoring, and evaluation of Kinship Connected; relationship management with local authorities and strategic partners; management and supervision of Regional Programmes Lead; Designated Safeguarding Lead; Communities of Practice lead.
- Laura Grainger (Kinship, Regional Programmes Manager) – Delivery lead; responsible for fidelity to the model, quality assurance of delivery and supervision, and development of delivery team.
- Anam Raja (Kinship, Research Manager) – Internal evaluation lead; responsible for collaborating with evaluation partners and advising on internal evaluation and programme processes to maintain the integrity of the evaluation.
- Lauren Jones (Kinship, Mobilisation and Delivery Project Manager) – Project operational lead; responsible for leading the day-to-day project activities, governance, and risk management.
- Ronan McGhee (Kinship, Programme Officer) – Support with day-to-day project activities and quality assurance.
- Faye Jones (Kinship, Navigator) – responsible for delivering the intervention in the four LA sites.
- Stephanie Moorcroft (Kinship, Navigator) – responsible for delivering the intervention in the four LA sites.
- Kirsten Rennie (Kinship, Navigator) – responsible for delivering the intervention in the four LA sites.
- Yewande Showunmi (Kinship, Navigator) – responsible for delivering the intervention in the four LA sites.
- Lucy Peake (Kinship, CEO) – Co-sponsor; responsible for LA engagement into programme; chair steering group of participating local authorities; EDI lead (with Trustee Beverley Barnett-Jones) and policy and research oversight.
- Emma Wrafter (Kinship, Director of Services and Digital) – Exec project lead; governance oversight and co-sponsor; supports LA engagement into programme.; delivery and quality assurance oversight; service design and manualisation to support fidelity; exec safeguarding lead.
- Joshua Marks (Kinship, Chief Operating Officer) – Governance oversight and co-sponsor; budget oversight; Data Protection Officer and contracting with local authorities.

Other stakeholders

- Advisory group: Representation from academics, LA practitioners, and people with lived experience, responsible for providing guidance and expert insight for the evaluation.
- LA: Partners in delivery, responsible for referrals, and providing administrative data to evaluation team.

Timeline

Table 8. Evaluation activities timeline

Dates	Activity	Staff responsible/ leading
Nov–Dec 2025	Contracting and project initiation	CEI
Jan–March 2026	Co-design and trial set-up	CEI, Ipsos UK, and Kinship
Jan–May 2026	Data protection, protocols, and ethical approval	CEI, Ipsos UK
Feb–March 2026	LA recruitment and onboarding	Kinship
March–June 2026	Navigator recruitment and onboarding	Kinship
May–Sep 2026	Kinship carer referrals	Kinship
May–Sep 2026	Baseline data collection and randomisation	Kinship, Ipsos UK
June 2026–Sep 2027	Delivery of intervention	Kinship
May 2026–April 2027	IPE data collection	CEI
Oct 2026–April 2027	Follow-up data collection	Kinship
Oct 2026–June 2027	Data analysis (quantitative and qualitative)	CEI, Ipsos UK
July–Nov 2027	Reporting and dissemination	CEI, Ipsos UK

Risks

Table 9. Risk register for the project

Risk	Likelihood	Impact	Mitigation
Low response rates on self-report survey, survey fatigue	2	Reduced data completeness and statistical power; risk of biased findings if non-response is systematic	Surveys will be kept as short as possible and use validated, user-friendly measures. Participants will receive reminders via multiple channels, and small incentives will be offered where appropriate. Response rates will be monitored in real time so that additional follow-up can be targeted at underrepresented groups.
Low referrals, low consent rates, or poor engagement with service	3	Underpowered sample; limits ability to assess feasibility and preliminary outcomes	Kinship Connected is an established service with strong referral and engagement rates. We aim to front-load referrals in May and June to minimise recruitment activity over the summer. We will monitor referrals/poor engagement and apply rapid-cycle testing approaches to improve recruitment and engagement strategies where needed, and an extension recruitment window in September has been planned for if necessary.
Operational capacity of Kinship	1	Inability to deliver intervention as intended; impacts fidelity, timelines, and internal validity	Detailed trial planning will occur during the set-up phase to ensure delivery is feasible within Kinship's planned resourcing, including service delivery to waitlist participants, rolling referral /randomisation processes and data collection capacity.

Risk	Likelihood	Impact	Mitigation
Local stakeholders do not engage with the evaluation	2	Reduced referrals; weak implementation context; limited learning from IPE	Capacity building regarding importance of evaluation with Kinship to facilitate clear and persuasive communication to local partners.
Contamination of control group	2	Blurs differences between arms; threatens internal validity and interpretation of findings	A clear definition of 'usual care' will be established and communicated to all partners. Exposure to intervention-like support in the control group (including Kinship national services) will be captured in the administrative dataset and monitored to assess the risk and extent of contamination.
High project team staff turnover	1	Delays, loss of knowledge, inconsistency in delivery and data collection	Both CEI and Ipsos UK have wide staff bases with relevant skill sets and experience, both in the UK and international offices. Key processes and protocols will be thoroughly documented. Frequent team meetings and senior leadership involvement will ensure interruptions are anticipated and positions are filled in plenty of time.
Delays in ethical approval	1	Delays to recruitment and delivery timelines; risk to funding milestones	Ethics applications will be prepared and submitted early, with input from relevant stakeholders to reduce the likelihood of revisions. Parallel preparation of study materials will ensure the project can begin promptly once approval is granted.

Risk	Likelihood	Impact	Mitigation
High participant attrition/loss to follow-up	2	Missing outcome data; biased estimates; reduced validity of conclusions	Kinship carers will be kept engaged through regular, appropriate communication and flexible follow-up options (e.g. phone, online, paper). Incentives may be used, and attrition patterns will be analysed to inform recruitment strategies.
Randomisation process not adhered to	1	Allocation bias; compromised internal validity	Randomisation will be conducted using a secure, standardised system with clear procedures. Staff will be trained, and audit trails will be reviewed regularly to ensure adherence to protocol.
Data quality issues (missing/inaccurate data)	1	Limits analysis; reduces reliability of findings	Data collection tools will be piloted by the evaluation's advisory group members, and refined before use. Staff will be trained in accurate data entry, and regular data quality checks and audits will be conducted to identify and resolve issues promptly.
Ethical or safeguarding concerns arising during trial	1	Potential harm to participants; reputational legal risks	Clear safeguarding and ethical protocols will be in place, with all staff trained in their application. Any concerns will be escalated and managed promptly in line with established procedures.

Risk	Likelihood	Impact	Mitigation
Bias from delivery organisation collecting outcome data	2	Positive response bias, demand characteristics, and differential attrition can distort effect estimates. Independent data collection is a standard trial quality expectation	Data collection independence protocol set out in the data collection plan. Structural separation of survey staff from delivery staff. Standardised follow-up procedures. Independent verification of a 10 to 15% subsample by Ipsos UK. Response rates monitored by arm. Sensitivity analysis for differential attrition.

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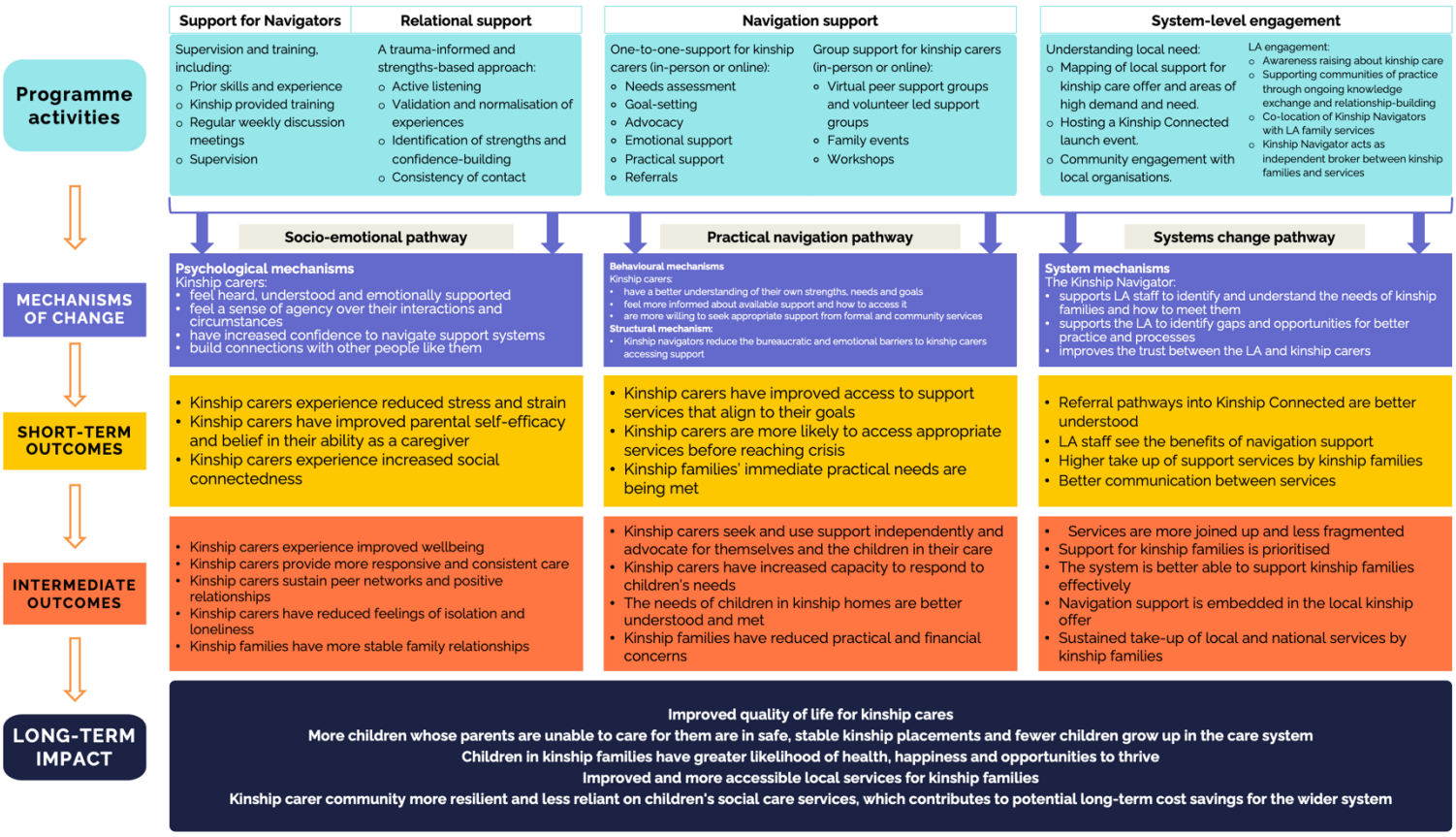
APPENDICES

Appendix A. Kinship Connected theory of change



Appendix B. Templates for cost calculations

The tables in Appendix B set out the detailed cost templates underpinning the cost analysis. They itemise the resources required to deliver Kinship Connected across the four participating LAs separated into pre-delivery costs (Table 10), delivery costs over the 12-month period (Table 11), and costs borne by participating LAs (Table 12). Each line records the cost item, unit cost, quantity, and the reason the resource is required, allowing decision makers in other LAs to adjust the estimates to their own circumstances.

Table 10. Pre delivery costs

A.1 Programme set-up & overall management: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (x months)**	**Total**	**Why is this expense required?**
Head of Programmes				Oversight of programme set-up; management of Programme Manager and Project & Mobilisation Manager
A.2 Programme set-up & overall management: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Overhead contribution				12.5% overhead contribution (central management, HR, IT, premises
B. Recruitment: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Recruitment				Recruitment, advertising, selection, interviews for new delivery roles
DBS checks				Safer recruitment for new delivery roles

C. Training QA and mobilisation of frontline delivery: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (x months)**	**Total**	**Why is this expense required?**
Programme Manager				Management, training, and QA of frontline delivery staff
Kinship Family Worker (LA 1)				Onboarding and training of frontline delivery staff
Kinship Family Worker (LA 2)				Onboarding and training of frontline delivery staff
Kinship Family Worker (LA 3)				Onboarding and training of frontline delivery staff
Kinship Family Worker (LA 4)				Onboarding and training of frontline delivery staff
Programme Officer				Support evaluation set-up and administration of new team
D. Data systems and data protection set-up: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Salesforce licences				Licences for new roles to enable data collection and monitoring
Notion licence				Notion licence; internal documentation of data protocols and project plans
Zoom licence				Remote meetings on data processes and internal governance
Lone worker app				Procurement and configuration of staff safety system (data and privacy compliant)
E. IT equipment and tools for new staff: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Laptop				Hardware for new roles

Mobile handset				Hardware for new roles
Screen				Monitors for staff
Printer				Printing of programme materials
Other technology				Any additional IT equipment needed

Table 11. Delivery costs (12 months)

A.1 Ongoing programme management & governance: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (12 months)**	**Total**	**Why is this expense required?**
Programme Manager				Management and QA of frontline delivery staff (12 months)
Head of Programmes				Management of programme delivery and Programme Manager and Project & Mobilisation Lead
A.2 Ongoing programme management & governance: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Overhead contribution				20% overhead contribution (central services leadership, premises etc.)
Team meetings				Case supervision and best practice sharing (venue/incidentals)

B.1 Frontline delivery participant engagement & recruitment: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (12 months)**	**Total**	**Why is this expense required?**
Kinship Family Worker (LA 1)				Delivery of programme (12 months)
Kinship Family Worker (LA2)				Delivery of programme (12 months)
Kinship Family Worker (LA 3)				Delivery of programme (12 months)
Kinship Family Worker (LA 4)				Delivery of programme (12 months)
Programme Officer				Ongoing administration of team; support to delivery
B.2 Frontline delivery participant engagement & recruitment: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Travel and expenses				Travel to kinship carers (home visits
Support group venue hire				Venues for group sessions/support groups
Support group refreshments				Food and drink for groups
Kinship Care Guide				Printed/digital guides to help carers navigate the system
Welcome pack				Explains programme and helps carers track progress
Leaflets				Promotion of programme and recruitment of participants
Kinship Care Week event				Builds community cohesion and celebrates kinship carers

Other kinship carer event				Additional engagement and peer support events
MaxCards				Supports children in kinship care (small incentives/ resources)
Advice line support				Part of programme delivery; supports carers between sessions
Communications and marketing				Promotion of programme and participant recruitment
C.1 Training supervision and professional development: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (12 months)**	**Total**	**Why is this expense required?**
Programme Manager				Ongoing supervision and QA for frontline staff
C.2 Training supervision and professional development: NON- SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Safeguarding training Level 3				Legal requirement for staff working with children/families
Other training				Specialist training (trauma-informed practice
D.1 Service/operational data collection & monitoring (non-evaluation): SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (12 months)**	**Total**	**Why is this expense required?**
Kinship Family Worker (LA1)				Kinship Family Worker (Area 1): routine recording of contacts, support plans, case notes, and outcomes needed for internal monitoring and safeguarding

Kinship Family Worker (LA 2)				Kinship Family Worker (Area 2): routine recording of contacts, support plans, case notes, and outcomes needed for internal monitoring and safeguarding
Kinship Family Worker (LA 3)				Kinship Family Worker (Area 3): routine recording of contacts, support plans, case notes, and outcomes needed for internal monitoring and safeguarding
Kinship Family Worker (LA 4)				Kinship Family Worker (Area 4): routine recording of contacts, support plans, case notes, and outcomes needed for internal monitoring and safeguarding
Programme Manager				Oversight of operational data (caseloads, throughput, waiting lists, core outcomes) to manage quality and performance
Programme Officer				Administrative support for routine monitoring reports and internal performance data

D.2 Service/operational data collection & monitoring (non-evaluation): NON-SALARY

Cost item	Cost/unit	Units	Total	Reason
Salesforce licence				Licence share required to record routine case data, contacts, and outcomes for service delivery
Admin and stationery				Printed forms, sign-in sheets, consent forms, and other materials for day-to-day data recording
IT support				Ongoing support to keep Salesforce and related systems functioning for operational monitoring

E. Staff tools: NON-SALARY				
Cost item	**Cost/unit**	**Units**	**Total**	**Reason**
Lone worker app licence				12-month licence to safeguard staff during visits
Mobile contract				12-month mobile contracts for frontline staff
Admin and stationery				Materials for day-to-day administration and data collection

Table 12. LA costs

A.1 LA Costs: SALARY				
Role	**Basic salary + on-costs per day**	**FTE days (12 months)**	**Total**	**Reason**
LA Project Lead time (main contact role)				A named lead is required to act as the primary day-to-day contact with Kinship and coordinate the LA's obligations
Staff time to generate and process referrals				Staff must identify eligible carers, complete referral forms and follow the agreed pathway to meet the referral targets
Staff time for Kinship-related meetings				Staff attend partnership meetings with Kinship to monitor progress, resolve issues, and plan delivery
Staff time for briefings/ training				Time is needed to brief referrers and social work teams so they understand the programme and can explain/refer correctly

Staff time to support local engagement events				LA staff support Kinship-led events (e.g. inviting carers, being present, linking to local services) to help engagement and uptake
Promotion/communications (emails, newsletters, etc.)				Staff use LA communication channels (emails, newsletters, etc.) to advertise the programme to carers and social workers

A.2 Ongoing programme management & governance: NON-SALARY				
Cost item	**Cost / unit**	**Units**	**Total**	**Reason**
Providing workspace/hot-desk and access to LA premises				The LA may provide a desk/hot-desk and access to offices / Family Hubs so the Kinship Navigator can be co-located and work with teams (cost will be pace/overheads per day/month)