Department for Education

Oversight of Out-Of-School-Settings (OOSS)

Lessons learnt from the DfE funded pilot

ASK Research

November 2022

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Contents

Executive Summary

In 2018 the DfE provided £3 million of funding to pilot an approach to demonstrate the benefits of multi-agency working between local authorities (LAs) and relevant agencies to help LAs enhance their identification and engagement with out-of-school-settings (OOSS), and intervention in those of safeguarding concern. Out-of-school-settings are a very wide and varied range of provision which include uniformed organisations, sports and leisure clubs, tuition centres and supplementary schools, faith-based organisations, arts and many others. They range from being part of an umbrella organisation or membership to a national body, through to being run by community groups, private companies, charities and private individuals. They can be staffed therefore by paid individuals, volunteers or parents. Many families send their children to OOSS, and it is assumed that most are run correctly, safely and with children's best interests at heart. However this currently remains unchecked.

This pilot was undertaken in 16 local authorities (LAs) over an 18-month period. The aims of the pilot were to:

- support these LAs to test approaches to map, identify, and intervene in OOSS of concern.
- improve understanding of safeguarding risks and, where these were identified, test intervention approaches in OOSS.
- consider how existing legal powers could be best utilised and identify any gaps in the current legislative framework.

In March 2020 six of the pilot LAs were given extension funding for an additional 18 months to further test specific approaches to oversee and improve safeguarding in OOSS. These approaches included:

- funding an assistant local authority designated officer (LADO) to focus specifically on child protection referrals about or relating to OOSS;
- local authority accreditation award schemes for OOSS;
- new child protection arrangements, by encouraging OOSSs to provide auditing and referral tools; and
- providing Rights Respecting Schools awards for OOSS.

This element of the project therefore covered the Covid-19 pandemic and the disruption related to that, which limited progress over this period (including because for a substantial amount of time OOSSs were not open).

This evaluation covers the initial pilot period of activity in 16 funded LAs and the extension period involving focussed activity in six of those LAs. We acknowledge that the extension phase was funded just as the Covid-19 pandemic started and so progress with this work was reduced slightly.

The evaluation found that:

1) The OOSS sector is vast and complex, which made LAs' efforts to undertake safeguarding activity in this sector challenging

- The term 'Out-of-School Settings' which the department uses covers a vast and diverse group of providers, which includes provision such as uniformed groups, sports and leisure activities, tutoring, faith-based provision, and arts activities etc. The providers of these activities range from: sole tutors operating in their own homes, to national businesses with branches offering clubs on school premises, to local people/communities organising sports events in public outdoor spaces etc. While it does to an extent accurately define the market, the term means little to parents, is not a term providers consider to cover their activities and is unrecognised by wider stakeholders.

- OOSS have no obligation to notify anyone of their existence, there is no formal register nor is there a centrally held database

- It is difficult, and resource intensive, to identify and map settings, and this is an ongoing task as they open, move and close with such frequency.

2) There is significant potential for safeguarding harm in OOSS

- Unlike other educational settings and childcare services, the OOSS sector is unregulated under education and childcare law.

- There were a variety of safeguarding risks identified throughout the pilot, including sex offenders working in settings, child grooming, corporal punishment being used, sexually explicit and extremist material being shared with children, unsafe buildings and environments, and inadequate safeguarding checks, including on staff and volunteer adults.

- No consistent standard of safeguarding exists in this sector – the only published guidance is voluntary; and no mechanisms are established for inspecting safety or quality of provision.

- The current legal framework does not enable LAs to compel OOSS in their areas to utilise even basic safeguarding procedures and practices.

- Some providers are affiliated to various membership or umbrella bodies, some of whom have their own safeguarding standards, although these are aften voluntary and do not necessarily feed into wider safeguarding systems.

- The pilot extension provided some indication of the level of risk OOSS may pose. For example, one LA, having raised the profile of safeguarding issues and processes, received 30 referrals of safeguarding concern in a six-month period. A

third of these met Local Authority Designated Officer (LADO) threshold, i.e. met the criteria for further investigation, but the remainder covered serious issues which at least required action to be taken to prevent greater harm.

- All LAs involved in the project acknowledged that the issues they received a referral about during the project probably only reflected “the tip of the iceberg”.

3) Existing legal powers are piecemeal, and application of how they can be used to intervene in OOSS of concern are not widely understood - making any intervention by LAs challenging

- LAs reported that they thought LADO thresholds were too high for the types of concerns they were likely to receive about OOSS and so there was no legal basis to follow them up. This was similar with referrals to the Police who required high levels of evidence and a desire from parents and children or young people to investigate issues further.

- As there are no basic standards to measure services against, or to require settings to take action to improve safeguarding, LAs experienced an inability to compel OOSS to change practice or to act where inadequate safeguarding standards were identified.

- Working with other multi-agency partners and the legal powers they could apply proved unclear and difficult, with varying parameters for what powers could be applied to which specific types of settings and activities, and limited capacity within agencies to engage with OOSS.

- Even where powers to compel action exist, they only relate to specific scenarios, and it is poorly understood how they can be applied to individual OOSS (for example what health and safety or safeguarding measures can be enforced in a domestic setting).

- Other stakeholders were not aware of OOSS or did not see work with them as a priority.

4) Settings’ take up of offers for free voluntary support from the LA were low

- Engagement with the LA OOSS Officers was low; where providers did engage it was often only by those OOSS who were open to change or aware of a need for improved practice. Many LAs tried to set up incentives to encourage OOSS to engage with them.

- Take up of training, including accredited schemes, was low.

- Take up of free DBS checks for staff was low.

- The approach of incentivising engagement with authorities was considered unsustainable in the long run without large injections of funding

5) There is limited awareness or understanding by parents of the unregulated nature of this provision

- Parents have a very limited understanding of guidance, regulations, and oversight in relation to OOSS.
- They often assume these settings are regulated in a similar way to schools and childcare providers.
- As they know little about the (lack of) regulation of the sector or LA structures to oversee them, they are often unclear when, or how, to raise concerns about a provider.

In summary

We found that the scope of this work and the level of safeguarding challenge presented by the range of OOSS was greater than anticipated, so less progress was made in piloting approaches than originally expected. However, key issues around safeguarding in OOSS were identified and the lack of consistent, enforceable regulation of OOSS potentially leaves high risk across the sector for safeguarding harm. LA staff who participated in the pilot suggested DfE needs to consider making LAs more accountable for the safety of OOSS, putting in place similar safeguarding frameworks to those that exist across the childcare sector. Our proposed recommendations would require:

- Considering greater capacity and funding to support and oversee these settings
- Exploring mandatory guidance on safeguarding standards expected of OOSS
- Proposing legal compulsion for OOSS to notify LAs about their provision and allow access to settings, so that LAs can ensure adherence to basic safety standards and close down settings who are unable or unwilling to address concerns
- Considering other agencies having the commitment and resource to support the addressing of issues in OOSS
- The possibility of establishing a registration and regulation system for those wishing to operate OOSS in order to keep children safe.

1. Introduction to out-school-settings and the evaluation

The current DfE definition of an out-of-school-setting (OOSS) is “an institution which provides tuition, training, instruction, or activities to children in England without their parents’ or carers’ supervision, that is not a: School; College; 16-19 academy; provider caring for children under 8 years old, which is registered with Ofsted or a childminder agency”[1]. Out-of-school-settings are a very wide and varied range of provision which include uniformed organisations, sports and leisure clubs, tuition centres and supplementary schools, faith-based organisations, arts and many others. They range from being part of an umbrella organisation or membership to a national body, through to being run by community groups, private companies, charities and private individuals. They can be staffed therefore by paid individuals, volunteers or parents. Many families send their children to OOSS, and it is assumed that most are run correctly, safely and with children’s best interests at heart. However this currently remains unchecked.

Analysis of millennium cohort data suggests that over half of 5-year-olds and around three quarters of all children at key stage 2 are engaged in out of school activities. A total of 73% of 11-year-olds are members of sports clubs, 16% are involved in religious activity and lessons, 21% take music lessons and 39% of 7-year-olds attend other clubs (which could include organisations such as Brownies, Cubs, Scouts, etc. as well as arts and drama-based activities). This means millions of children and young people are regularly engaged in many hours of out of school activities[2].

The DfE initially provided £3 million of funding to pilot an approach to multiagency working to address oversight of OOSS in selected local authorities (LAs) through voluntary engagement. In total sixteen LAs took part. The aims of the pilot were to:

- support sixteen LAs to test approaches to mapping, identifying, and intervening in, OOSS.
- improve understanding of risks and intervention approaches in OOSS.
- consider how existing legal powers can be best utilised and identify any gaps in the current legislative framework.

The pilots commenced late 2018 and funding ran until March 2020, covering an 18-month period. This was followed by a pilot extension period, detailed later in the report.

[1] Out-of-school settings: voluntary safeguarding code of practice. Government consultation, DfE, December 2018.

[2] https://www.nuffieldfoundation.org/project/out-of-school-activities-and-the-education-gap

This report details the findings of the DfE-commissioned evaluation of this work. The initial aims of the evaluation were to:

- understand how LAs map and monitor, work with and, where necessary, intervene with OOSS to ensure children in their area are safe.
- suggest the benefits of the approach being piloted and lessons learnt, to inform recommendations for further development of the approach.

2. Method

The initial pilot evaluation methodology involved:

- Desk-based research which included reviewing documents from DfE, LAs and stakeholders.
- Attendance at national Steering Group meetings.
- Five strands of fieldwork collected over three time points. These involved:
    - interviews with pilot leads/coordinators on three occasions (baseline (Jan-Feb 19), mid pilot activity (Jun-Aug 19), end of pilot (Jan-Mar 20) in the 16 pilot areas.
    - telephone interviews with local stakeholders (at end of pilot only) including other LA staff, partners, and providers involved in the activities carried out across the 16 pilot areas.
    - telephone interviews with 8 non pilot LAs (half at baseline and half at the end of the project) to understand any comparable work in areas not receiving funding.
    - interviews with national stakeholders – including those involved in the national steering group by the DfE, those who are known to have carried out work on safeguarding, and those who provide national services to support safeguarding in OOSS (at the end of the project).

This was followed by an evaluation of the pilot extension which involved:

- interviews with pilot leads in the six LAs with project extensions on three occasions (December 2020, October 2021, December 2022).

Chapters 3 to 14 of this report focus on findings from the initial pilot project, with chapter 15 detailing the pilot extension.

3. The complexity of OOSS

The definition of OOSS means that the sector is broad and varied. Selected LAs improved their understanding of OOSS through taking part in this pilot and this section sets the context for this report and explains the sector's complexity.

A variation of OOSS exists in terms of:

- **Type** – based on the activity undertaken OOSS could broadly be categorised as:
    - Uniformed groups such as cubs, brownies and similar
    - Sports and leisure activities
    - Tuition centres and supplementary schools
    - Faith-based provision
    - Arts activities
    - Other.
- **Governance** – OOSS range from being part of an umbrella organisation, having membership/accreditation to a national body, or being activities provided as part of another organisation (such as children's groups run by a mosque or church) through to community organisations, private companies, charities or private individuals offering services.
- **Venue** – OOSS can take place in a wide range of venues e.g. community spaces, schools, private homes or outdoor areas.
- **Size** – provision can be delivered to large groups at one time, smaller groups or on an individual basis.
- **Hours offered** – OOSS can operate for many hours every day of the week. Individual children can then attend for certain hours within this. Whereas some children attend daily, others take up services weekly. Some provision only operates for certain times of the year, such as during school holidays or only during sports seasons, for example. Although some OOSS operate during the day, many take place outside of typical school hours, in the evenings and at weekends.
- **Staffing** - this can range from having many paid staff, multiple volunteers (including children's parents) to single individuals working by themselves.

This means that there are a range of people and organisations that may have knowledge of, or encounter OOSS. These include:

- **Local Authority (LA) departments –** including Education; Home Education; Early Years and Family Information services; Faith officers; Safeguarding; Local Authority Designated Officers (LADO); Social Care; Community safety and community liaison teams; Health and Safety officers; Youth workers; Probation; Business, Planning and Building Control; Traffic, Parks and Open Spaces teams; Sports and Activities teams; and Emergency services teams.

- **National agencies**; Police; National Fire Service; Health and Safety Executive
- **Umbrella organisations** – such as The Scout Association; Brownies; the Football Association; Sports Federations; Afterschool and Breakfast club franchises; dance and drama accreditation schemes etc; as well as faith organisations including churches, mosques and madrassahs, synagogues and yeshivas etc.
- **National institutions** – such as the Charity Commission; HMRC; Ofsted; NSPCC; Childline.
- **Organisations who have previously been involved in other Government initiatives** such as through Prevent or school improvement.
- **External organisations** – including those who work alongside and hire spaces to OOSS such as churches, schools, community settings, childcare providers.
- **Community** – including parents, other education providers and family support services as well as children and young people.

Unlike schools and childcare services, the OOSS sector is unregulated under education and childcare law. OOSS providers have no legal obligation to register and no requirement to engage with the LA in any way. They do not have to be affiliated with any umbrella organisation or to have any skills, qualifications or training in order to operate. They reportedly open and close frequently and commonly have changes in staffing, parts of this sector also rely heavily on volunteers.

4. What did LAs do as part of the pilot?

From gathering examples of practice from across all sixteen LAs it is possible to outline the main activities and steps they all took. These are summarised below. However, it is important to note that LAs varied in the range and extent of work they carried out and therefore not all LAs did all the activities cited.

The expectations set out by the DfE, the proposed activities set out by the LAs in their funding applications, along with considering the limited funding and available timescale, reflected a naivety about how straightforward it would be to identify and map the OOSS sector; and build relationships with key players within the LA and across the wider safeguarding system. With hindsight, participating LAs could see that the idea of being able to map all OOSS provision in their large and diverse areas, as well as to assess the level of safeguarding in place was unrealistic (especially where they aimed to progress this to the point of disruption, when needed, as well as undertaking other community engagement works). Another complicating factor was the lack of any compulsion for providers to engage with LAs or comply with their requests. As the project progressed, this need to scale down the scope of what they undertook meant focussing on and prioritising certain activities and limiting others.

This had several implications for LAs, which meant:

- there was a large variety in approaches between LAs, which carried out different activities in different ways with different cohorts of providers;
- variation in where the project sat within the LA and the amount of appropriate knowledge and understanding held by project coordinators brought in to manage the project work locally;
- participants reported they took time to develop an understanding of what they should do with the funding, their role within the pilot, and differing interpretations of the project focus and actions to be undertaken;
- not all the stakeholders appropriate to both OOSS and safeguarding issues were engaged. This included colleagues within the LA, local partners or national organisations and stakeholders; and
- sometimes appropriate lessons were not learnt, or existing knowledge built upon across the pilot locations (for example using existing guidance and knowledge or sharing lessons learnt from some LAs as the project progressed).

Despite this variation all LAs took steps across three common areas which can be summarised as follows:

1. Engaging with OOSS providers, through:
    a. Mapping and assessing settings.
    b. Providing advice, support and training.

    c. Intervention and disruption.

2. Informing parents.
3. Identifying multiagency partners.

LAs varied in the sequencing of this work (i.e. some did parent work first, while others focused initially on providers, and some did both in parallel) and the amount of effort they put into each (several made much less progress on multiagency work).

Coordinators' role

All LAs were encouraged to employ a member of staff as a Coordinator for the OOSS project.

Although some LAs had managed to fill their Coordinator post fairly early in the project others faced more difficulties. Examples of difficulties included identifying someone with the appropriate skills at the right pay level and this person having the necessary influence in an LA. All pilot Coordinators were finally in post by November 2019 (i.e. some LAs did not have staff in post until eleven months after the project started). Coordinators were enlisted from a mixture of open recruitment, secondment of existing LA staff or adding the role to an existing post (such as Educational Welfare or Community Engagement Officers).

There was wide variation in the type of people LAs had appointed to carry out this role, in which team they were based (and therefore who managed them), their seniority and experience in this field, and their skill set.

5. How LAs mapped OOSS

LAs tried to map OOSS in their areas - in other words they tried to pull together a list of the OOSS operating locally, whilst also identifying where these settings are located.

They did this in a range of ways including:

- **OOSS provider self-identification** - publicising the OOSS pilot project to get providers to identify themselves and provide basic details about their setting (although see later section [p26] on how in some cases incentives had to be offered for this).
- **LA identification** - consolidating information, contact lists/databases from other LA departments (including those detailed above).
- **Outreach activity** - e.g. walking the streets to look for OOSS.
- **Desk research** - e.g. googling for settings in the area.
- **Local partner identification** - asking local partners from outside of the LA to provide information about potential OOSS or pass on information about the project to them. These partners included: venue owners (e.g. community centres, libraries, etc.), community and faith groups, voluntary and youth organisations, schools and parents.
- **National stakeholders** - LAs asked specific national organisations to provide them with information about potential OOSS. National stakeholders included umbrella organisations (such as uniformed groups), the Charity Commission (who register and regulate charities, some of whom may be OOSS), and Ofsted (who have a team to investigate and inspect suspected illegal schools).
- **Referral systems** - whereby anyone could contact the LA to identify or report concerns about OOSS.

The process of mapping included checking if activities being carried out would categorise the provision as an OOSS as well as capturing basic information on them (such as contact details, type of setting). Some LAs captured more detailed information including details of operating hours, number of staff and volunteers, number of children attending, ages of those attending and activities undertaken. Mapping was not a stand-alone activity but often interlinked with other strands of activity such as assessment of risk or attempts at engagement.

Mapping was not considered a one-time only activity. Providers were reported to open and close, and change ownership, contact details and staff constantly. This meant the process of keeping an up-to-date list of OOSS was ongoing.

Most LAs conducted outreach activity whereby they walked around their local area looking for signs of, or trying to identify, OOSS. Although they could see that this was effective in terms of finding providers they may otherwise not have known about, many stopped this process as it was time and resource consuming and – beyond providing details of where potential provision might be operating – often did not help with speeding up the identification or engagement process.

Likewise, others found that the quality of data they received from other stakeholders was often limited and dependent on what exactly they requested.

Case studies of approaches to mapping

Area B mapped around 500 OOSS across a range of different organisations including youth groups, sports groups, clubs, and dance groups through a range of pilot activities. Initially, mapping was widespread using information from the Family Information Service (FIS) combined with outreach activities. This included going out on the streets to identify settings and via word of mouth from partners such as community leaders and councillors. Given the scale of mapping activity and timescale available for the pilot, the LA focussed mapping and training activities to just Supplementary Schools and Faith and Tuition centres.

> "We drew on information from the FIS to generate a map of OOSS. From that list we looked for organisations that we may have already been aware of through family support services. What we have found is it has been more about face-to-face contact." *Coordinator*

Area O mapped just under 200 OOSS around two-fifths of which were newly identified (i.e. not previously known to the LA) through pilot activities. Mapping processes included using an external consultant to do outreach work. It also involved liaising with other LA staff and departments to draw on information and lists they had of OOSS. This included work with the FIS and the Safer Neighbourhood Team.

Area H carried out a mass scoping exercise to identify OOSS, finding over 900. They found that using existing LA knowledge and contacts, such as the Early Years team and FIS, Prevent and Faith officers identified very few providers - around 25%. They found that using the Charity Commission 'alert' system was useful in directing them to providers they should probably investigate further, as was walking the streets looking for signs of OOSS at venues or advertising their services (for example around schools and community centres).

Area M identified 146 settings, but this excluded any in private dwellings. They used old lists from building and planning to see who had registered as businesses and then called them to see if they were still operating. They also deployed engagement officers to walk the streets in a small number of neighbourhoods 'to see what OOSS they could find'. Another strand of work involved them sorting through a list of over 300 local organisations provided by the Charity Commission. There were no addresses provided so an officer had to try and find their contact details from the web. They linked with safeguarding officers to get a list of organisations supported by them; pulled together a list of religious providers that officers then visited to see if they offered classes for children and young people that could be classed as OOSS; and checked a list from another LA team of mother tongue and supplementary classes run in the area.

Through mapping OOSS, LAs learnt many lessons about the barriers and drivers that exist to this work. These covered both delivery issues and the wider implications of these. Mapping was seen as an important process for LAs. However, mapping all existing OOSS in an area emerged as a huge undertaking. It was seen as too big a task to be feasible within the timescale of the pilot. LAs reported that this was exacerbated by fast-paced changes in the OOSS market. For these reasons LAs tried to narrow their focus when mapping.

They did this in different ways, for example by focusing on a certain geographical area or on certain types of setting.

> "This (mapping exercise) is huge and from the outset should have been a five-year project, the time it takes." *Coordinator*

> "We're up to almost 900 now and we know that we've deliberately not included some settings. So this figure is just the tip of the iceberg." *Coordinator*

> "We realised we need to be realistic. We needed to be focussing on those we may not have had any information on, whereas the others, potentially we were aware of." *Coordinator*

By narrowing down the focus of activity or dealing with the most obvious or known providers first, other issues emerged. LAs reported concerns about:

- missing certain types of providers e.g. private tutors, OOSS operating from private dwellings;
- only identifying those who want to engage and improve; and
- missing providers who may be 'off the radar' and potentially of concern.

Summary: Identifying OOSS

There is currently no requirement for OOSS to register (with the LA or a national body) and therefore no easy way to find them all. However, for an LA to contact or work with out-of-school setting providers, LAs needed to know where they are and with whom to get in touch.

Some LAs attempted to more comprehensively map than others, but none generated a full list of OOSS in their areas. So, although one area had identified over 900 providers, the LA noted this did not reflect the actual amount of OOSS in the area, as many are either difficult to track down, due to constant relocation, or difficult to identify in the first place. From the project we are unable to say exactly how many OOSS are operating across the 16 LAs, or how many children are attending these settings. When LAs realised the potential scale of the task, some focused on certain types of providers, or

chose not to try and identify those that were more difficult to get information on (such as those operating in the home / private dwellings).

6. Identifying issues or concerns in OOSS

LAs tried to identify whether there were any safeguarding issues or areas of concerns in their local OOSS.

They did this in up to three key ways, by:

- **referrals/complaints -** establishing or strengthening processes for people to report concerns about OOSS - (e.g. linking to multiagency referral processes or establishing a new OOSS referral mechanism e.g. a mailbox) and raising awareness of how to report concerns.
- **desk-based review** - e.g. looking for basic web-based information, for instance, to see if there was evidence that the OOSS had safeguarding procedures in place or were covered by an umbrella body that could be providing them with advice and/or checks on safeguarding.
- **establishing checklists** or other basic systems to audit or assess OOSS provision on a range of markers of 'safety.' These markers varied in scope and scale but generally included examining the safety of premises and staff as well as wider checklists on safeguarding practices.

Albeit to varying degrees, all LAs collected data to assess the safety in OOSS of:

- **premises and equipment** - this covered for example health and safety, first aid kits, fire, insurances (building and public liability), building access;
- **recruitment of staff** - covering vetting and barring checks of staff (paid and volunteers), presence of a designated or nominated safeguarding lead;
- **child protection** - covering safeguarding policies and practices including knowing children's medical requirements and having emergency contacts etc.

In assessing risk, very few LAs included an assessment of the content (i.e. what the adults were saying or doing with children) or quality (e.g. the management of settings, behaviour and admission policies, effectiveness of teaching and learning) of provision. This was due to LAs either not feeling this was a 'risk' or safeguarding concern for them to be responsible for assessing, or not being sure what features of content would legitimately pose a safeguarding risk. They were unclear what would count as safe and unsafe in terms of content, and signs to look out for to identify particular safeguarding concerns, such as extremism and radicalisation. LAs had concerns about whether their 'assessments' would be in contravention to religious or cultural beliefs, and whether this overstepped the mark in terms of LAs regulating families' choices.

Case studies of approaches to assessment of risk

In Area B once an OOSS had been identified, the LA used a RAG rating system to indicate if a setting had appropriate safeguarding policies in place or was a risk (because it did not). The RAG rating was determined based on information gathered from a range of sources including previous contacts the LA might have had with the setting; concerns raised through any multiagency partners such as the police or LADO; and outreach work by visiting the setting. To further support risk assessment, they developed a checklist audit to assess the setting's safeguarding practices. The audit helped to determine if the premises were safe and if staff were suitable to work with children. The checklist audit looked at whether staff had been DBS (Disclosure and Barring Service) checked, if the setting had a safeguarding and child protection policy, and a health and safety policy etc. An OOSS officer would also visit the setting to go through the checklist audit. This audit process was aimed at identifying what the setting's needs or issues were and how the LA could then support them to improve.

Area D assessed settings as high, low or unknown risk based on what the LA knew about the settings and safeguarding practices in place. Through the pilot a process was established to engage OOSS and determine what safeguarding practices they have in place and what training they've had. The process involved contacting OOSS (by email/letter) and requesting them to complete an evidence form about safeguarding. If an OOSS did not respond after three attempts at contact, or if the information gathered was incomplete, the LA visited the setting to try to collect the information required for the evidence form face-to-face.

Area J set up a system where OOSS providers identified were asked to submit evidence showing they complied with the standards the LA had set for 'safe' providers. The provider had to produce copies of their fire and health and safety certificates as well as insurance documents, DBS checks for staff and safeguarding policies and procedures. The OOSS Officer might then go out to the premises to see if the building and activities themselves are safe.

Assessment challenges

During the course of the pilot, LAs realised there were several issues that needed to be overcome to enable better assessment of the safety of children attending OOSS. These included:

- **OOSS details are held across different teams within LAs** - LAs realised that different departments within their own LA have contact with OOSS for different reasons (for example Planning Departments might have details of an OOSS who had applied to them, or the Health and Safety team may have details if an OOSS had made an enquiry to them). There is not one person or department within the

LA with clear responsibility for OOSS. Therefore it was not obvious to LAs who may have information on OOSS and who may have helpful knowledge. LAs had to find all this out as part of their activities and that took time and resource.

- **OOSS are not a single entity** - many bodies and organisations only had contact with certain segments of the sector – such as charities, sports clubs, those registered as businesses, or operating in community venues and so on. This meant that a wide range of partners had to be consulted in order to cover the whole of the OOSS sector.
- **Wide variety of management structures in OOSS** - LAs identified systemic differences (e.g. management structures and cultural issues associated with religious institutions overseeing OOSS) across the range of OOSS. Working with OOSS often required building a trusting relationship before any actual engagement could take place. This took time to develop and in some cases was not possible.
- **Issues with sharing data -** there were issues encountered with partners or individuals sharing information on OOSS. OOSS, partner organisations and, in some case, other departments within the LA were unsure about sharing information on provision, including personal data such as names and contact details with the LA OOSS team or coordinator. This was not only due to perceived GDPR issues but also concerns about how the LA / team would use the data and for what purpose.

Wider issues and implications from assessment

The processes of mapping and identifying risk revealed that many OOSS often lacked safeguarding policies and practices. Feedback from LAs, suggests this was more due to OOSS being uninformed or lacking knowledge rather than unscrupulous practice.

Some national stakeholder organisations (such as Sport England, and the NSPCC) had developed resources including checklists and self-assessment tools. These too differed in scope and coverage. Some local approaches built on these resources, often tailoring them in different ways. Some areas realised that checklists for safeguarding provision for children already existed within the LA and so built on them.

Assessment and RAG rating parameters varied across LAs and settings. These ranged from basic safety checks, to safeguarding audits, to assessment and observation of practices. What was rated as ‘red’ was in some areas a lack of response following contact; in others, it was that a LADO investigation was underway; in others, it was lack of a fire safety certificate. Likewise, when rating providers as ‘green’, some areas took membership of an umbrella organisation as a sign of being safe whereas other areas realised many umbrella organisations do not check safety of provision and therefore did not use this as an indication of ‘green’ provision.

LAs were aware that identifying and checking providers using an opt-in approach meant most of their resource was used on the more engaged providers, meaning the provision

most likely to require support/intervention would not be identified. LAs felt that this left them little capacity to identify those of greater concern.

> "We need a better way to narrow this all down. What we really need to do, in terms of efficient working, is to be able to focus our resource on hunting down and dealing with the unsafe ones." *Coordinator*

> "We're making the good better, but not doing anything with the worrying ones at all." *Coordinator*

Summary: identifying safeguarding issues in OOSS

These processes were used to determine how 'safe' provision was, identify issues of potential concern or areas for development or training in OOSS.

Markers of safety varied as there is currently no national system applicable to all types of OOSS to determine whether or not they are safe settings for children.

Some LAs had more rigorous systems to identify concerns than others, and what deemed a provider as 'safer' varied across areas. However, due to the scale of the task, no LAs 'assessed' or looked for potential issues of concern in all of the OOSS in their area. They were also all less likely to be assessing the content of provision, i.e. what the adults were saying or doing with children as part of the tuition, training or activities offered.

7. Providing training, advice and support

Training provision differed across the pilot areas with LAs developing various forms and types of training, including:

- providing training for OOSS - e.g. on health and safety or safeguarding practices;
- developing kite marks or local 'accreditation' schemes;
- carrying out site visits to assess provision and advise on areas for improvement;
- developing toolkits, guidance, and model policies e.g. on safeguarding and hiring and letting premises to OOSS;
- providing additional support to help OOSS make their settings safer - e.g. by providing access to Disclosure and Barring System (DBS) checks to promote safer recruitment, and access to cheaper rents to promote OOSS operating in safer buildings;
- up-skilling the whole LA on the Rights Respecting Schools approach, established by UNICEF[3], which develops children's empowerment and respect of children's rights as a driver of referrals of issues in OOSS; and
- applying Section 11 of the Children's Act 2004[4] and the corresponding guidance 'Working Together to Safeguard Children' (2018)[5] to OOSS providers.

Overall LA delivery of training varied in terms of:

- **cost** - in some cases training was provided free of charge (using funding provided by the project), in others it was subsidised or charged for in full;
- **content** – the type and range of issues covered, varying from basic health and safety considerations through to implementing safeguarding processes and managing allegations;
- **where it was delivered and how** – some LAs delivered in individual settings, others held training events (for example in their premises), a small number hosted training online;
- **who delivers the training** - whether it was delivered in-house (by OOSS Coordinators or other LA colleagues, such as the LADO or Prevent Officer) or through external providers;
- **level of specificity -** whether it was targeted specifically at OOSS providers or more generic; and
- **level of formality -** whether or not it was 'certified.'

[3] https://www.unicef.org.uk/rights-respecting-schools/

[4] http://www.legislation.gov.uk/ukpga/2004/31/section/11

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722307/Working_Together_to_Safeguard_Children_Statutory_framework.pdf

Badging provision (certification or kite mark)

LAs in some areas developed accreditation or quality mark schemes to signify adherence to certain standards.

The incentive for participation in such schemes was often around help with marketing participants' provision. For example, the LA might list trained OOSS on local family information directories or suggest that parents would be more likely to use them as they were considered safer than those without any accreditation. OOSS providers wanted to be able to prove to parents that training had been undertaken.

> "Feedback from organisations was that if they came to training, they wanted certificates so that they could show them to parents." *Coordinator*

Accredited, certified or quality mark schemes varied in terms of: the extent to which they provided more intensive training; whether they were delivered in-house, across neighbouring LAs or by external partners; and whether or not they included observation and verification of practice. They also varied in terms of scope of content and depth of coverage.

Badged content included some or all of the following:

- health and safety (including fire and first aid training);
- safe recruitment and employment/use of volunteers;
- appropriate safeguarding, law and practice (including appropriate adult behaviour and in some cases training on Prevent); and
- appropriate quality and content of provision (from external bodies).

In three areas a 'higher level' training offer had been developed by the LAs. These varied in issues considered, but included:

- Safety of premises
- Safe recruitment of staff and volunteers
- Child development
- Behaviour Management
- Special Education Needs and Disability (SEND)
- Equality
- Financial Management
- Children's rights
- Education law
- Safeguarding.

Nearly all LAs had originally proposed to develop an accreditation scheme supported by a training offer. However, as their understanding of the sector, issues and processes involved, developed they decided not to do this. They cited the reasons for not doing this as:

- the lack of consistent measures of safety;
- the scale of the undertaking (to ensure all, regular changing staff were kept trained);
- the sustainability of ensuring providers remained safe once accredited – this would need frequent (often suggested to be annual) checks, which requires resource; and;
- the accountability on LAs once they had deemed providers as 'safe' or accredited, if any issues then arose.

Case studies examples of certification and quality marking

Joint LA Quality Mark

Two areas worked in partnership to develop a Foundation and Higher-Level Quality Mark for OOSS. At the end of the initial pilot funding period, five OOSS had expressed an interest in doing it in one area and three had completed up to the Higher award in the other.

The certified quality mark was delivered through a booklet that set out five key areas that OOSS work on. Evidence against these areas was captured via observation and visits - from an OOSS or Safeguarding Officer. Once the information was collected the OOSS or SG Officer discussed the evidence gathered with a panel. The panel comprised LA staff from both LAs, councillor, an OOSS Provider that had already achieved the quality mark and a representative from a supplementary school. If the panel deemed sufficient evidence had been provided the OOSS was awarded a certificate that they had met the criteria for the Foundation or Higher Quality Mark.

Single LA Quality Mark

In this LA, out-of-school settings could register with the LA to voluntarily put in place policies and safeguarding measures to better ensure children's safety and wellbeing. The measures covered practical issues like premises and equipment, as well as safer recruitment of staff and volunteers. Settings that registered for the scheme were assessed on whether they met the safeguarding guidance and those that did were awarded the assurance mark. By the end of the initial pilot funding period, only four settings had shown interest in the Mark.

Training, advice and support issues

Several issues were identified by LAs with regards to offering training, advice and support to OOSS. These varied across regions but there were some common themes highlighted which included:

- **Location and time of training -** LAs highlighted that the hosting and timing of delivery should be considered. They felt it worked best when delivered at providers' premises and at timings to suit. This was most typically evenings and weekends, in order to be accessible to OOSS staff, despite being outside of LA staff's contracted working hours.

> "We have done a mixture of both centralised training and bespoke at a providers' premises. So we have got set days in the LA where we try and advertise a course for OOSS, and you can book on - which we do have an uptake for. But what we have found is where we have gone out and done the relationship building one-to-one… yes it takes more resource, but the OOSS want the training to be delivered and taken out to them.… This is because most of these organisations operate with volunteers who don't have the time. Take up has been better going out to OOSS rather than the other way round." *Coordinator*

- **Requires skilled trainers** - training was seen as needing to come from someone who was experienced in safeguarding and/or educational welfare and understood the OOSS sector.
- **Limited funds in OOSS** - many OOSS providers are not money-making or do not have resource to fund training or DBS checks, etc. Many LAs offered this support for free or subsidised it for the duration of the project.
- **Limited LA capacity** - LAs expressed concerns about resource available to support a large number and wide range of providers. Internal capacity was not seen as sufficient to meet potential need. Some LAs had had to outsource the training delivered through the pilot or offer online courses. LAs were aware and concerned that any training delivered would need regular updating, as staff turnover is so frequent in the OOSS sector, increasing need for delivery capacity.
- **Limited take-up** - Although reported need and enthusiasm for training from providers was high, take-up was relatively low. This was attributed in part to the delivery issues highlighted above such as availability of trainers in evenings. LAs were generally of the belief that once sufficient numbers of providers could evidence higher levels of training and safety others would look to follow. LAs and national stakeholders felt that market forces would drive greater participation as parents start to choose 'safer' settings.

> "We just hit a brick wall with training. We offered it for free but there was just no response. We think the reluctance was around being too busy, they all already work during the day, and not being able to find a time or place that was suitable." *Coordinator*

> "We have forged ahead with the quality scheme but because it is voluntary - so far only four settings are interested in our assurance mark." *Coordinator*

- **Contradictory advice -** There were examples where different training gave contradicting advice and recommendations. This included different views, for example, across LA partners about whether advice to use CCTV is good practice. This suggests there might be a need for a national training package.
- **Limited focus on what is taught -** Some LAs and national stakeholders have a more wide-ranging training offer with coverage from minimum requirements for safeguarding though to the development of quality and standards for managing behaviour. However, only a small number looked specifically at training providers on the content of what is taught in OOSS.

> "We challenge settings on what resources they are using. We are of the same faith, so we are able to question them, and are very informed about texts and interpretations. We have our own content that we can offer to exchange theirs for if we don't feel it's in line with Fundamental British values. We challenge them on this and point out why some of their writings are not acceptable." *Stakeholder*

Incentives for OOSS to engage with LAs

As many OOSS felt they had no reason (legal or otherwise) to engage or comply with LAs, LAs had developed a range of enticements to engage providers to work with them and provide details of provision, including:

- offering financial incentives such as:
    - minimal/peppercorn rents – for using LA owned/community venues. This was a way to encourage OOSS into premises that were likely to be safer and more visible.
    - releasing grant funding from other LA schemes to OOSS who could prove their safety or signposting them on to voluntary body grant funding that is only available to providers who can evidence adequate safeguarding practice.
- support to become registered childcare and therefore be able to access financial support.
- providing a system for OOSS to complete Disclosure and Barring Service (DBS) checks to help them make safer recruitment decisions. DBS checks can only be carried out by approved providers know as a Responsible Organisation (RO) that is registered with the DBS to submit basic checks through a web service. Many individuals or smaller organisations do not have access to ROs. Some LAs therefore set themselves, or partners, up as 'DBS hubs' who could process DBS checks for OOSS staff and volunteers.
- establishing OOSS networks allowing providers to meet each other, share ideas, issues and practice in the hope that this raised quality of provision and raised expectations of standards.

"We explain to them that if they have this [safeguarding] all in place we can help them learn about where and how to access funding." *Coordinator*

"We set up a networking event and invited the settings we know exist to it. We think it's important to build relationships with providers. They were wary at first that something was wrong. So we set up the agenda to have guest speakers on useful topics and advertised it as a way to share good practice. We don't want to alienate or stigmatise them. We want to bring them on board and help them help themselves." *Coordinator*

Strategic levers used by LAs to increase compliance

Some LAs had looked how they could address consistency of safeguarding in OOSS by other strategic actions. There were three key ways LAs had suggested addressing this:

- **establishing hire and letting agreements or guidance for venue owners to use with OOSS** – which ensured checks were carried out on the safety of providers, and that owners also considered the health and safety and fire safety of premises they own;

  "We worked with our community hall team in Lettings to tighten up hire arrangements. There now have to be checks on the suitability of those that spaces are being hired by. And we've included safeguarding in these checks." *Coordinator*

- **raising the profile of children's rights and empowering children** – to increase awareness of how children should be treated by setting out norms of good, safe treatment of children in line with the UN Convention on the Rights of the Child, for all adults and children. This was expected not only to improve the safety of provision for children but also to enable children to know what is not safe for them and how to act if they experience this; and
- **making OOSS relevant agencies** – since 2019 Local Safeguarding Children's Boards have been replaced by Safeguarding Partners. These partners can identify agencies who they believe Section 11 of the Children's Act, which sets out safeguarding responsibilities, should cover. LAs saw that by naming OOSS as regulated agencies they could then raise awareness of providers about the need for them to meet certain safeguarding standards (and potentially have the legal power to require it).

Case studies of strategic levers

The Right Respecting Schools Award

The Rights Respecting Schools Award is run by UNICEF for individual schools to sign up to.

The approach is based on the UN Convention on the rights of the child. Schools, stakeholders and children are trained on the principles and practice of equality, dignity, respect, non-discrimination and participation. Schools involved in the Rights Respecting Schools Award work towards bronze, silver and gold awards recognising that they have embedded children and young people's rights in their school's practice and ethos. Schools are required to implement three evidence-based strands that cover the leadership of the school, knowledge and understanding of children's rights, ethos and relationships and the empowerment of children and young people. UNICEF staff work with the school to support their progress and make the appropriate awards. The belief is that children and families are then empowered to understand what 'safe' practice is and what to do if they do not feel safe. Their evidence shows that where the scheme is implemented disclosures related to child protection increase.

As part of the pilot the contents of this scheme were tailored for delivery with OOSS providers and stakeholders. Training was delivered to providers, but the belief of LAs was that children whose schools had signed up to the award would apply their understanding of 'being safe' to other activities they undertook, including at OOSS, and therefore be more likely to report any concerns they had there.

Some areas adopted the Rights Respecting approach across the entire LA, in the hope that all local practice became centred on child wellbeing.

Relevant Agencies – Section 11

Section 11 of Children Act 2004 places duties on a range of organisations and individuals to ensure their functions promote safeguarding and welfare. One area has looked at how it can better engage OOSS in improving their safeguarding practice. Under the new Local Safeguarding Children Board rules they have named OOSS as one of the Relevant Agencies with specified safeguarding responsibilities. It is not clear yet whether they will use this as a 'carrot', for example presenting it as 'you are now a named body and we can help you to meet the standards this sets out for you', or more of a 'stick', presented as 'you are a named body and therefore should be adhering to the standards set for you'. There are still questions about what actions this means the LA can take with providers who do not meet the standards and to what extent there is a legal duty for them to do so.

Summary: Training, support and engagement

These inputs were all designed to develop and improve safeguarding in the OOSS sector. They were also a means to tackle concerns identified (e.g. by addressing limitations in existing safeguarding practice or concerns about safe staffing). The support was also developed to address weaknesses in the system uncovered through other strands of activity. For example, LAs realised many OOSS do not own the premises they operate from and therefore there needs to be greater accountability from both the OOSS and building owner about safety in the premises.

These support offers also acted as ‘hooks’ to incentivise OOSS to engage with the LA. Providers were seen as being more open to giving details of their service and allowing the LA to assess them if this was accompanied by the offer to help to improve their provision. However LAs still felt this only engaged those more aware of risks and more open to change.

Some LAs decided to develop more intensive support and training than others. However, the numbers trained in the project timescale were very small and take up was low. Similarly the effect of strategic incentives could not be assessed during the timescale of the evaluation.

8. Tackling concerns or issues identified

Through the mapping and assessment processes, LAs identified several safeguarding issues that required intervention. Since providers' engagement with the LA was with their consent, any issues identified were usually addressed through building positive relationships and informing them of safe practice. However, on occasion it required a more significant intervention with direct action where children were in immediate danger.

The types of concerns identified included:

- unsafe premises – including lack of a fire safety certificate, unsafe buildings;
- unsafe practices – including inappropriate: children's changing facilities, transport and collection arrangements, public access to OOSS spaces, behaviour management and exclusion, safeguarding policies or procedures;
- peer on peer issues – such as bullying or sexual abuse; and
- unsafe staff – including those not checked to be fit to work with children, or untrained or inexperienced to do so.
- inappropriate adult behaviour with children – including:
    - verbal, physical abuse (most commonly physical chastisement),
    - inappropriate sexual behaviour including reports of sex child abuse
    - grooming
    - inappropriate use of social media, such as staff befriending and private messaging children.

Disruption by LAs to OOSS with safeguarding issues

In some cases, safeguarding concerns raised by LAs were deemed to require more substantial intervention than positive support, advice or training. In these cases, LAs were looking at the processes and powers available to them and other partners to tackle the concern raised.

LAs were therefore disrupting safeguarding issues in OOSS by:

- seeking to reduce risks (for example by offering guidance or training on good practice) – mitigating the need to take stronger action;
- establishing processes for managing or taking actions around severe risks (such as working with or understanding LADO and police referral procedures); and
- exploring ways to try and 'enforce' compliance (such as by using the fire service to gain entry, requesting Charity Commission investigations, or liaising with Ofsted).

Legislative Powers

LAs identified that, to oversee OOSS in ways other than with their consent, they needed powers to:

- access OOSS;
- identify OOSS and collect basic information on their provision;
- assess the safety of OOSS provision;
- make OOSS providers meet certain standards and act on identified concerns;
- share information across all partners that could support monitoring of, and intervention in, OOSS; and
- close down OOSS and prevent them from re-opening elsewhere.

Very few managed to fully test or utilise existing legislative powers during the pilot, although many stated that powers available included those held by several departments and organisations, including:

- **Fire** – which allows access to public buildings to check fire safety (through prevention and protection measures);
- **Planning** – whereby planning officers can check use of buildings and that any building works comply with regulations;
- **Health and safety** – where providers in public settings have a duty to ensure safety of premises;
- **Charity Commission** – who can oversee charities and investigate their activities;
- **LADO** – who has responsibility to coordinate response to concerns about individual children and the staff working with them;
- **Police** – who have the power to investigate allegations around criminal activity (including child protection); and
- **Ofsted** – who can investigate whether educational provision is correctly registered as a school and adheres to applicable legislation.

DfE initially detailed all these as available powers LAs could try to use. Through the pilot, some LAs also identified additional powers – under:

- **Business regulations** – for example requiring health and safety at work or activating responsibility for employees' duties.
- **Prevent duties** – through which LAs can audit the content of 'meetings', which could be applied to activities taking place in community settings.
- **Section 11 of the Children's Act**[6] - some LAs interpreted the Act and Working Together guidance[7] as meaning anyone working with children (i.e. including all OOSS staff) is bound by the safeguarding processes within the Act.

[6] Children's Act 2004: Section 11 http://www.legislation.gov.uk/ukpga/2004/31/section/11

[7] Working Together to Safeguard Children, HM Government 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Intervention and disruption issues

In many cases LAs did not manage to achieve a satisfactory solution to safeguarding issues. Most experienced the barriers of providers not consenting to work with them, refusing to allow access to their premises, or to provide any information about their provision. Further issues highlighted by LAs included:

- **Many of the existing powers only cover certain parts of the OOSS sector** – such as registered charities or registered businesses. Many OOSS are neither of these. Even if they are acting as a business and charge for their services, many are not registered and proving they are a business was found to be difficult. For example, one LA received a complaint about the conduct of a tutor operating from their own home. When the LA OOSS team approached the reported provider, he claimed that he did not run a business and so the LA had no power to enter his home, or require any information from him.

- **Thresholds for external agency involvement –** Often issues of concern with OOSS do not meet the thresholds to engage different partners. Most frequently this was the case with the LADO or police. Their processes are focused on individuals at risk, or specific concerns about child protection or where a crime has been committed. The threshold of what cases they can and cannot take on is also down to local interpretation and often linked to available resource.

  For example, a child disclosed inappropriate behaviour by a private tutor. The case was passed on to the LADO. However, the claim was uncorroborated, and the tutor (who, as the business owner, was responsible for investigating the claim) stated that no such behaviour had taken place. The LADO therefore decided this did not meet the threshold for further action.

- **Lack of clarity about the issues raised** – Risks or referrals of concern around OOSS are often vague and this can make it unclear who has the duty to investigate them further and what powers they have to do this. LAs were also concerned that without a designated role and reason to do this (which would often be the case outside of this funded project), they may be overstepping their remit and potentially holding sensitive information on individuals without their knowledge, consent or a justifiable reason. For example, if a child reports concerns about staff at an OOSS, but it is decided no action needs to be taken, it is unclear whether the LA should record that information. While recording the information may help piece together evidence if further issues are raised later, it potentially involves holding sensitive and unsubstantiated data on an individual.

- **Lack of information on any investigations** – When LA OOSS teams felt a raised issue needed further investigation, or the potential for charges to be brought, they often passed concerns on to other agencies, such as the LADO or

police. Often these agencies may have taken the investigation on, but due to the sensitive nature of their work, they were unable to share updates with LA colleagues or divulge what they had learnt from their investigations. Their work might also have taken many months to progress. This could lead to the LA OOSS team feeling the case had been dropped, or was unsubstantiated, or simply not knowing what the outcome was. This clearly impairs their oversight and management of safeguarding.

- **Lack of power in private dwellings -** Existing powers were more likely to cover activities taking place in public spaces and could not be applied to those in private dwellings.

  "We have a duty to check all public premises for fire safety and through our protection and prevention work when we are out in the community. But we can't just turn up at someone's front door and demand they let us in." *Stakeholder*

  For example, a complaint of inappropriate behaviour was received from a child attending lessons in a tutor's home. The LA OOSS team tried to contact the provider to carry out initial investigations. They received no response to emails or telephone calls and so went to the tutor's address. The tutor denied that he ran any sort of business or worked with children and so would not answer any questions or let them see inside his house. The LA OOSS team therefore could take their concerns no further.

- **Lack of powers of enforcement and information sharing -** Despite existing powers and various legislative duties and levers all LAs identified that unless an individual is prosecuted for a crime there is very little they can do to warn parents of potential risks, prevent closed providers from reopening elsewhere or to stop unsafe staff from moving on to another provider. Many felt this gap was putting children at risk. Likewise, by not keeping records of reported incidents, data could not be gathered, and evidence pieced together to identify providers or individuals of potential concern.

Summary: issues around disrupting providers

LAs felt that if safeguarding issues had been identified, or were suspected in OOSS, some action had to be taken. In some cases, requests to address issues identified required stronger action than just advice giving and support. LAs found that they needed to look to a range of powers and partners to respond appropriately and effectively to the broad range of issues they found in OOSS.

The ability for LAs to test and use the range of existing powers listed by the DfE was limited in the project timescale. This is perhaps not surprising as it takes time for LAs to identify providers, attempt to assess provision or identify concerns, and to realise that

‘softer’ options (such as offering free training, support and guidance) may not have traction. Where LAs were able to use them, the powers they used the most often, during the project, were around: gaining access; requiring information on provision and practice; and addressing basic health and safety issues. However this ‘mix and match’ approach of using powers held by different agencies to try and apply to OOSS with different characteristics was felt to be a major barrier, whereby LAs were having to manoeuvre action around powers that were not specific to the issues they were trying to address (e.g. having to use the fire service to gain entry to premises where safeguarding issues were suspected).

Powers that do exist often only apply to very specific types of providers and LA staff may not have access to this information, or be able to use the powers they want with different types of providers. A further barrier was that this required joined-up work, information sharing and understanding across a range of teams, adding to the time and resource implementing any of the existing powers took (and often therefore meaning the lack of satisfactory resolution).

LAs identified a need for improved reporting, record-keeping and information sharing within the LA (for the LA OOSS team and colleagues in other departments). They felt this was needed to help other departments or agencies to examine and respond to concerns referred on, and to test out the capacity of existing powers available.

9. Multi-agency working

LAs worked with a broad range of other agencies for their work with OOSS during the project. They worked with various local (within and outside of the LA) and national partners to support them with attempts to identify settings and concerns, train and support providers, and address issues.

Examples included working with:

- various LA departments (including Early Years and Childcare teams, the Family Information Service, building regulation and planning teams) to gather any data they held on potential OOSS;
- the Charity Commission to get lists of charities in their LA to screen and see if they were OOSS;
- the fire service to try to gain access to premises to assess safety;
- the Local Authority Designated Officer (LADO), MASH and Police to determine how to respond to concerns identified;
- organisations used to support segments of the OOSS sector to better engage them with the LA and provide tailored training; and
- schools and school engagement officers (and home school education teams) to gather information on local OOSS and inform parents about how to choose safe providers.

Challenges faced with multi-agency working

The key feedback around multi-agency work was that all partners are busy. Due to the lack of clarity and obligation to work with OOSS, it was difficult to make this a priority for them. This meant getting cooperation was difficult and took time. Other challenges highlighted for multi-agency working included:

- **Lack of senior buy-in** - Unless senior leaders in different organisations engaged with the project, understood its purpose and impressed upon partners the importance of supporting the work, multi-agency working was difficult. Jointly considering multi-agency partners' roles, knowledge and duties locally was helpful and informed who should carry out what work.
- **Concerns about information sharing** – both letting providers know about the project and passing on details for LAs to identify them.
- **Outsourcing training** – whereby LAs did not have the capacity or skills to deliver training and support in-house, so commissioned private and community groups to carry it out. However this was not always delivered as the LA would have wanted, often because the deliverers were concerned about the purpose, content and coverage of training or how the LA's requirements fitted with their personal beliefs. This meant some OOSS providers were not being fully informed of local

processes, or how to manage the whole range of safeguarding risks and potential issues.

- **Lack of understanding of the sector -** national partners reported they were keen to support the work and committed to ensuring the safety of children. However, they needed a better understanding of the sector and issues, a remit to be engaged in it, and resource to do so.

> "We should be involved. We often do joint visits with the LA and the public understand our role in that. But we have very limited capacity, and we'd have concerns about the management of this and our reputation. We'd need clear reasons to enter somewhere. So then we'd need to know how big an issue this is. How would we be able to support it within our existing teams?" *National Stakeholder*

- **Inertia** - Existing cases can take time to be resolved and it was not always the case that the OOSS staff were involved in this process or aware of the outcomes. This was especially the case with investigations involving the police.

DfE Networks

A cross-LA, cross-partner team was set up by the DfE for the project, in the form of a steering group. It included key multiagency partners including the fire service; police and Ofsted representatives. The purpose of this was seen as strategic management of the project but also to share emerging issues and practice. Attendees varied in terms of their role in the project, seniority, and experience of OOSS and safeguarding. LAs reported not finding this as effective as a partnership working group.

However a "networking group' established later in the project was seen as a more beneficial way to contact those performing similar roles and experiencing similar issues in other areas. There were questions about the issues covered in these meetings, led by DfE, not reflecting the issues LAs were encountering.

Summary: Multi-agency working

The activities LAs were trying to undertake cut across the knowledge or remits of a range of organisations and partners. Partners were used for: their knowledge of OOSS provision; to facilitate engagement with the LA; to advocate for and support implementation of safer practice; and to act where more serious concerns were identified. What became clear to LAs during the project was just how many different partners could be involved in this work in various different ways and for different reasons. Some

partners had legal duties, others just had ‘suggested practice’ or guidance[8]. Some had remits that were seen as covering some OOSS but in others these were less clear cut.

Most participants felt that more multi-agency work, looking at roles, remits, responsibilities, and existing powers, would need to be carried out for any work continued after the pilot project.

[8] For example, The Children’s Act is a legal duty but only applies to a very small, specific set of Statutory providers; Working Together to Safeguard Children is guidance, but many LAs have taken it as requiring a level of Statutory and Voluntary sector response; NSPCC produce guidance for providers and parents with no legal duty; Sport England provide a framework for their affiliated members, but with no legal duty.

10. Parental engagement

Parents were a key partner in this work, as users of OOSS. LAs engaged with parents in several ways, including by:

- asking them what settings they send their children to (typically as part of information collected by schools or others);
- consulting with them on the draft voluntary code of practice for OOSS, and the accompanying guidance for parents and carers that DfE had published as part of public consultation[9] during the pilots;
- informing them of questions they could ask when deciding whether or not to send their child to an OOSS; and
- informing them of how to report concerns.

Most LAs produced communications (e.g. leaflets, radio campaigns, videos for parents) as part of the project. Some had distributed these communications widely, through schools and community centres and on bus stops, for example. A small number had deliberately engaged with certain sectors of parents, such as those facing disadvantage, or from specific communities (for example where levels of English were low). Others had only reached the stage of obtaining internal sign-off for communications to parents in the project timescale, so some work is still ongoing.

Parent engagement issues

Although parents are seen as a key stakeholder by LAs, they identified a number of issues with parental understanding of the system. Through engaging with parents, LAs identified that:

- there is a general lack of awareness that OOSS are unregulated, with many parents believing OOSS adhere to safe practice protocols or are governed by someone else (such as the LA or Ofsted). Raising awareness of this fact means that further work may now be needed to manage parental expectations;
- parents want an indication that settings are safe – e.g. via a quality mark scheme; and
- parents don't understand some of the common terminology used – terms like DBS, OOSS, safeguarding – these terms need to be explained or referred to in a different way.

With regards to selecting specific providers, LAs and stakeholders identified that:

[9] Out-of-school settings: voluntary safeguarding code of practice - GOV.UK (www.gov.uk)

- there are a range of factors that parents consider when choosing out-of-school settings for their children. These include proximity to home, cost, peer recommendation and cultural preferences. However, there is no evidence from the pilot to determine how far these factors interact with concerns around safety; and
- parents may be reluctant to query settings about their safeguarding practices. Parents would not necessarily feel able or comfortable asking questions on OOSS safeguarding standards, as they do not know what to look for, or may not understand what should be in place. Similarly, they want their child to attend the OOSS, so often want to avoid offending the providers, especially if they are seen as holding a position of power in the wider community (such as with religion based OOSS).

Some LAs and stakeholders also felt that parents should take more responsibility for ensuring the settings they leave their children in are safe.

> "Parents need to be clear that they need to take responsibility when they send their children places. They need to be aware that they should be asking questions about whether or not they have got a safeguarding policy and a health and safety policy. Parents weren't aware that that is what they needed to do. Our LADO was very strong that under existing legislation it is the parents' responsibility." *Coordinator*

Many LAs saw parents as the drivers of the OOSS market and therefore able to influence the safety and standards of the sector, i.e. if they only chose safer ones, or those that the LA had deemed safe, then other providers would want to address their standards. This in turn would drive up standards across the sector. Some therefore placed greater emphasis on informing or 'training' parents in how to select safer providers.

Several LAs and national stakeholders felt that there is a need for centrally produced information, and advice to parents and guidance on acceptable practice or minimum standards to ensure consistency. DfE has published guidance for parents on the 'red flags' and positive signs to look out for when selecting settings but that there may be a need to go further with this.

Summary: parental engagement

Many LAs felt parents need to be aware of what questions they could ask to help them make more informed choices about where they send their children. This would require parents to be cognisant of how the OOSS market works (i.e. what processes and standards exist). Without this knowledge LAs felt parents were ill-equipped to make safer choices, preventing the "market" from functioning.

11. Non-pilot local authorities

The evaluation included interviews with eight LAs not involved with the pilot, the purpose of which was to explore what work, if any, they had undertaken with OOSS. This included whether they had taken any steps to improve understanding of safeguarding practice in OOSS, to identify risk and intervene or, to engage parents and communities. In this section we summarise what was learned from non-pilot areas.

Any work carried out with OOSS had generally evolved for one of two reasons:

- there had been an impetus to focus on particular settings or themes - for example to support and improve supplementary schools, or to engage through the Prevent agenda; and
- members of LA staff had identified that safeguarding practice in OOSS was potentially an issue of concern. This was either due to previous work on safeguarding in the LA, or by assessing referrals or details of previous local safeguarding concerns emerging through existing routes to report concerns e.g. multiagency boards or the LADO.

Those who had carried out work on safeguarding in OOSS had carried out some similar actions to those in pilot LAs. They:

- **identified settings** – often from existing lists or contacts;
- **assessed needs in terms of safeguarding and risks posed** – from administering checklists with providers or asking for evidence of safeguarding practice and policies, or by reviewing issues identified from referred cases;
- **developed a support and training package** – often offering visits to the setting and providing training packages to increase safeguarding awareness in OOSS or to develop safer practices and procedures; and
- **informed parents** – by developing parent focussed information disseminated in a range of ways.

All of this work was on a small scale compared to the pilot areas and very few had carried out more than one of these activities. One area who took a more LA-wide approach also explored what existing powers could be used with providers of concern.

Lessons learnt from non-pilot areas

LAs, who had done little or no work on OOSS, did not see or prioritise this as a responsibility for them, or did not consider it part of their remit. This is supported by the fact that, even in areas who had carried out some work, this was not a strategic decision but made more on an individual basis.

LAs who had specifically worked on safeguarding in OOSS had done so as previous work had identified to them, or the LA, that this was an area of potential concern and

therefore a much-needed area of work. They also reported it was very resource-intensive to be effective in this area but that they considered the potential for harm to children to be fairly widescale, so action in this area was needed.

12. What resulted from the pilot?

LAs took a while to understand the work needed in this area and to develop a strategy to take locally. They needed to understand what the focus of the pilot funding was, what the different strands of work expected from them were and how they could go about implementing this (including scoping existing within-LA practice and knowledge). In most cases, after an initial planning phase, they began work around May/June 2019, however one of the pilots did not begin until September 2019, meaning the pilots were only operational for a proportion of the pilot period (between six and nine months). Nevertheless during this time the LAs:

- improved systems for engaging with OOSS from what was in place previously;
- improved understanding of the OOSS sector and the multiple systems that interact with it;
- established better relationships with some sectors of the OOSS market (depending on where their activity was focused) and supported them to develop their practice;
- identified a variety of concerns relating to OOSS. These ranged from limitations in safeguarding practices and health and safety concerns, to potential allegations of physical chastisement and abuse, convicted sex offenders working in OOSS, extremism and radicalisation, and concerns about OOSS potentially operating as illegal schools;
- established better relationships with, and knowledge of, other departments or organisations that come into contact with OOSS and who therefore hold intelligence or powers to support the LA in overseeing OOSS; and
- developed strategies for giving parents information about OOSS to help them make more informed choices about where their children were spending their out-of-school time.

13. Lessons about oversight of OOSS

The pilots generated a great deal of learning about overseeing OOSS at a:

- **practical level** - to help inform or improve any future localised attempts to replicate the approaches taken by LAs involved in the pilot, and
- **strategic/policy level** - to provide information to inform decision-makers about the issues emerging from attempts to have a better oversight of OOSS.

Practical issues

The types of lessons that LAs learnt about the practical work carried out with OOSS and the recommendations they would make to other areas included:

- look at what data is held by various LA teams that may cover OOSS. This will require them to have an understanding of what counts as an OOSS, and will then need to be filtered and checked;
- categorise local OOSS provision so that all communications, engagement and offers can be tailored to best meet their needs;
- consider all the work that needs to be carried out with OOSS: research, engagement, training, evidence collection, enforcing action, etc and who has the skills to deliver this;
- consider the working times of those working with OOSS as many providers operate outside of office hours;
- use partners who have established links with OOSS as intermediaries (such as community organisations and local leaders);
- develop an offer to support OOSS' engagement with the LA;
- consider tailoring and building on existing guidance on standards for OOSS to suit local provision;
- offer training at times and in venues (often at their place of operation) suitable for OOSS;
- consider how funds can be accessed by OOSS to address issues raised;
- map everyone locally who may come into contact with OOSS, job titles and names and powers/duties they hold that could be applied to OOSS; and
- consider how best to inform and up skill parents to make informed choices about OOSS they use for their children.

Policy/strategy issues

Through delivering strands of activity, pilots encountered challenges and exposed a wide range of issues that may have wider implications for policy and decision-makers. These are detailed below.

Mapping

Identifying all OOSS in an area is a big undertaking that is challenging to deliver and requires significant time and resource, including to keep it up to date. Several LAs felt that this challenge would be removed if OOSS were required to register (either with them or a national authority).

Assessing provision and identifying risk

This was carried out by LAs in different ways, for different purposes and using different indicators.

- Some used assessment information to mark settings as 'safe'. This raises implications about what factors should indicate settings are safe, who is responsible for checking this, and what parents and others can infer from these markings.
- Some LAs had decided not to accredit any providers as the resource required in ensuring they maintain standards was too great, and they did not feel they could take on the accountability this entailed.
- Wider stakeholder feedback also suggested external organisations use different markers of safety. Both they and LAs felt that a strong steer from government on minimum standards for safety would be helpful – what should they be assessing OOSS for, what marks them as safe, and where responsibility lies for checking this.

Examining safeguarding processes in OOSS

The pilot revealed a high need for development and improvement on safeguarding practice and policy. This implies a need for training that many OOSS cannot afford and have limited time to attend. LAs also expressed concerns about the resource implications for them of providing training to all OOSS in their areas.

There is already a range of publicly available resources (free and chargeable), for example from NSPCC[10] and umbrella/governing bodies like Sports England[11]. However it is not known how far OOSS will engage with or act upon these in the absence of an impetus to do so. Several LAs reported frustration that they could identify a safeguarding concern or gap at a provider but could not compel settings to address them. Furthermore feedback from stakeholders and a small number of OOSS who attended training showed that whilst they valued the input received, few had taken significant actions based on it.

[10] https://www.nspcc.org.uk/keeping-children-safe/away-from-home/sports-clubs-activities/

[11] https://www.sportengland.org/how-we-can-help/safeguarding

Reviewing referral mechanisms

Some LAs publicised and strengthened existing referral mechanisms for reporting concerns about OOSS during the project, whereas others established new ones to specifically cover OOSS. Both raised issues, for example about duplicating effort or the potential for concerns not to be dealt with or missed; and issues around agreeing how and what actions to take, and sharing information and outcomes.

Use of existing powers

Although there was limited time to fully test the powers available, LAs reported a range of issues and challenges, they had considered, relating to the powers they have to apply to OOSS. These included:

- **Lack of power – concerns** about a lack of power to access premises to assess practice, and to compel settings to act on weaknesses in safeguarding practice exposed (such as addressing health and safety concerns, staff vetting or controlling access to premises hosting children).

- **Confusion about current powers –** challenges with navigating the wide range of powers available to determine which can and should apply in which circumstances and for which issues.

- **Lack of consistent applicability across settings –** weaknesses in the applicability of powers and legislative requirements to a wide range of settings, as a power may only cover a certain sector of the OOSS market or those operating in certain ways (such as a charity or business) with much less applicability to sole traders (for example the need for an organisation to have a designated safeguarding lead who investigates any complaints when they are the only member of staff) or those operating from private dwellings (which are seen as common).

- **Inconsistent interpretation –** powers and existing rules and requirements can be, and were, differently interpreted across areas and partners. To support future work in this area these need to be clarified. For example to what extent Section 11 and Working Together can or should cover practices in OOSS and LAs role in overseeing them.

- **Remit of different stakeholders –** uncertainty about the extent of power and/or remit of other multiagency partners – for example the LA OOSS team could refer a concern or allegation, for example, of physical abuse to the LADO. The LADO only has a duty to manage allegations that meet their threshold (that are about a specific child and with evidence of certain seriousness). Those that do not should be managed internally. This raises

questions about the capacity of both OOSS coordinators and providers to this in terms of resource and the skills and capabilities to do so.

Formal mechanisms for recording and sharing concerns

Few LAs had developed formalised mechanisms for recording and sharing concerns about OOSS, and those that did were unsure about who this could legitimately be used and shared with, and how this could be maintained without further funding. Furthermore, feedback with national stakeholders shows that they hold information about some sectors of the OOSS market, but this is not necessarily shared outside of their organisations. For example, several sports bodies have their own systems for managing issues in providers, but it was not clear how or whether these were consistently fed into the LA.

Lack of clarity in referrals

LA staff reported that referrals about OOSS were often vague with reports such as “there seem to be a lot of cars dropping off children at this house” or “a child in school said his tutor upset him”. These therefore required a lot of investigation and evidence gathering, to see if there was any foundation to them. These reports also often had the potential of never reaching a clear threshold of requiring action, or resulting in resolution. It was not clear who within the LA had the role, capacity, or skills to carry this out effectively. It was also noted that without information on these concerns being recorded and collated, issues could be missed.

Support required from senior levels in LAs and stakeholders

Senior commitment to this work is necessary to engage multiagency partners locally and nationally, as well as make this a priority for staff and commit resource to it. This type and level of facilitation is required to support concerted efforts and joined up actions. This focus and joined up approach was seen as necessary not just at LA level but also national stakeholder and government level.

Lack of understanding about the sector among parents

LAs reported that parents were unaware that OOSS are unregulated or had assumed that someone assessed or was responsible for the safety of them. It was identified that this ‘gap’ exists nationally and that it may be addressed best by a national publicity campaign (which would also better inform providers and those in the community).

A potential requirement for regulation of the sector

Many LAs felt that some level of regulation of the sector, similar to schools, registered childcare providers and, increasingly, online services used by children, should also be brought in for OOSS. This would set out a requirement of basic standards to be met by

providers and a framework for someone (either LAs or a national body, such as Ofsted) to check provision and address concerns.

However, they also expressed concerns that this level of scrutiny may still not address safeguarding in all OOSS, as some may choose to operate outside of this framework. It could also risk OOSS closing if they cannot meet the standards, potentially reducing the range of provision available – especially those operating at low cost, which may be more accessible for disadvantaged families or communities.

Sustainability

All LAs indicated that they would not be able to sustain all of the activities undertaken in the pilot, or to the same extent, without continued funding and commitment to the pilot project. Some may look to integrate this work into existing roles but at a less intensive level. Most felt that they would try and carry on some of the work undertaken for the project by:

- continuing engagement of OOSS in the existing LA offer (such as inviting them to LADO training);
- maintaining a referral route, although it was unclear who would continue to respond to issues raised through this route;
- continuing to host provider network events;
- keeping all of the resources they had developed on their website (such as toolkits and good practice guides); and
- multi-agency teams continuing to have awareness of OOSS and safeguarding issues.

Wider stakeholders also felt that the project had identified a need for more work to be carried out in this area and had raised questions that still needed to be answered – at a local and national level.

Feedback from a small sample of non-pilot LAs showed that they were either doing no activity to monitor and oversee OOSS, or they had carried out some work similar to pilot LAs but on a much smaller scale. They reported facing the same issues and had also struggled to sustain work in this area beyond an initial push.

14. Pilot conclusions and next steps

Pilot LAs have learned a lot about the OOSS sector in their area. They've improved the processes to engage them and yielded improved relationships as a result, both with OOSS themselves and multi-agency partners.

However, the mechanisms employed and tested in the pilot which intended to provide better oversight of OOSS have not been without challenge or limitation.

Practical lessons can be learned to inform delivery in other areas considering employing a similar approach. The pilot also raises a range of strategic issues and questions that LAs, stakeholders and the DfE should explore further.

Due to lack of time and progress made during the pilot it was recommended that some work was continued beyond the main phase to try out suggestions made and give certain approaches more time to be developed. These areas for further development were tested in a small subset of providers and included:

- Training and accreditation schemes;
- Specific role for OOSS coordinator alongside the LADO;
- Investigating Section 11 of the Children's Act 2004 as a lever for engagement; and
- The Rights Respecting Schools Approach.

15. Pilot Extension

In March 2020, six local areas were given extension funding in order to further trial:

- Rights Respecting Schools awards for out-of-school settings;
- local authority accreditation award schemes for out-of-school settings;
- new child protection arrangements by encouraging out-of-school settings providers to provide auditing and referral tools; and
- funding an assistant LADO to focus specifically on child protection referrals about or relating to out-of-school settings.

These projects were evaluated between March 2020 and December 2021.

Overall feedback – unfortunate timing

The funding for these extensions was agreed just as the Covid-19 pandemic hit. This was followed by three national lockdowns in England, during which OOSS were not operating as normal or had had their activities curtailed due to government restrictions.

At the same time, staff in LAs were working from home, not allowed to be meeting people face-to-face and, in many cases, were redeployed onto other LA work (most notably safeguarding) to prioritise need to issues emerging from the pandemic.

The progress made by these projects was therefore necessarily limited. Despite a three-month extension of work until December 2021, there were only really 3-4 months when OOSS were operating normally during the funded period.

Additionally, findings from the first phase of the pilot were not published or shared with LAs and mechanisms for sharing lessons and information were not established by the DfE. The six LAs set up their own network and tried to meet regularly (remotely) over the period of the project. They found this beneficial.

The pandemic brought about changes to how OOSS operated. This proved to be a useful hook for OOSS to engage with the LAs. OOSS Officers in LAs often sent out information, to the contacts they had mapped in Phase 1, about what settings were or were not allowed to do throughout lockdowns, and advice on operating remotely. Enquiries to OOSS Officers often increased over this period. OOSS had questions about what was allowed and were seeking advice on remote operations and access to funding sources.

Mapping – existing and new settings

LAs identified that the pandemic had resulted in a huge churn of providers. Many providers who had been mapped in Phase 1 ceased to operate during the pandemic and shut down. Conversely, it became apparent that many new providers set up from Summer 2021.

For example:

- Area 1 had 850 contacts in Phase 1 and only 450 were still live in Phase 2
- Area 2 had mapped 1300 providers in Phase 1 but only 500 of those were still live in Phase 2.

LAs did not have the resource or the capability to re-map or add new providers and so they felt there were still large numbers of OOSS providers who they were unaware of and had no contact with.

One LA added questions on OOSS to the forms completed by their Elective Home Education families in order to map additional providers that this population were using. The LA found that this was difficult to ask of parents and did not result in quality or complete data that could assist in the mapping process. For example, parents may only have been willing to provide partial information, such as the type of OOSS, but not details of the owner or address.

In addition, providers who did remain functional were often reported to be preoccupied with maintaining their business and becoming operational after lockdowns, and in some cases dealing with increased demand. This meant that their capacity to engage with the LA (for example to attend networking events, take part in training, or complete paperwork) appeared to be further reduced.

Feedback on project strands

Rights Respecting Schools Award (RRSA) extension to OOSS

The RRSA scheme is managed by the charity UNICEF (details of the scheme outlined in Chapter 7 above 'Case studies of strategic levers'). Their work was severely disrupted during the pandemic as staff were furloughed, working from home and unable to be contacted, and not allowed to carry out visits or training. This resulted in the RRSA strand of work being severely hampered during the project extension.

The idea had been to develop the award to suit OOSS and encourage them to undertake the steps required to achieve the award. Very small numbers of OOSS were engaged in the award across the 3 LAs that trialled it. Those OOSS that had engaged generally only started at the lower award level – the Bronze. The Bronze level is the first stage of the award and is primarily a planning stage which requires setting out plans but not taking any particular action. Less than a handful of OOSS had progressed onto the second, Silver stage of the Award (that requires an assessment) and none had completed this stage in the funding period.

- Area 3 had 14 OOSS start on the Bronze level, with 7 completing; 4 started on the Silver level, but none completed in the project timescale.

The OOSS who participated were those already known to the LAs and selected as they

were most likely to be able to achieve the award.

Due to lack of progress and the available timescale, none of the LAs carrying out this project were able to say whether being part of the RRSA scheme improved practice or safeguarding in the participating OOSS over the duration of the project.

The effort involved from the LA appears to have been quite high, in terms of supporting OOSS, with very little reward.

In addition, LAs were not able to provide any evidence that increasing take up of the Award resulted in an increase in safeguarding referrals being made.

One LA was also looking to become a Rights Respecting City (i.e., to adopt the principles across their whole area) but progress with this again was slow. LA processes made getting agreement to participate and progress the idea difficult, and it was acknowledged that to get children's rights properly reflected in all local policies and departmental practices would be a very long-term undertaking.

Accreditation

Three LAs piloted accredited training programmes during the pilot extension period. Initial ambitions for the number of OOSS who would access these programmes and the levels of accreditation that would be developed had to be scaled back. There were also issues around delivering training during the pandemic. While one area set up a university delivered training course, the others created their own.

In these two areas the initial ambition was to refine and test both a Foundation and Higher-level award with OOSS that were not Supplementary schools (as they had already worked with these settings). However, it was only feasible to test a Foundation level award.

Overall, small numbers of OOSS were engaged:

- In area X – 10 OOSS started and completed the Foundation award. An additional 10 OOSS are waiting to start the Foundation Award.
- In area Z – 5 OOSS had started the Foundation award but had not completed it in the evaluation timeframe.

Those achieving the award receive a certificate that is valid for two years from the date of issue. There had been an intention for LA areas to cross check each others' providers. This was unable to take place, and there was less joined up working across areas than planned because of the pandemic.

In the area where OOSS had completed the award (i.e. area X), it was reported that these settings had: better safeguarding policies and practices; safer staffing and recruitment processes (e.g. with staff being DBS checked when they weren't before);

improved risk management practices (e.g. attendance registers and fire evacuation procedures) and improved governance. In the other two areas, the project leads were unable to say whether participating in the award scheme had led to better provision within participating OOSS because of the stage reached, or because the settings engaged already had some level of safeguarding practice in place. Moreover, the training coverage was relatively basic (getting staff DBS checked, writing safeguarding policies, planning actions to take) and so the impact is likely to have been small. In addition, only providers who were engaged and willing to be trained took part, and these were more likely to be those who already had basic safeguarding practices in place, or who were motivated to improve their practices.

There were thoughts that getting high profile providers to be accredited might lead to a snowballing effect on other OOSS signing up to the accreditation, but this was unproven during the pilot. Likewise LAs were unable to evidence that accreditation affected the choices or behaviours of parents.

Naming Relevant Agencies

Working Together to safeguard Children[12] states that "Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children". We have included the detail it sets out around OOSS.

> It sets out that *"Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children…The safeguarding partners should set out in their published arrangements which organisations and agencies they will be working with to safeguard and promote the welfare of children, and this will be expected to change over time if the local arrangements are to work effectively for children and families.*
>
> *When selected by the safeguarding partners to be part of the local safeguarding arrangements, relevant agencies must act in accordance with the arrangements. Safeguarding partners should make sure the relevant agencies are aware of the expectations placed on them by the new arrangements. They should consult relevant agencies in developing the safeguarding arrangements to make sure the expectations take account of an agency's structure and statutory obligations*".

One LA therefore named all of the OOSS they had mapped during the pilot phase as "Relevant Agencies" on their local safeguarding plan. The LA then notified all of the

---

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

OOSS providers and explained how this placed certain expectations on them with regards to safeguarding. The LA offered OOSS support to comply with the requirements and sent them their local Safeguarding Audit tool to complete, but very few (less than 10) did. The LA sought advice from their legal team on what powers they had to enforce compliance and engagement from OOSS and were told there were not any.

The LA felt they were, therefore, left only with the option of informing OOSS in their area about the need for effective safeguarding practices as much as possible.

They developed a portal with guides to practice and expectations around provision. However, again, when they came to release this their legal team was concerned that there was no legal status or powers to require, or enforce, such expectations; and as DfE were unable to issue set guidance, the LA would be too exposed to do so.

Instead, they set up an App which directed providers and parents to information about the voluntary code and guidance around safeguarding for professionals.

Employing an Assistant LADO

One area decided to employ a member of staff not as an OOSS Officer (who in other areas tended to be based in Education Welfare teams) but as an Assistant LADO within the Safeguarding team. Their role was to identify referrals coming through to the LADO that concerned OOSS. Due to recruitment and contractual issues this post was only able to be filled in June 2021 (allowing 6 months to pilot).

The Assistant LADO had experience and knowledge of safeguarding but did not have a social work qualification. The Assistant LADO contacted all of the previously mapped and newly identified OOSS in the LA area and reached out to wider stakeholders. They positioned themselves as a ‘one stop shop’ within the LA for all OOSS enquiries and advice (such as planning issues, food hygiene, national guidance and safeguarding queries). They felt that being based in the LADO team made their role clear.

All referrals received to the LADO that could be classed as related to OOSS were discussed between the LADO and Assistant LADO. Those that met threshold were led by the LADO with the Assistant LADO monitoring and keeping on top of progress and keeping the process going. Support was also offered to the OOSS during the process to address issues of concern.

Referrals that did not meet threshold were followed up by the Assistant LADO contacting the OOSS, setting out what they could offer them in terms of support and guidance and arranging a visit. These offers were frequently taken up by providers.

In terms of scale, this borough is a mid-size London borough with a population of around 250,000. In 2019, the LADO received 4 referrals concerning OOSS and 2 in 2020. However, since the Assistant LADO has been in post (a six-month period), contacted providers and raised the profile of their post, work and processes, there have been

around 30 referrals to the LADO concerning OOSS.

One third of these referrals met LADO threshold. These included issues around historical sex abuse, emotional abuse and neglect.

The other two thirds concerned issues such as physical chastisement and inappropriate adult involvement. For example, one case involved a father of a child attending an OOSS making contact through social media with other children he had met at the OOSS. The Assistant LADO was able to advise the provider what steps they should take to address this and to prevent further similar issues arising in the future. The Assistant LADO feels strongly that in all these cases the LA was enabled to carry out essential preventative measures by early engagement with providers of potential concern.

"It is like the Early Help service for the MASH. Intervening to prevent harm." (Assistant LADO)

LADO Referrals

We asked other areas participating in the extension phase for comparable data on LADO referrals. In four areas the OOSS officer was unable to gather the data. This was because:

a) the LADO believed they could not share such information with the LA OOSS team. This reflects an issue identified in that the LA OOSS teams could not establish productive working relationships with their local LADO, or a view that the Working Together document suggests limiting LADO's sharing information.

b) LADO referrals were not categorised in a way that allowed OOSS related issues to be collated. LA OOSS teams in these areas spoke about how frustrating it was that the LA systems were not, and in several cases apparently could not, be set up to allow this information to be collected.

However, in one other area the LA OOSS team had established regular meetings with their LADO to discuss referrals concerning OOSS. This LA also reported an increase in referrals concerning OOSS. In 2020, there had been 6 relevant referrals. Across 12 months in 2021 (when they started working more closely) this increased to 23. Of these four met LADO thresholds and 19 did not. The overwhelming majority of all cases related to physical chastisement, with the remainder being Health and Safety issues (often in private dwellings). Prior to this pilot activity the LADO would not have recorded that an allegation was related to an OOSS and if it had not met threshold then no action would have been taken. Now any referrals are followed up by a visit to the OOSS and the LA working with them to address issues raised, review safeguarding and practices and try to change the organisation's approach.

All the participating sites identified that referrals through to the LADO are dependent on:

- People understanding what safeguarding concerns are
- The culture of raising concerns
- Being aware of the process for raising concerns

Therefore, they all felt that issues reaching LADO referrals would only be the very tip of the iceberg. They also identified that, by the time concerns have been raised, harm may well have already been done. LAs all would have preferred the ability to take preventative actions to address safeguarding in OOSS.

These findings show that having an Assistant LADO role clearly increased referrals regarding OOSS, helping to identify OOSS that may be of concern. This allowed resource to be focused on taking action with OOSS experiencing issues, preventing further or worse issues occurring.

When there was a structure established in an LA for joint working between OOSS and LADO staff, and work to raise the profile of safeguarding issues had been carried out, numbers of referrals also increased, although to a lesser extent.

Whilst the data collected for this evaluation is limited it does illustrate that without attention being drawn to OOSS through this pilot project a number of issues would have been missed, along with the chance to potentially prevent further harm. Also, in order to identify such issues and take preventative action there is a need for someone to be working alongside the LADO for whom this is a focus.

Legal Powers

In this extension phase of the pilot very little follow up work was carried out specifically regarding testing the extent of legal powers to disrupt providers. Similar issues were identified to in the first phase – that:

- LA colleagues are not clear on their role, remit or regulations regarding OOSS and that this is not an issue of priority for them (as they have no specific requirement or resourcing). This often means collaboration within LA departments is not possible.
- the LADO referral route means issues have already occurred and the threshold for them taking action is very high (with many barriers to addressing issues or disrupting provision)
- the legal status of OOSS is unclear and blurred across various remits (for example when/if the Charity Commission can act; when/if anyone can require an OOSS to cease operating; whether anyone has the right of entry, especially in relation to private dwellings). This means it is difficult to navigate what powers can be used, how and when. It means LAs are having to manoeuvre action around powers that are not specific to the issues they are trying to redress (as outlined in section ‘Summary: issues around disrupting providers’ on p34)
- the time taken for other organisations to respond to LA calls for collaboration (e.g. Charity Commission) can take too long.

- whilst health and safety and planning powers can be useful to help to close an organisation, this does not necessarily solve the issue/concerns raised e.g. the initial concern may not specifically have been about site safety and a setting could close to then reopen somewhere else.
- there are no legal powers to require OOSS to work with the LA, submit any information to the LA, or to comply with safeguarding regulations.

Summary of Phase 2 pilot findings

Participants in this round expressed a frustration at the little progress they had been able to make during this phase. Although they fulfilled the tasks they had been funded for, this was often much reduced, and had led to little evidence-based impact.

It is clear from the findings that the level of input of effort and resource has in general resulted in very small gains.

LAs were still experiencing all of the barriers identified in the first round – no legal power to act; limited knowledge of what OOSS there are in the area, due to there being no requirement for registration; no compulsion for providers to work with the LA, only being able to access those engaged; only able to address basic safeguarding practice (such as ensuring DBS of staff), and still a lack of understanding or importance given to this issue by wider stakeholders, including their own LA.

OOSS staff have become highly aware during this project of the scale of the issue OOSS present in terms of safeguarding, the enormity of the task of monitoring provision within a local area, without any registration systems or statutory obligations, clear and specific legal powers, and the potential scale of harm that could be going unnoticed and unaddressed.

They had concerns that having identified these issues and set up basic processes and methods of communication to address these locally, the lack of further funding meant that this work would now be quickly undone. Only one LA OOSS team had secured any LA funding for short-term continuation of their role, albeit as part of their wider role. LA staff felt that having identified that issues of concern are being identified in these settings, and having set up a way of addressing these, the expectation they have set out can no longer be fulfilled. Similarly, while the Code for OOSS remains voluntary only and there are no statutory powers that govern even basic safeguarding in OOSS, the potential for children to be harmed remains. They identify that this seems at odds with the governance of schools, Ofsted registered childcare providers, chaperones, and even online activities. These issues were set out in the IICSA report, but there appears to be no Departmental or LA interest in addressing them.

“This will be like sexual exploitation was 15 years ago. What are we waiting for? IICSA identified risks exist. It needs action now otherwise we’ll all be called to give evidence at IICSA 2” (OOSS Officer)

Extension project conclusion

Our overall view is that the pilot and extension activities did not provide a solution to the issue the DfE was looking to address – for LAs to identify OOSS in their areas and to intervene in those where there are safeguarding concerns, using the existing powers available to them. The pilot shows that the existing system does not easily or effectively help LAs to do this. It has also evidenced that there are safeguarding concerns in OOSS that would have been missed had it not been for pilot activity. Whilst the data is far too limited to make any estimation of scale nationally, the issues raised by the pilot suggest that the government should take more action to improve safeguarding in OOSS since the number of children who attend them and therefore who are at potential risk, is high.

16. Overarching Conclusions

When this project started, DfE and LAs had limited insight into how challenging mapping and engaging with the OOSS sector in local areas would be.

There was also a lack of awareness around whether basic safeguarding was in place in OOSS and the challenges of implementing that and working in a multi-agency manner to address concerns would present.

On paper (including from the 2018 LA guidance on unregistered schools and OOSS[13]) it looked like there were multiple legal powers available to ensure safety in this sector, but there was little understanding of the complications of operating these powers; how disparately they were held by different agencies; and what implementing them actually involved.

Therefore the objectives of what to 'pilot' in this space were not pitched correctly. The pilot approach assumed the sector was further down the road than it actually was – both in terms of how engaged LAs were with OOSS providers and the level of safeguarding in place across the OOSS sector.

This pilot has instead identified some key issues around safeguarding in the OOSS sector:

- OOSS (from tutors to sports clubs; tuition centres to arts and drama groups; youth organisations to afterschool clubs) have no obligation to notify anyone of their existence. This means that every day of the week millions of children attend activities that have no mandatory compulsion to be checked, have no requirements for basic safety standards to be in place, nor are regulated by a government or regulatory agency.

- OOSS have no compulsory obligations with regards to their safe practice. Although some providers will choose to put checks and safeguarding policies in place, there is no national requirement to prove children in their care are at no risk, staff do not have to be DBS checked, and they don't have to have basic first aid knowledge in order to run their business. There is therefore no way for LAs, or LA OOSS teams where they exist, to check if providers have any of these practices in place or to require them to do so.

13 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/690495/La_Guidance_March_2018.pdf

- The capacity of agencies and local authority teams who are set up to deal with safeguarding issues (such as the LADO or police) is limited, evidence thresholds for raising concerns in OOSS are high and there is a lack of clear legal accountability – including no nominated person within an LA with responsibility for OOSS specifically. This lack of accountability for OOSS within LAs means that issues raised (including those that are not taken further) are not consistently recorded and monitored. This all results in these settings being more susceptible to abuse.

- There are limited, disparate and poorly understood powers for anyone to get entry to OOSS premises, especially if they take place in a private dwelling. This means that unless very specific circumstances are satisfied (for example, the home is registered as a business premises; evidence of fire or health and safety standards has been provided) it is very difficult for anyone to intervene.

- The DfE OOSS Safeguarding Code of Practice is voluntary and very few providers or parents are aware of its existence. It therefore only impacts those who are proactive and engaged and is unlikely to shift the behaviour and practice of those who want to remain under the radar, which are the settings of highest concern.

- From their work with parents, LAs identified that there is a common misconception that the OOSS sector is regulated and that there are similar levels of oversight in place as there are with other educational and childcare providers. It was reported that some parents also said they would have concerns about what questions to ask of providers to ensure they were safe, or how to raise concerns about them.

The wide variety and diversity of OOSS, lack of legal powers that can easily be applied to cover them all and the lack of consistent standards and oversight means that it is not clear who has responsibility for making sure providers are keeping children safe in these settings. These limited powers, inability to access settings to gain information and investigate concerns means that ensuring safeguarding in the sector is time and resource intensive. Many LAs do not have dedicated teams with responsibility for this and other departments and agencies are at capacity and have other priorities. There is a danger that concerns about OOSS are being lost and issues are not being dealt with, let alone prevented.

There is little joined-up thinking and no consistent, mandatory national guidelines on what safe provision looks like in these settings. Larger OOSS organisations seem to want to deal with safeguarding ‘in house’ but, as seen in the Sheldon Review of child abuse within the Football Association[14], it has been shown that there are barriers to them acting

[14] https://www.thefa.com/about-football-association/sheldon-review

on concerns raised and there can be 'a reluctance to recognise it'. It is unclear how effective these internal systems can be and how they can or should feed into the wider knowledge base.

In addition to findings from this project, issues with safeguarding in various OOSS have become increasingly known about, including high profile cases within the Football Association, gymnastics clubs and Church providers[15]. This project has identified that all these factors are resulting in a lack of preventative work around child safeguarding. Instead issues are only dealt with once the harm has been done. Even at that point it is not clear who is or should be accountable.

Recommendations

Through this evaluation we worked closely with 16 LAs and wider stakeholders over an extended period. The suggestions they made for how DfE should consider addressing these issues were clear:

- Consider aligning safety in OOSS to existing practice in schools, childcare and other services for children.
- Explore making all OOSS providers register with the LA or an appropriate agency with oversight responsibilities, as is the case with childcare[16] providers and others who work closely with children, such as chaperones[17]. This could be a resource intensive system, but necessary in order to keep children safe. It would differ from the register proposed in 2015[18], in that the register would be held within the LA, and the LA would be responsible for knowing who was providing OOSS and would be able to check basic safeguarding procedures, such as DBS checks, were in

[15] See for example:
The FA (https://www.theguardian.com/football/2021/mar/17/football-sexual-abuse-report-scandal-sheldon-fa); Catholic church (https://www.bbc.co.uk/news/world-44209971); The Scouts (https://www.telegraph.co.uk/news/2021/07/25/250-scout-leaders-have-convicted-child-sexual-abuse/); Gymnastics (https://www.bbc.co.uk/sport/gymnastics/56203877); Tutors/instructors (https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-58802111; https://www.bbc.co.uk/news/uk-england-manchester-11143918); African church (https://www.standard.co.uk/news/london/torture-of-african-children-for-being-witches-is-spreading-7880442.html); Private tutors (https://www.dailymail.co.uk/news/article-9173983/Private-tutors-charged-sex-offences-continuing-work-bail.html); Tuition centres (https://www.mylondon.news/news/west-london-news/illegal-brent-school-masquerading-tuition-17878886; https://schoolsweek.co.uk/illegal-schools-have-drills-to-avoid-scrutiny-says-ofsted-director/); IICCSA (https://www.iicsa.org.uk/reports-recommendations/publications/investigation/cp-religious-organisations-settings/part-h-conclusions-and-recommendations/h1-conclusions)

[16] https://www.gov.uk/guidance/apply-to-register-your-nursery-or-other-daycare-organisation-eyo

[17] https://www.legislation.gov.uk/uksi/2014/3309/regulation/15/made

[18] https://www.gov.uk/government/consultations/out-of-school-education-settings-registration-and-inspection?msclkid=18072d0fcd4a11ecb44eb4b1099a41be

place (as opposed to checking the content of teaching or activities being delivered).

- Investigate making all OOSS comply with basic (and repeated) safeguarding checks – DBS, first aid, health & safety, safeguarding policies, etc.

- Consider increasing capacity in LAs and designating them as responsible for supporting and overseeing that OOSS are safe – to ensure safeguarding requirements are being met, take preventative action, and investigate and record issues that do not meet LADO threshold. This could either be through increased LADO capacity or with a designated role for OOSS responsibility within LAs.

- Clarify guidance and applicability of 'Working together to safeguard children' to make regulations apply to OOSS. Review further legislation to enforce compliance with safeguarding practice, to record individuals in breach of this (for example through the DBS system, which may then prevent them operating) and to close down OOSS who are not compliant.

- Set up clear routes to enable the notification of issues of concern in OOSS, identifying them as such (for monitoring purposes) and escalating them effectively – from LADO level to local MASH teams and through to senior LA Departments.

- Improve and effectively disseminate information for parents on using only 'safe' providers.

This is such a competitive, lucrative sector that providers are likely to make the effort to comply as it is in their interest, especially if parents' awareness is increased and they start to ask questions about the safety of the settings they use.

It was beyond scope of this project, but we suggest that the next step with this work is to consider the recommendations above, their enforceability and potential impact along with a cost-benefit analysis of their implementation.

Annex A: Department for Education Multi-Agency Pilot Scheme - Safeguarding Risks Identified

As part of the department's multi-agency pilot scheme, the out-of-school settings (OOSS) policy team asked each of the participating 16 LAs to record safeguarding risks occurring in OOSS that they became aware of during the pilot period.

The following data below focuses on the risks that LAs identified during the period of the pilot: Autumn 2018 – March 2020. Pilot LAs did also note down 94 additional examples of historic risk (i.e. pre pilot). These data were provided to the department rather than to ASK Research as part of the evaluation so are included as an annex.

The below tables showcase the types of risk identified (grouped by the DfE policy team) and the settings where risk occurred.

Type of Risk

Physical Chastisement / Corporal Punishment	26
Grooming / Sexual Abuse / Child Exploitation	16
Health & Safety / General Safeguarding Concerns	13
Extremism / Radicalisation	13
General Safeguarding Concern	8
Lack of safeguarding to young people/ appropriate boundaries	7
Inadequate staff training / Lack of safeguarding awareness	5
Suspected unregistered school	4
Emotional abuse	3
Fire Risk	2
Unregistered school	1
Historical Child Sexual Abuse	1
Child protection concerns	1
Total	**100**

The type of settings where risks were identified?

(To note, this data will be biased and cannot be treated as an accurate reflection of the settings of most risk, due to some local authorities choosing to focus on certain types of providers, e.g. religious or tuition settings, whereas others took less targeted approaches)

Extracurricular clubs or activities - e.g. Football, Tennis, Gymnastics, Dance	27
Religious setting - e.g. Madrassah, Sunday School, Yeshiva	26
Tuition centre / Supplementary School	18
Private / Home Tutor	14
Other	4
Unregistered school	3
Uniformed Youth Organisation - e.g. Scouts, Guides	2
After School Club	2
Language classes	2
Youth Club	1
Holiday Club	1
Total	**100**

The LAs reported to the department that they became aware of these risks through a multitude of ways, including through planning and enforcement, health and safety teams, the pilot out-of-school setting coordinator, Social Services or through the Police. The main form of notification was through the local authority LADO, where schools, membership organisations, members of the public alerted the LA to a specific risk in OOSS.

All of these risks were examined and reacted to, some escalated to other agencies such as Ofsted or the Police, whilst others did not meet thresholds or lacked evidence to warrant action.

Department for Education

About this publication:

enquiries www.education.gov.uk/contactus

download www.gov.uk/government/publications

Reference: RR1269

ISBN: 978-1-83870-413-1

Follow us on Twitter: @educationgovuk

Like us on Facebook: facebook.com/educationgovuk