Leicestershire County Council

LLR ASB Case Management Review

Examining the consistency of ASB case management across the sub-region

Rik Basra
June 2016

LLR ASB Case Management Review

Executive Summary

1. Background and Methodology:

1.1 The management of anti- social behaviour (ASB) across a multi-agency environment brings many challenges. In recent times additional factors have come to bear, each with the potential to impact service delivery, these include:

- An ongoing trend of reducing reports of ASB nationally and locally
- Major legislative updates, including a revamped ASB practitioner 'toolkit'
- Organisational and infrastructure changes amongst partners
- Austerity and the ongoing savings agenda
- The impact of inter and intra-agency conventions and working practices
- Statistical ASB trends and service user feedback

In this context a review was commissioned to evaluate the consistency of ASB case management across the sub-region, examining common threats/risks and opportunities.

2. Summary of Findings

2.1 ASB practitioners are undeniably knowledgeable, passionate and committed in their role. However, the review has highlighted potential areas for development. Headlines are listed below with a more detailed commentary and examples within the body of the main report; the observations by no means apply universally, some elements bear more relevance to a locality than others and the report should be read with this in mind.

2.2 *Local arrangements for taking reports and a potential procedural delay in risk assessment:*

An early risk assessment triggers enhanced supervision and bespoke case management. The most expeditious and effective risk assessments are those undertaken directly by practitioners. In many cases however there was an inherent delay in the risk assessment process, chiefly as consequence of locally adopted reporting arrangements such as the use of call centres. Investigation regarding the merits of such arrangements was not within the scope of this review; however effective strategies to mitigate the risk are readily available yet surprisingly remain largely un-adopted. Solutions include the use of supporting scripts to instil consistency and induction training to attain a level of awareness regarding relevant questioning amongst generalist call-takers.

More involved solutions take in the direct imputing of reports as well as technical solutions to map across data to Sentinel from call taking databases. Whereas the latter are aspirational solutions necessitating development the former are very much low cost readily deployable solutions which would significantly improve reports and better support victims/callers.

2.3 The victims reporting experience, a potential gap:

Written material serves to reinforce verbal advice and sets 'customer' expectations, generally victims/callers for service received little in the way of supporting literature. Understandably cost was cited as justification for the lack of provision; the option for digital versions is a partial solution, accepting of course that not all sections of the community will be able to access information in this format. Accessibility will improve as the proportion of the population comfortable with technology inevitably grows over time. Electronic support literature has the advantage of being more cost effective to produce, allows easier update and distribution and given emerging communities multiple language versions can be produced at relatively low cost.

2.4 Keeping victims apprised of case progress:

Unsurprisingly practitioners agreed that victims should be kept informed of case progress. In reality however there was little in the way of a coherent set of standards for doing so. The victim care package on Sentinel provides a technical aid to practitioners but appears largely unused a situation that highlights a secondary issue regarding adequate supervision of cases. A concerted effort to raise awareness regarding the care package together with accompanying supervisory oversight and compliance checking is a ready solution in an area that profoundly impacts victim satisfaction.

Additionally, there may also be value in adopting some of the principles within the 'victim's code'. The 'code' is mandatory for criminal justice (CJ) partners; there would be value in a similar vein to incorporate sub-regionally agreed obligatory timeframes for victim updates at key points in the life of a case. There may also be scope to provide a technical solution, 'intelligent triggers' to support compliance in the form of flags to remind case workers of overdue contacts as well as supervisory alerts.

2.5 The Incremental Approach but only up to a point:

Practitioners outlined a clear commitment to the principles underpinning the Incremental Approach; however a closer examination of outcomes revealed a skewed implementation across the sub-region. There was a strong use of non-legal interventions, however with some notable exceptions there appeared to be a reluctance to proactively utilise legal remedies. This has clear implications for the consistency of decision making, outcomes for victims and sanctions for perpetrators

across the sub-region. The reason for the failure was difficult to discern, the tactics may of course have been entirely appropriate, it may be due to a lack of confidence, problematic implementation of the ASB toolkit, lack of resources, cost or indeed a combination of factors.

Further training and logistical support are obvious solutions but these are not resolutions in themselves. Across the sub-region there was feedback from practitioners that they felt isolated and in effect left to interpret and implement the ASB toolkit locally. It seems at the very least inefficient that a major piece of legislation has been implemented piecemeal when it actually affects all. The reconfigured ASB Delivery Group provides a timely and opportune forum for practitioners to address this and other important issues. The aim should be to mutually support practitioners to utilise the incremental approach fully based on the circumstances of the case rather than other considerations.

2.6 Problems with local ASB toolkit process design and implementation:

Developing the above theme, the ASB Crime and Policing Act 2014 brought about a wholesale update of the ASB toolkit. Unlike previous legislative rollouts, deployment was very much left to local design and implementation. 'Responsible bodies' were left to create their own bureaucracy and processes, in many cases the resultant lag in administrative support has stifled utilisation of the full range of options present in the ASB toolkit. Anecdotally there have been instances of practitioners hunting for documentation or having to design process from scratch which may have delayed or even stifled use of a particular power.

With hindsight it would have made sense to undertake a collective design process in partnership with the production of a single version of common documentation. That said this process can still be undertaken retrospectively to help remedy the situation. The latest update of Sentinel V2.8 will introduce folders and a document/template library and there is no reason why a full suite of documentation cannot be collated, agreed and put on the system for all to use.

2.7 The threat from internal silo working:

A major driver for a single case management system was the desire to gain greater local visibility of circumstances relevant to an individual or locality. However, ASB is cross-cutting and can be dealt with by many specialists including internal experts and/or departments. Case primacy can depend on how internal services are configured, community safety, environmental health, housing, street cleansing etc. Such cases have the potential to bypass scrutiny by community safety specialists. Partners need to ensure a way is found to ensure relevant cases recorded and managed on disparate internal systems and by specialists are highlighted to

community safety practitioners and vice versa, giving case managers the best information upon which to base decision making and actions.

2.8 That said, in general, community safety practitioners appeared comfortable with their current internal information sharing arrangements; some partners benefited from technical support with search engines such as 'Genie' (Police) or 'Enterprise' (Leicester City Council) to aid data aggregation. Others, particularly those dealing with lower incident numbers, relied on ad-hoc arrangements with internal colleagues. Such arrangements may be entirely proportionate, however, accepting incident numbers and resources there may be value as a minimum in formalising internal protocol's to ensure information is not missed or ignored. It seems risky to say the least to rely on ad-hoc arrangements with colleagues who may be absent or simply fail to disclose at a critical point in the life of a case.

2.9 The threat from non-participant stakeholders:
Taking the above principle further, the ASB Crime and Policing Act 2014 brought in some supplementary powers and responsibilities for a number of additional stakeholders. Perhaps the most notable of these being registered social landlords (RSL's) a sector that has seen recent wholesale growth. However, with one or two notable exceptions, ASB dealt with by RSLs runs the danger of remaining largely hidden unless the relevant RSL wishes otherwise. There are some RSLs attending JAGs although even in these cases there appears to be little in the way of formalised protocols to escalate, appraise and advise on cases. This does not mean of course that appropriate cases are not being disclosed; however there is no defensible process to hold such key stakeholders to account. Given the growth in this sector this issue requires attention.

2.10 Sentinel, a partnership system, requiring proactive commitment and support:
The original driver for the introduction of a single cross-partner case management system was to engender greater incident visibility, in-turn supporting more informed responsive evidence based decision making. Sentinel was the system 'chosen' to undertake this vital role. The circumstances of system selection is not within the scope of this review or indeed relevant.

2.11 User Feedback reveals a number of issues; some based in fact, some anecdotal, each however if left unaddressed have equal potential to undermine the credibility of the system:

i) Image/reputation: some users held the view that Sentinel was functionally a poor system, however when asked many were unable or unwilling to

elaborate or spoke of historical issues that had been remedied in subsequent versions of the system.

ii) There was amongst some an unsubstantiated supposition that Sentinel would either be imminently replaced or abandoned, in part this belief may have been fuelled by the relatively recent loss of the Sentinel Coordinator.

iii) Further feedback included a sense of frustration with some users feeling they were unable to influence system development and/or a belief that this would be inordinately slow.

iv) Steps need to be taken to recover system reputation with a transparent accessible process to address legitimate issues/concerns/gaps in knowledge; there needs to be an effective means not only to communicate developments in usability but also to proactively address negative anecdotal rhetoric.

v) Feedback: Potential solutions must offer the opportunity for users to easily post concerns (anonymously if required) mirrored by a timely transparent response for all to see. This may take the form of:

- An ongoing programme of user training and development
- Identified local system administrators to act as system champions and source for advice and direction
- A 'suggestion box' and/or a 'question and answer section' or blog on the system for users to 'air' issues
- A 'how to' section on the system to take users through typical functions and tasks or indeed refresh knowledge regarding seldom used or more advanced tasks such as 'back-end' searches.

There are help files on the system but these may benefit from re-launch, update and/or revamp.

2.12 *System administration and functionality:* Sentinel is not a fully automated system and from time to time physical intervention is required to ensure smooth running, examples include:

- System administration, ensuring smooth running such as addressing user password issues or access levels etc.
- System governance and coordination; garner partnership agreement for system configuration changes and address conflicts and competing agendas.
- Managing the deployment/implementation of system changes
- Coordination of system snagging and development

- Providing a single point to address knowledge gaps, training and development amongst system users

Historically the Partnership collectively funded a Sentinel administrator to undertake the above; the post-holder built up considerable expertise and the scope of responsibilities expanded over time.

2.13 The loss of a Sentinel administrator resulted in the loss of coordination. The reasons for the lack of succession planning for the role is not within the scope of this review, however, in the medium to long term processes and procedures must be developed to supplant the administrative responsibilities detailed above.

There are a number of possible options; an obvious solution could make use of enhanced Sentinel users to undertake the administrator role locally and this is currently being worked through by the ASB Delivery Group.

2.14 *System Development:* Sentinel is subject to ongoing development, such requests can emanate from a number of sources; it is absolutely vital that practitioners have an input and help decision makers filter and prioritise proposed enhancements such as the proposal to include/update intelligent triggers on the system. Previously this scrutiny occurred within the 'Sentinel User Group' (SUG) a now obsolete entity.

Moving to the present; practitioners now attend The ASB Delivery Group, this provides the most pragmatic solution to reinstate the SUG function and incorporate it as a standing item within the ASB Delivery Group meeting agenda.

2.15 *Training and System Use*: User confidence and competence showed extreme variance and unsurprisingly the demand for further training was universally advocated amongst users. However, past approaches to this important area reveals a rather incoherent picture. To add clarity and aid prioritisation a logical next step would be to undertake a training needs analysis to properly scope the training requirement. Failure to do so runs the danger of undertaking inputs that fail to address the true training requirement.
Anecdotally practitioner feedback outlines a plea that training should be based on user function rather than a 'one size fits all' approach. A suggested training continuum as a minimum should cover:

- Basic User - training must be task focused with attention to basic system functionality, giving training on advanced functionality is wasted and more likely to confuse.
- Enhanced User – additionally covering administration and interrogation of the system.

- System user support; readily accessible, up to date step by step "How to" help files designed to support occasional users who may wish to refresh knowledge.
- The above may be supported by 'you tube' style screencasts covering system functions.

2.16 Practitioner feedback suggested a feeling that system development was developer led and to some degree past incremental system development had focussed on acceptance of offered enhancements rather than the development of user led requirements. Whether a perception or a reality this is of course unacceptable, the system clearly needs to service practitioners and a transparent practitioner led development process is vital.

Next Steps & Recommendations:

3. A multi-faceted approach is required to deal with the issues outlined, in addition to some of the possible solutions referenced above utilising a combination of the following tactics may also help:

3.1 *Mentoring:*
Some local authorities have more experience in certain areas, they may have already undertaken particular tactics, for example undertaking applications for a civil injunction or a closure order. Having built up this expertise it would make sense to share it in a reciprocal arrangement with less experienced colleagues in other authorities.

3.2 *Formalised Partnership:*
Acting as mentor to any number of partners may appear too onerous especially for smaller teams, there may be scope as has already happened in some localities for a less burdensome formalised partnership arrangement.

3.3 *More effective meetings/practitioner forum's:*
ASB practitioners attend meetings regularly, interacting with fellow specialists; the ASB Delivery Group is an example. Examination of past agendas reveals what appeared a skewed focus on planning for future campaigns and work-streams. There is real scope to better utilise these gatherings to focus on problem solving, acting as a forum to share issues and solutions amongst peers. This change in focus is beginning to happen, such practise is identifying issues and engendering solutions or resource provision for mutual support.

3.4 *Joint commissioning and purchasing of services:*
Contracting legal services is an obvious example; greater workloads and buying power potentially may result in better rates together with an opportunity to pool and enhance expertise amongst lawyers and in-turn outcomes. It is accepted that there are political as well as practical considerations but even in these circumstances there may be scope to partner with any number of other LA's with real benefits to those less well resourced.

3.5 *Joint working groups:*
Guarding against 'reinventing the wheel' to work together to solution issues that communally impact all. For example, it seems at the very least inefficient to design and draw-up individual documentation for a bureaucracy that is common to all.

3.6 *Utilising joint infrastructure more effectively:*
For example Sentinel is a common system and achieving a common standard would be more easily achieved if practitioners realised its full potential. For example, there may be scope to utilise it as a common repository for documentation and stationary and promote a single version of the ASB documentation. Sentinel developments should soon incorporate a folder structure which can be utilised for the purposes described.

3.7 *Better use of what we already have:*
The victim care package is an example; there seems little value in having a wish list of system enhancements for Sentinel, undertaking (and paying) for development to then fail to support deployment with an effective training/awareness programme and communication plan.

3.8 *Revamped and updated protocols:*
This does not necessarily require a rewrite of all procedures and associated documentation but at the very least a revisit to ensure they remain relevant and are cognisant of the revised toolkit. The Incremental Approach and JAG Terms of Reference are two obvious examples.

3.9 *Training and system user support:*
Undertaking a training needs analysis to better understand the user requirement is needed followed by rollout of tiered training reinforced by user development support materials.

4. Conclusion:

4.1 The recommendations are not exhaustive but intended as a starting point to prompt discussion, engender strategic decision making and support tactical delivery across a

range of key business processes. The ASB Delivery Group is the obvious coordinating body for work-streams with larger pieces of work assigned to working groups.

4.2 Many of the remedial work-streams require collaborative working and clearly the potential benefits to some partners will be greater than others. Ultimately there will be collective benefits for all but perhaps more importantly a better service for victims.

The LLR ASB Case Management Review.

1. Background & Purpose…

Anti-social behaviour (ASB) can profoundly impact quality of life for many and disproportionately effects the most vulnerable; in response our ongoing efforts to mitigate its effects are unrelenting. There have however been a number of recent developments in the 'world of ASB' which have the potential to directly or indirectly impact service delivery.

These changes/developments are continuously evolving but most notably include…

- *Major legislative updates*: most recently the ASB Crime and Policing Act 2014: this introduced wholesale changes to the 'toolkit' available to ASB practitioners. Unlike previous more prescriptive legislative rollouts the current ethos has been to permit local implementation. The design, embedding of new processes and procedures has implications, not least consistency across the sub-region and partners.
- *Organisational and infrastructure changes*: these include key partners and service providers, Leicestershire Police, CPS, and victim services amongst many undertaking reorganisation. The catalyst may be a bid to gain efficiencies or commission new services, either way the resultant change in equilibrium has implications, staff churn and potential loss of expertise for example pose significant challenges.
- *Austerity and the savings agenda*: diminishing budgets have the real potential to impact service provision and directly affect the capacity to effectively case manage ASB. Issues can take many forms including reductions and/or redeployment of staff or reduced or realigned resources and capability for example with regards to enforcement and the ability to finance and therefore offer positive requirements.
- *Statistical trends and victim/service user feedback*: Statistically speaking reported ASB has shown a sustained downward trend, this may of course be due to positive remedial action and/or changing behaviours. Assurance is required regarding the factors contributing to the reductions such as a shift in recording practice or at the very least some reassurance that the reductions are not contrived.
- *Inter and Intra-agency convention*s: there are of course many inter-agency matters affecting ASB case management…data sharing, the governance and operation of the Sentinel case management system etc. Intra-agency issues are often overlooked, internal organisational structures and dynamics can define who deals with the ASB and indeed which system is used to record it. The protocols in place (or lack of them) for aggregating this data are a potential threat in the context of case and risk management.

In response to these multi-faceted issues a review has been commissioned. It aims to identify examine and assess sub-regional practice in regards to ASB case management.

2. A Caveat…

The delivery of services will inevitably differ across partners, justification invariably being based on a requirement to cater for particular local circumstances and needs or indeed the availability of resources and infrastructure.

Accepting this context the review is not intended as a detailed critical inspection of specific local practice and procedure. Indeed some of the observations contained in this report may not wholly apply to the reader's organisation; this is unavoidable without bespoke site specific analysis. Rather this review is an assessment of overarching principles utilised in ASB case management and aims to…

- Identify common threats, risks and opportunities across key business areas across the sub-region.
- Provide some assurance that service delivery achieves an acceptable level of consistency across the sub-region and where it does not highlight the issues.
- Highlight areas requiring further work and form a basis for stakeholder scoping and discussion.

3. Methodology…

Information/evidence was gathered across broad themes using a number of methods…

- Site visits and face to face discussions with practitioners.
- Completion of a self-assessment by service providers, this took the form of a pro-forma template with an outline of key themes
- Observations/interviews with users and practitioners
- Assessment of current practice, procedure, protocols, documentation and infrastructure arrangements.

To aid transparency and encourage candour there was an undertaking that practices undertaken by specific individuals/localities would not be identified in the report without prior agreement…

4. Summary of Findings…

Findings have been placed into broad themes it is accepted however that most issues are cross-cutting and will not sit in isolation…

5. Managing the Report of ASB:

Preventative strategies accepted ASB case management begins from the initial call for service from a victim, witness or other interested party. Actions undertaken at this critical juncture can profoundly impact effective and timely case resolution and ultimately victim satisfaction with the service received.

Ideally a person making contact regarding an issue should be able to…

- Make a seamless report with an unambiguous pathway, minimising the need for repetition and delay.
- Be dealt with by trained staff able to obtain necessary relevant information to assess vulnerability and support decision making based on threat risk and potential harm.
- Receive early assessment and decision making regarding case supervision, information sharing with other specialists and referral if required.
- Service providers should possess the capability to flex and respond with an ability to escalate and work to relevant timescales based on case urgency?
- Victims/callers should be left with clear unambiguous expectations regarding management of their case… necessary information together with confirmatory documentation should be passed to the victim/caller at an early stage and timely updates given.

6. First Contact

Reports can of course be received in a number of ways… personal visit, phone call, information via third-parties or agencies, on-line report or even text... The availability of reporting method varies from organisation to organisation. Certainly in the past increasing the availability of reporting methods was seen as desirable, however this trend has reversed and in any case in general terms only larger organisations/departments have the resources and infrastructure to service such an approach.

In most cases there has been a rationalisation of reporting channels mainly in favour of initial contact via telephone reporting. Convenience and cost effectiveness are drivers for such an approach but there are consequential issues which require ongoing consideration…

- ASB practitioners taking reports directly provide the ideal scenario, taking reports ‘first hand’ builds in quality, provides the best opportunity to assess needs and minimises information seepage. From a victim/caller perspective the need to repeat potentially upsetting circumstances is reduced and practitioners can impart first-hand advice and outline next steps or indeed early notification of closure if appropriate. Having expounded the benefits, there is in reality obvious difficulties not least availability and access to practitioners set in the context of public demand for seamless expedient reporting.

- Call centres provide another channel with generalist call takers taking initial reports for onward resolution by specialists. In principle there is nothing wrong with such an approach, however such arrangements bring additional challenges and steps may be required to mitigate these, most obviously…

    - A need to upskill or raise awareness amongst generalist call takers to ensure they ask callers appropriate questions and make necessary decisions in response to information gleaned.

    - To some degree this can (and in some cases is) mitigated by the use of supporting scripts with call takers going through a set of questions to add consistency and assess victim needs, vulnerability and risk.

    - Induction/training for staff dealing with ASB calls…assessing the level of training given to call takers was not within the scope of the review but logical areas for consideration could include…
        - Training content
        - Training frequency
        - Provisions for new staff to address staff churn
        - Briefing arrangements to support any temporary personnel

- It is preferable that reports taken by generalist call takers once logged and recorded are passed to those able to progress enquiries with minimal delay, practitioner feedback suggested this was the case but it was not possible to test this in reality.

  Direct skeleton record input by call takers either directly inputting to Sentinel or via an interface would minimise delay… obstacles to such an approach include additional staff training and the cost and development time required to design a technical solution to allow call taker data to map across onto Sentinel. There was a widely held view amongst local authority ASB specialists that relatively speaking a short delay in data transmission was not an issue, and that calls for service to them were not intrinsically ‘urgent’. They held the view that ASB victims always had the option to use the police emergency number if an immediate response was required.

  The merits of such a view are debatable however it is perhaps more relevant that callers (whether their enquiry is urgent or not) are given a realistic timeframe within which they should receive further contact; this was not always the case. Locally set contact standards would ‘sets the scene’ for victims/callers, conversely ambiguity fuels dissatisfaction which is difficult to recover.

7. Information Visibility

A key driver for the introduction of Sentinel was at least in part motivated by a desire to gain local cross-agency visibility of ASB and in so doing reduce hidden occurrences and mitigate risk. Practically speaking however there are issues which at least in part frustrate this aspiration.

Reports of ASB are of course received by disparate agencies; however, they can also be received by different internal departments within organisations. The processes and procedures to map across or even search different internal systems for information about a particular individual or locality presents a real challenge. The ability to search across systems utilising a technical solution such as a search engine is of course the panacea, the police Genie system and LCC Enterprise system are examples. Such solutions however come at logistical and monetary cost which impacts their viability as a solution particularly for smaller authorities.

In practice most practitioners rely on ad-hoc local arrangements or such low tech solutions as fellow practitioners in other departments highlighting information verbally. There are inherent dangers in such a people centred approach particularly if at some crucial juncture the relevant staff are absent or simply fail to disclose. In the absence of technical remedy robust internal information sharing procedures should be employed to mitigate human error.

General feedback gave a sense that the report taking infrastructure was considered adequate and commensurate with the level and type of reporting being received. Reporting levels varied, in some cases these were in single figures with others considerably more. The robustness of internal arrangements for the sharing of information between or by other specialist colleagues or across disparate internal IT systems was to say the least vague. It would be more accurate to describe the situation as a resigned acceptance of the status-quo rather than a belief that it was a satisfactory situation.

Relying on the professional judgement of internal colleagues to simply tell you if they deem it appropriate has inherent dangers. There are potential solutions; suggestions are placed in a continuum below…

- The use of a common intra-departmental system would be the ideal but in reality unlikely to be implemented for administrative, cost, logistical and technical reasons.
- A technical solution to search across disparate internal systems.
- Established internal processes to share information stored across internal systems rather than relying on ad-hoc notifications by colleagues.

- As an alternative and/or to support the latter the relevant dept. /colleague placing a skeleton record on Sentinel with a back reference to the main case. As a negative some double keying would be required as well as the granting of access to a larger cohort of users with the accompanying training and security implications.
- Do nothing and rely on colleagues telling you and vice versa if they/you feel it is necessary.

8. Literature

Surveying the customer 'experience' was not within the scope of this review; however it was noted that generally victims/callers for service received little in the way of supporting literature. Such written material serves to reinforce verbal advice and sets 'customer' expectations. Lack of provision however is perhaps not so surprising given the potential costs. There are however some low cost partial solutions…

An alternative may be to formulate electronic leaflets to send to victims/complainants. It is accepted that not all will have access to such a format. Limitations accepted e-versions provide a lower cost strategy with the ability to make alterations easily, provide a multitude of formats and language versions with the ability to distribute speedily and cheaply across a range of platforms.

There may also be scope to jointly design and produce literature to support victims, there was some duplication with in the form of a 'partnership victim pack' giving generic advice and information. Literature has been produced before on an ad hoc basis, an agreed cross partnership set adds consistency and assurance regarding provision and with economies of scale hard copy versions may come at lower cost.

9. Assessing and Managing Risk

Reassuringly the principle that risk should be assessed at the earliest possible opportunity was consistently expounded by practitioners across the sub-region. It is perhaps an obvious statement but the effectiveness of any risk assessment is at least in part dependant on reporting methodology adopted and the expertise and experience of those undertaking the task.

Reports taken directly by practitioners provide the most reliable assessment of risk. Conversely arrangements to take initial reports using an intermediary such as a call taker or service desk can potentially cause issues. Apart from delays, victims/callers can find themselves having to repeat circumstances, with the potential for missed information or worst still opportunities lost to support victims or reduce risk.

There are a number of suggested mitigating strategies available…

- Scripted questions for call takers to support consistency, particularly useful when reports are being taken infrequently by non-specialist staff.
- Expedited practitioner follow-up, there should be minimal delay between report and practitioner follow-up, particularly important for higher risk cases. Ideally call takers should be able to directly input information onto systems and minimise delay and avoid double keying etc. However, logistically and technically mapping information across from call taking systems to Sentinel may prove too onerous at least in the short to medium term.
- Cross system checks and information gathering, such checks are particularly important to ascertain repeat victimisation and assess vulnerability. Anecdotally feedback suggested intra- system checking between departments such as housing and environmental health was limited.

With regard to the documentation and recording of risk, there initially appeared universal adoption of the matrix on Sentinel; this was indeed true of community safety practitioners. However, with one or two exceptions the same risk assessment process was not necessarily undertaken for cases managed by other specialists such as housing or environmental health officers. This did not of course mean no risk assessment was completed; just that it was not the Sentinel Matrix.

This review did not have the scope to examine this area further but potentially there may be ASB cases that fail to receive a consistent level of scrutiny simply because primacy for the case sits outside community safety. There may be value in examining the risk assessment process (if any) employed by non-community safety colleagues dealing with ASB.

The Sentinel risk matrix system has a heavy reliance on the use of professional judgment; the system was redesigned to minimise bureaucracy whilst allowing the practitioner to incorporate nuanced expert judgement. The latter however can subsequently be difficult to recall/justify with the passage of time. Striking a balance in streamlining assessment with minimal form filling and adequately recording justification is important particularly for high risk cases. In such circumstances in addition to the matrix it would be best practice to document decision making on the system, this occurs on an ad-hoc basis but should be part of a formalised protocol.

Perhaps obvious but nevertheless reassuring was a very strong link between risk and escalation, high risk incidents receiving priority with multi-agency referral and management. Examination of the referral process did however reveal an anomaly with regard to high risk ASB cases managed on internal systems other than Sentinel. The method of referral was such that non-Sentinel cases may fall through the gaps and never be seen by ‘Victim First’ (VF). VF receives police and partner high risk ASB cases managed on Sentinel for scrutiny and follow-up as required. A similar issue exists for other important groups, at time of

writing they do not receive any referrals from non-statutory stakeholders the most notable being registered social landlords. Accepting many will take high risk cases to JAG a process is required within RSL's to refer high risk cases to VF and address this gap.

10. Recording:

Systems:

A single accessible case management system for ASB was the aspiration behind Sentinel, in reality the partnership 'landscape' is rather more complicated. ASB isn't confined to a single defined department and those charged with dealing with it are configured differently across the sub-region. Specialists may include housing or environmental health staff, some of these utilising different systems to record different aspects of community safety. There did not appear to be any clear inter-operability between departmental collegial practitioners. Add to this the operating practices of non-statutory partners such as registered social landlords (RSL's) and the picture becomes even more complicated.

There was a clear differentiation between crime and non-crime ASB incidents; predictably the Police take primacy for crimes. The situation became less clear for non-crime incidents… there was some feedback albeit anecdotal that victims for certain 'types' of call such as 'noise' complaints were being inappropriately signposted … it was not within the scope of the review to substantiate this however there was a general working practice that an agency taking a non-crime report of ASB retained case management ownership and recording responsibility.

Sentinel: the original driver for the introduction of a single cross-partner case management system was to engender greater incident visibility which in-turn would support more informed responsive evidence based decision making. Sentinel was the system 'chosen' to undertake this vital role. The circumstances of system selection are not within the scope of this review or indeed relevant.

Sentinel as a case management system has been subject to incremental development much of which has been user led. Despite this some users held the view that Sentinel was functionally a poor system, however when asked to elaborate they were unable or unwilling to do so or spoke of historical issues that had been remedied in subsequent versions of the system. Obtaining coherent user feedback regarding the system was challenging.

It was difficult to decipher fact from anecdotal feedback; there was however a great deal of frustration regarding the lack of ownership, governance, development and succession planning for the system. This has resulted more recently in individual approaches by/to local authorities commissioning local system enhancements a situation which has inherent

dangers. A more joined-up approach is required to avoid duplication and fragmented development, a logical way forward would utilise a reinstated Sentinel user group or similar with a clear and jointly coordinated process for partners to effect system change.

There was amongst some an unsubstantiated supposition that Sentinel would either be imminently replaced or abandoned, in part this belief may have been fuelled by the relatively recent loss of Sentinel coordinator. Further feedback included a sense of frustration with some users feeling they were unable to influence system development and/or a belief that this would be inordinately slow.

Proactive steps need to be taken to recover system reputation… legitimate issues/concerns must of course be addressed; key is an effective means not only to communicate developments in usability but also to proactively address negative anecdotal rhetoric, left unchallenged such rumours can be extremely damaging.

Potential solutions must offer the opportunity for users to easily communicate concerns (anonymously if required) mirrored by a timely transparent response for all to see. This may take the form of…

- A ‘suggestion box’ and/or a ‘question and answer section’ on the system or elsewhere,
- A ‘how to’ section to take users through typical functions and tasks, seldom used or more advanced tasks such as ‘back-end’ searches.

There are help files on the system but these may benefit from update and revamp.

Partner Internal Systems: ASB reports do not solely reside on Sentinel; other departments such as housing and environmental health have their own case management systems. Generally speaking arrangements to map across or view this information was inconsistent and usually relied on individuals rather than systems and processes. Such a situation has inherent flaws with the potential for practitioners to be working with incomplete information. It is accepted that local setup and arrangements differ however a formalised process for information sharing should be in place.

Taking the above principle there is a similar issue with non-statutory agencies who now have responsibilities to manage ASB. Indeed under the ASB Crime and Policing Act 2014 registered social Landlords (RSL’s) now have responsibilities in this area, with local authority housing stock diminishing their role in this area is set to expand. Accepting some JAG attendance there appears to be limited formal protocols between RSL’s and local authorities regarding ASB case management. With what appears to be an acceptance that RSL’s decide what and when they impart information

Administration and functionality; Sentinel is not a fully automated system and from time to time physical intervention is required to ensure smooth running, for example;
Administration such as addressing user password issues or access levels etc.
Coordinate and garner partner agreement for system configuration changes.
Managing the deployment/implementation of system changes
Coordination of system snagging and development
Providing a single point to address knowledge gaps, training and development amongst system users.
In the past the partnership collectively funded an administrator post to undertake this role. The post-holder had over time built up considerable expertise and the scope of responsibilities expanded over time.

The loss of a Sentinel administrator resulted in the loss of coordination around the above 'services'; The reasons for the lack of succession planning for the role is not within the scope of this review, however, in the medium to long term processes and procedures must be developed to supplant administrator responsibilities above. As a priority a procedure is required to bridge the administrative gap around system passwords access etc. There are of course a number of possible options; an obvious solution could make use of enhanced Sentinel users to undertake the administrator role locally.

System Development; Sentinel is subject to ongoing development, such requests can emanate from a number of sources; it is absolutely vital that practitioners have and indeed feel they have an input and help decision makers filter and prioritise proposed enhancements. Previously this scrutiny used to occur within the 'Sentinel User Group' (SUG) a now obsolete entity.

Moving to the present; practitioners now attend The ASB Delivery Group, this provides the most pragmatic solution to reinstate the SUG function. It can either be incorporated into ASB Delivery Group business or perhaps more appropriately form a standing item within the ASB Delivery Group meeting agenda.

Procedurally there needs to be a clear process, (which is in development). Cost is always a factor when considering system development, the requirement for collective decision making across partners complicates matters still further. There is always the danger that inordinately lengthy and inflexible decision making protocols can frustrate and stifle system development… A solution would be to have a pre-determined cost threshold for developments, in so doing attaining a balance between unwelcome bureaucracy for smaller changes and required scrutiny and mandate for higher cost developments. The ASB Strategy Group provides a forum to sanction the latter with smaller low cost changes dealt with speedily through the SUG sitting within the ASB Delivery Group.

A clear coherent, transparent process to sanction system change and development will of course support system functionality. It will also if effectively supported and publicised help address many of the reputational issues referred to previously.

Training and System Use; Sentinel system users vary from extremely adept to those much less confident. It was no surprise that many system users giving negative feedback were typically only occasional users. Correlation between user ability and system usage is predictable and strategies need to be found to address the knowledge gap across the assortment of users of the system. A developer led 'one size fits all' training strategy is unlikely to suffice, instead there needs to be a user led training approach, one which accommodates the disparate types of user and supports the knowledge gap apparent for occasional users. This subject is examined further in the report.
A training needs analysis needs to be undertaken to better understand the user requirement across the partnership. Inputs are likely to cover…

- Basic User; training must be task focused with attention basic system functionality.
- Enhanced User; covering system administration.
- System support; readily accessible, up to date step by step "How to" help files designed to support occasional users who may wish to refresh knowledge.
- The above may be supported by 'you tube' style screencasts covering system functions.

11.Tactical Management:

Assessing and managing the threat risk and harm to people or instances in a locality…
Areas examined…?

- Management at the correct level concurrent with risk
- Systematic recording of actions
- Appropriate sharing of information/referral/case management.
- Use of incremental approach employing the range of options available in the ASB 'toolkit' ensuring tactics are consistent, proportionate and appropriate to circumstances.
- Do we utilise additional tactics to support victims and build the case, use of professional witnesses etc.
- Quality of recording and systems to support organisational memory and preventative strategies.
- Examination of tactical infrastructure, systems, forms, legal provision, training and expertise, does this stifle or support deployment of the range of tactical options.
- Support for victims, do we refer high risk cases to Victim First, what about ASB cases dealt with by other departments not on Sentinel?

- What about cases going to court, are high risk cases considered for special measures? Witness care?

Legislation:

The ASB Crime & Policing Act 2014 rationalised and simplified the suite of options available to ASB practitioners; it was a wholesale revamp of the ASB toolkit. Encouragingly feedback from practitioners would suggest there is confidence regarding knowledge of the new suite of powers.

That said, additional barriers are evident that may stifle full utilisation… this has in some cases resulted in a skewed 'bottom heavy' utilisation of the incremental approach, with a propensity to robustly utilise non-legislative tactics with what appears to be a reluctance to support the full range of more punitive actions when required.

Why the reluctance?

- Cost… the new suite of ASB powers brings into play a great deal of civil litigation.
- Confidence in using a new suite of powers
- Lack of local arrangements…
- Poor preparatory bureaucracy

There is some credibility for the latter two points… compared to previous legislative rollouts there was little in the way of accompanying procedural support from the Home Office, this was left for local design and implementation… The result has been inconsistent administrative and legal provision with larger authorities able to fund and cater for the changes more effectively than more poorly resourced ones. There may be scope in pooling resources and expertise, formalised logistical partnership arrangements e.g. pooled legal services which may bring cost savings and build expertise.

Response & Escalation:

12. Case Progress and Closure:

Ideally a victim or caller for service should…

- Have a clear and unambiguous understanding regarding the status of their case. For example cases going to JAG should have a clear process and protocol for case closure with an identified and accountable individual with the requisite knowledge and mandate to convey the necessary information
- An unambiguous process to inform the victim/complainant of the outcome and any further action intended. Actions should be documented and recorded onto Sentinel, both as a record required actions and to minimise duplication.

Feedback suggested that the above

- Consider communications and media strategy, do we want to publicise what we've done?
- Post incident analysis/ organisational learning, supporting future preventative strategies.
- Linked to the above consider post incident surveying/questionnaires to inform future service delivery.

Practitioners appeared confident that they had a clear protocol for case closure; however there was little to show post incident victim feedback, either via questionnaire or survey. That said there are more generic surveys such as the Crime Survey for England and Wales

Other Matters

- Partners had a good understanding of the incremental approach and endorsed the principles underpinning it. Non legal sanctions were well used however there were real issues with implementing elements of the ASB Crime & Policing Act 2014 which severely curtails the available 'legal options'

13. Next Steps & Recommendations:

A multi-faceted approach is required to deal with the issues outlined in this report; in addition to some of the possible solutions referenced in the report itself utilising a combination of the following tactics may also help…

- *Mentoring*; some local authorities have more experience in certain areas; they may have already undertaken particular tactics, for example undertaking applications for a civil injunction or a closure order. Having built up this expertise it would make sense to share it in a reciprocal arrangement with less experienced colleagues in other authorities.
- *Formalised Partnership*; acting as mentor to any number of partners may appear too onerous especially for smaller teams, there may be scope as has already happened in some localities for a less burdensome formalised partnership arrangement.
- *More effective meetings/practitioner forum's;* ASB practitioners attend meetings regularly, interacting with fellow practitioners; the ASB Delivery Group is an example. Examination of past agendas however reveals what appears a skewed focus on planning for future campaigns and work-streams. There is real scope to better utilise these gatherings to focus on problem solving, acting as a forum to share issues and solutions amongst peers. Such practise may well identify issues early and engender solutions or resource provision for mutual support.
- *Joint commissioning and purchasing of services*; contracting legal services is an obvious example, greater buying power potentially may result in better rates

together with an opportunity to pool and enhance expertise amongst lawyers and in-turn outcomes. It is accepted that there are political as well as practical considerations but even in these circumstances there may be scope to partner with any number of other LA's with real benefits to those less well resourced.

- *Joint working groups*; to work through issues that communally impact partners, it seems at the very least inefficient to design and draw-up individual documentation for a bureaucracy that is common to all.
- *Utilising joint infrastructure more effectively;* for example Sentinel is a common system and achieving a common standard would be more easily achieved if when practicable practitioners realised its full potential; for example there may be scope to utilise it as a common repository for documentation and stationary and promote a single version of the ASB documentation. Sentinel developments will soon it is hoped incorporate a folder structure which can be utilised for the purposes described.
- *Better use of what we already have!* the victim care package is an example; there seems little value in having a wish list of system enhancements, undertaking (and paying) for development to then fail to support deployment with an effective training/awareness programme and communication plan.
- *Revamped and updated protocols*; this does not necessarily require a rewrite of all procedures and associated documentation but at the very least a revisit to ensure they remain relevant and are cognisant of the revised toolkit. The incremental approach and JAG TOR are two obvious examples.
- *Training and system user support*; A training needs analysis to better understand the user requirement followed by rollout of tiered training reinforced by user development support materials.

14. Conclusion:

The recommendations are not exhaustive but intended as a starting point to prompt discussion, support strategic decision making and support tactical delivery across a range of key business processes. The ASB Delivery Group is the obvious coordinating body for work-streams with larger pieces of work assigned to working groups.

Many of the remedial work-streams require collaborative working and clearly the potential benefits to some partners will be greater than others. Ultimately there will be collective benefits for all but perhaps more importantly a better service for victims.