Better Security, Better Care

Evaluation of the Better Security, Better Care Programme 2023-24

November 2024

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1 Executive Summary

1.1 Summary of findings and recommendations

The evaluation of the BSBC programme between 2021 and 2024 shows a highly effective implementation of a decentralised model that has led to significant increases in DSPT take-up at a relatively low cost.

There have been significant wider benefits to the programme, which has seen local support organisations (LSOs) contact a significant proportion of the 27,000 social care locations in England to improve their understanding of the importance of data security and protection for their service users and their businesses. A significant proportion of these (75% as of August 2024) have gone onto publish the complete the Data Security and Protection Toolkit (DSPT), compared to 15% in April 2021.

Engagement with social care providers is challenging and the programme has been very successful in achieving this, even with the hardest to reach small domiciliary care agencies. This has led to benefits in the wider health and care system, with many local authorities and Integrated Care Systems (ICSs) recognising the value of local delivery partners through care associations and LSOs.

The development of the Digital Care Hub is happening at a time when there are two significant opportunities to shape digital developments in social care. The new Labour government's early proposals on data and digital developments align well with the Digital Care Hub's experience and aspirations. At the same time, the potential re-shaping of the operation of the CQC provides an opportunity for the Digital Care Hub and LSOs to shape the future of digital initiatives and data security in social care services.

The rest of this report provides a review of the programme since 2021. This is presented in the form of an overview report, with a data appendix, which provides a detailed breakdown of changes in DSPT compliance in different geographical areas and different social care provider types.

1.2 Summary of recommendations

1.2.1 Recommendation 1 – Engaging small providers (section 3.1.3)

Several LSOs have had success in engaging small providers over the last year, including Bradford Care, Care & Support West, SE and SW London and Dorset PIC. Further work should be undertaken to understand what has driven this success and the extent to which it is due to the actions of the LSO or other factors (such as local authority commissioning practices) and the learning disseminated to other LSOs.

1.2.2 Recommendation 2 – Regional providers (section 3.1.3)

Regional providers, that is those that operate within several local authorities within a single region, should be identified and a plan for engagement developed. There are concentrations of these providers in a relatively small number of areas in the country, including Tyneside, Cumbria, West Yorkshire and Bristol.

1.2.3 Recommendation 3 – DSPT completion targets (section 3.1.3)

DSPT completion targets should be set for organisation sizes, with a recommendation that the target for large national organisations should be 100%, medium-sized and regional providers should be 95% and small providers 75%.

1.2.4 Recommendation 4 – Providers publishing at DSPT Standards Exceeded target (section 4.4)

There should be a new target for the percentage of providers achieving Standards Exceeded. We suggest a target of 15-20% initially (currently 7% of providers exceed standards). The programme would require additional resources to support this recommendation so an initial step would be to quantify the cost of the resources required.

1.2.5 Recommendation 5 – LSO outcome measures (Section 3.2.5)

LSO performance should be measured on outcomes as well as activity. We recommend that the number and names of providers engaged each month should be recorded. These data would enable the central team to measure the percentage of engaged providers that subsequently achieve Approaching Standards, Standards Met or Standards Exceeded.

1.2.6 Recommendation 6 – Action Research Fund projects (section 3.4.2)

There are several recommendations related to future Action Research Fund projects which we have grouped under one overall recommendation:

- The initial specification of projects should clearly set out the expected outputs, specifically in terms of actionable findings
- There should be additional support for organisations that have limited research experience.
- There should be regular ongoing support for projects consisting of both 1:1 sessions and group sessions with other projects to share experiences and support.
- There should be a clear report template which sets out how findings and recommendations are to be identified and the benefits of these.

2 Introduction

This is the third evaluation of the Better Security, Better Care programme undertaken by Cordis Bright. The programme has seen considerable change over the three years that we have been undertaking the evaluation, with the percentage of social care providers achieving Approaching Standards or Standards Met standing at 14.5% in April 2021 and at 76.1% in August 2024. Large providers are now 99% compliant and some service types operated by large providers are 100% compliant, such as care homes.

For this evaluation, we have looked back over the last three years to provide an overview of the progress made by the programme. Overall, it has been extremely successful, exceeding all performance expectations and representing excellent value for money. More importantly, the programme has contributed to the growth of the Local Support Organisations (often care provider associations) becoming a significant partner in the development of local health and care systems and providing an interface between the NHS, in the form of Integrated Care Systems (ICSs) and the many disparate care providers that make up the social care market.

2.1 Report Structure

We have focused on providing an overview of the programme in the main body of the report. We recognise, however, that many readers of the report will value the detailed data, and this can be found in an appendix to the report (Appendix 1 - Data on DSPT Compliance – Size and Scope of the Programme on page 36).

The main body of the report covers a review of the programme from 2021 to 2024, including:

- DSPT compliance (page 10)
- Local Support Organisations (page 16)
- Programme Management (page 21)
- Action Research Fund (page 24)

We then looked at the value for money of the programme (page 27), using research on cyber incidents in social care providers undertaken by Ipsos / IPC early in 2024 to update our value for money calculations.

Finally, we present a summary of the recommendations on page 34.

Over the course of the evaluation, there has been a change of government and more recently two reviews of the CQC which suggest that there could be major changes in how the regulator is structured and operates. Both these events have impacts on the programme, and we reflect on these in the report.

We wish to thank all the LSOs, stakeholders and members of the central Digital Care Hub team who have supported this evaluation.

3 Review of the Better Security Programme, 2021-2024

3.1 DSPT Compliance

3.1.1 Compliance Overview

In April 2021, DSPT compliance stood at 15% and has climbed steadily since then to reach 75% in at the end of June 2024, and 76% in August 2024. This is illustrated in the table below.

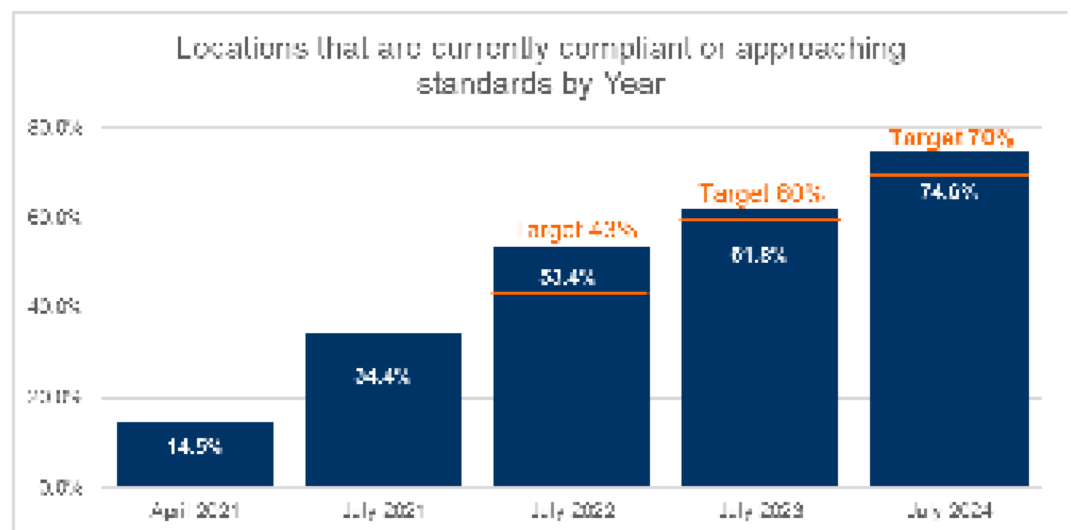


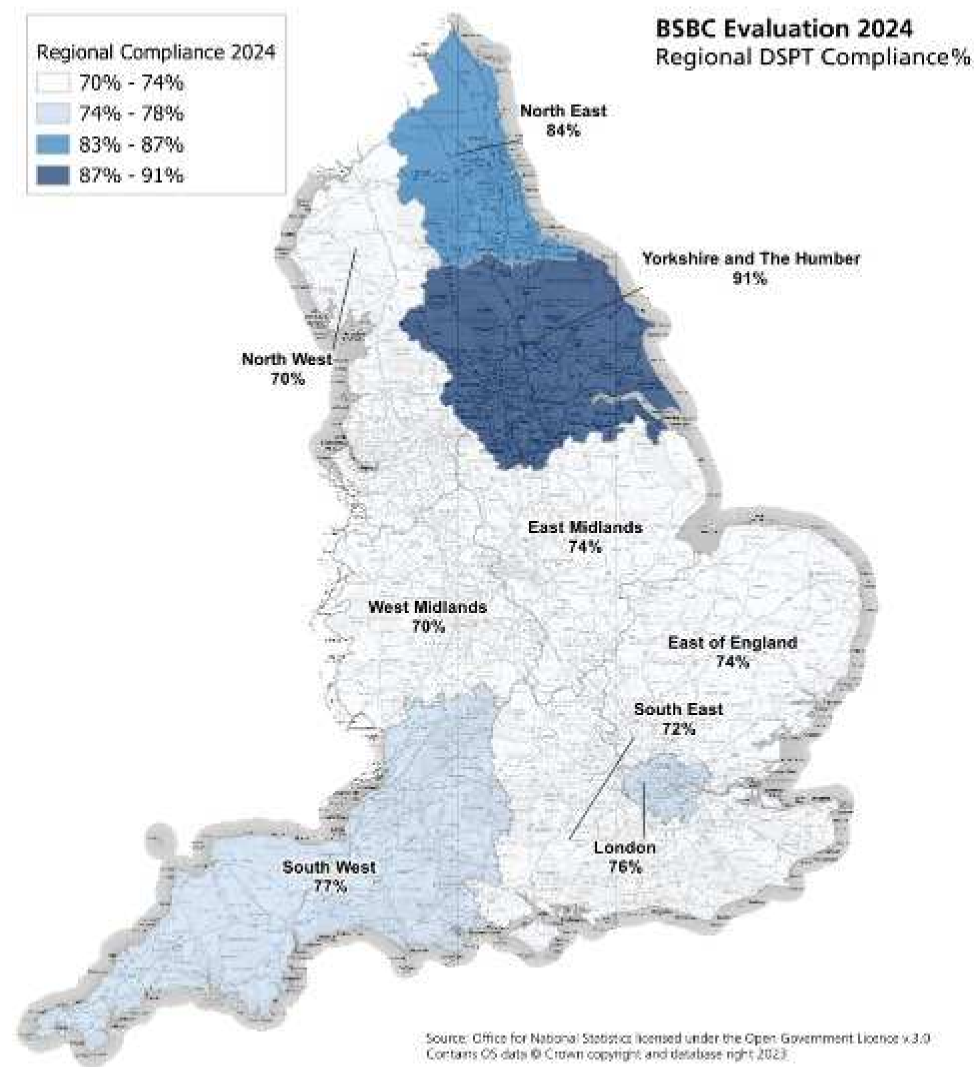
Figure 1 - Chart showing compliance against target for each year

By July 2024, DSPT compliance amongst the largest social care providers had reached 99%, whilst compliance amongst small providers showed a 16% increase in the year to July 2024.

The BSBC programme has been set and has met a challenging target for DSPT compliance for each year. There continues to be a wide variance in compliance between different types of social care provider, although this gap is narrowing. This is explored in more detail below.

Data in July 2024 show that all regions met or exceeded the target DSPT compliance, which is the first time this has been achieved. At a local authority level, the average DSPT compliance of provider locations is at or above the 70% target in 71% of authorities, again an improvement on previous years.

Figure 2 - Map showing location DSPT Compliance Percentage by Region

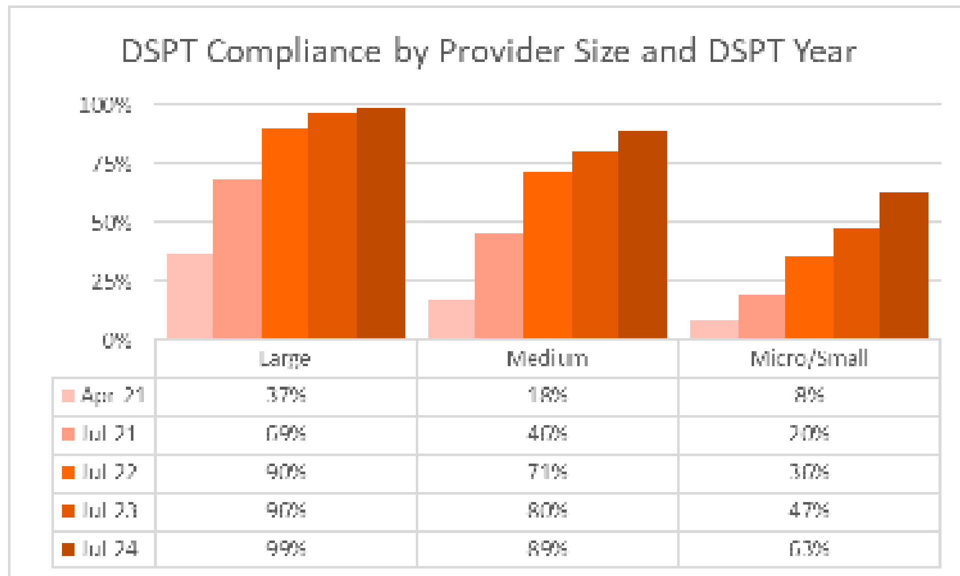


3.1.2 Compliance by provider size

In previous years, there has been a marked difference in DSPT compliance by the type of provider, with larger providers, particularly large nursing home providers, achieving high levels of DSPT compliance, whilst small providers, particularly small homecare agencies, show much lower levels of compliance. See section 6.6.2 for definitions of scale and scope of providers.

Whilst this pattern continues, there has been a marked improvement in the DSPT compliance of small providers, which has increased by 16% in the last year.

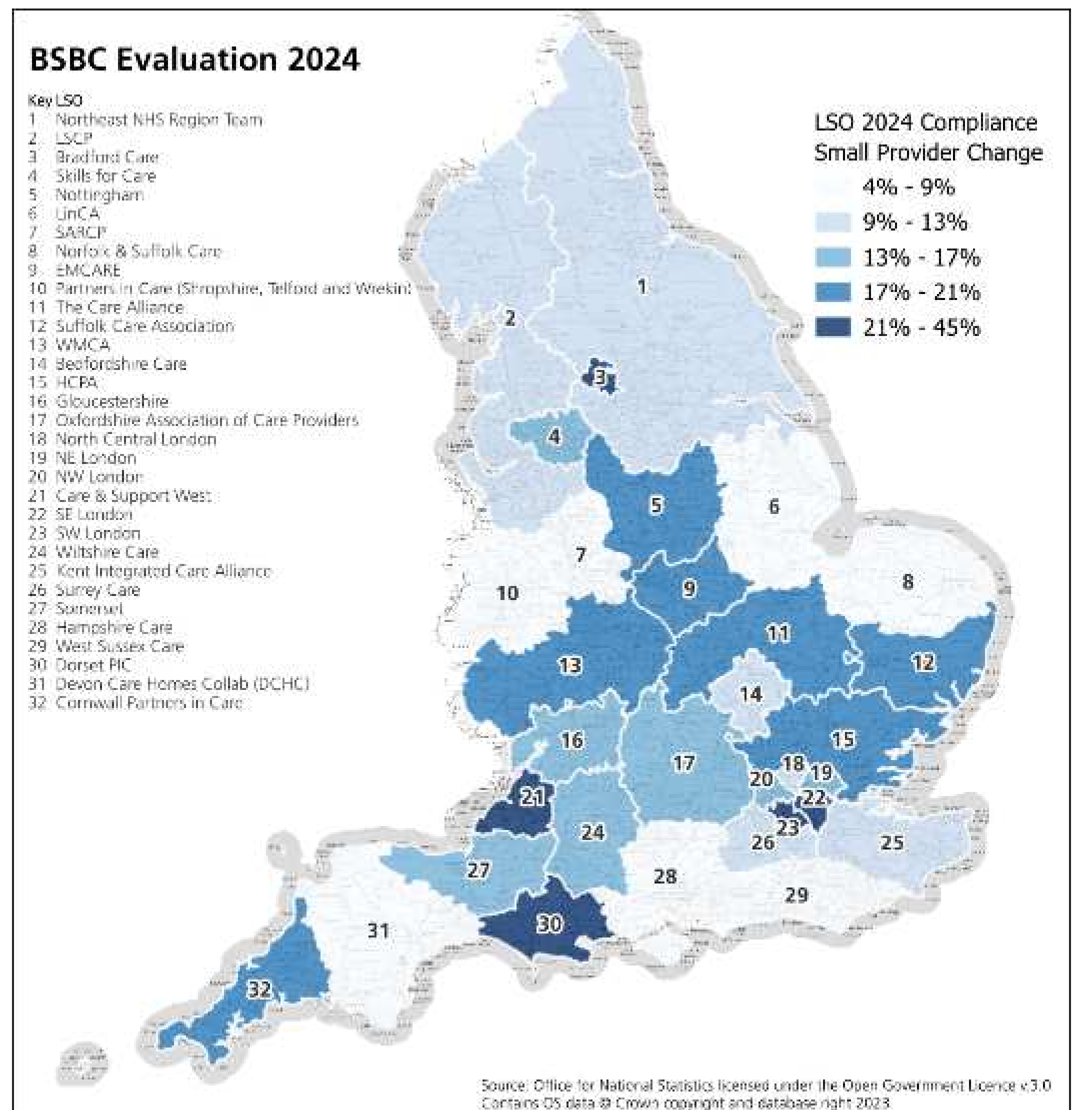
Figure 3 - Chart showing DSPT compliance by Provider Size, 2021-2024



	Large	Medium	Micro/Small
Apr 21	37%	18%	8%
Jul 21	69%	46%	20%
Jul 22	90%	71%	36%
Jul 23	96%	80%	47%
Jul 24	99%	89%	63%

As reported in previous years, small providers are always going to be hard to engage with and convince to complete the DSPT. However, the data from 2024 shows that some LSOs have been particularly successful in engaging with small providers. The map below shows the change in DSPT compliance in micro/small providers by LSO area:

Figure 4 - LSO Change in DSPT compliance of small providers 2023-24



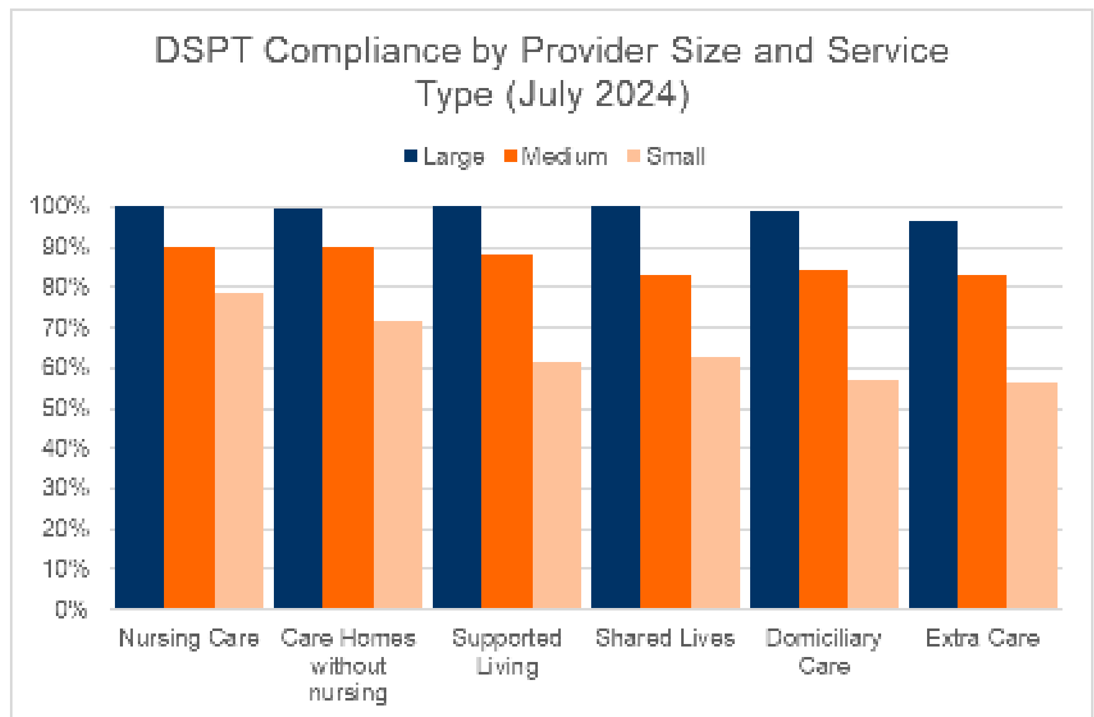
Bradford Care, Care & Support West, SE and SW London and Dorset PIC all show increases in small provider DSPT compliance of between 21% and 45% between July 2023 and July 2024, with SE London having a 45% increase in small provider compliance. This highlights the benefits of the systematic engagement of small providers in getting these providers to recognise the importance of cyber security for their businesses and prioritising the completion of the DSPT. This is an approach that the Northeast NHS Region Team has taken with all providers and has resulted in the high levels of DSPT compliance within that LSO.

It continues to be the case that larger providers have higher rates of DSPT compliance, regardless of CQC registration type, as illustrated in the table below. Compliance by client group is shown in the Data Appendix (see Figure 25 – Table showing DSPT compliance July 2024 by provider size and client group).

Figure 5 – Table showing DSPT compliance July 2024 by provider size and CQC registration type

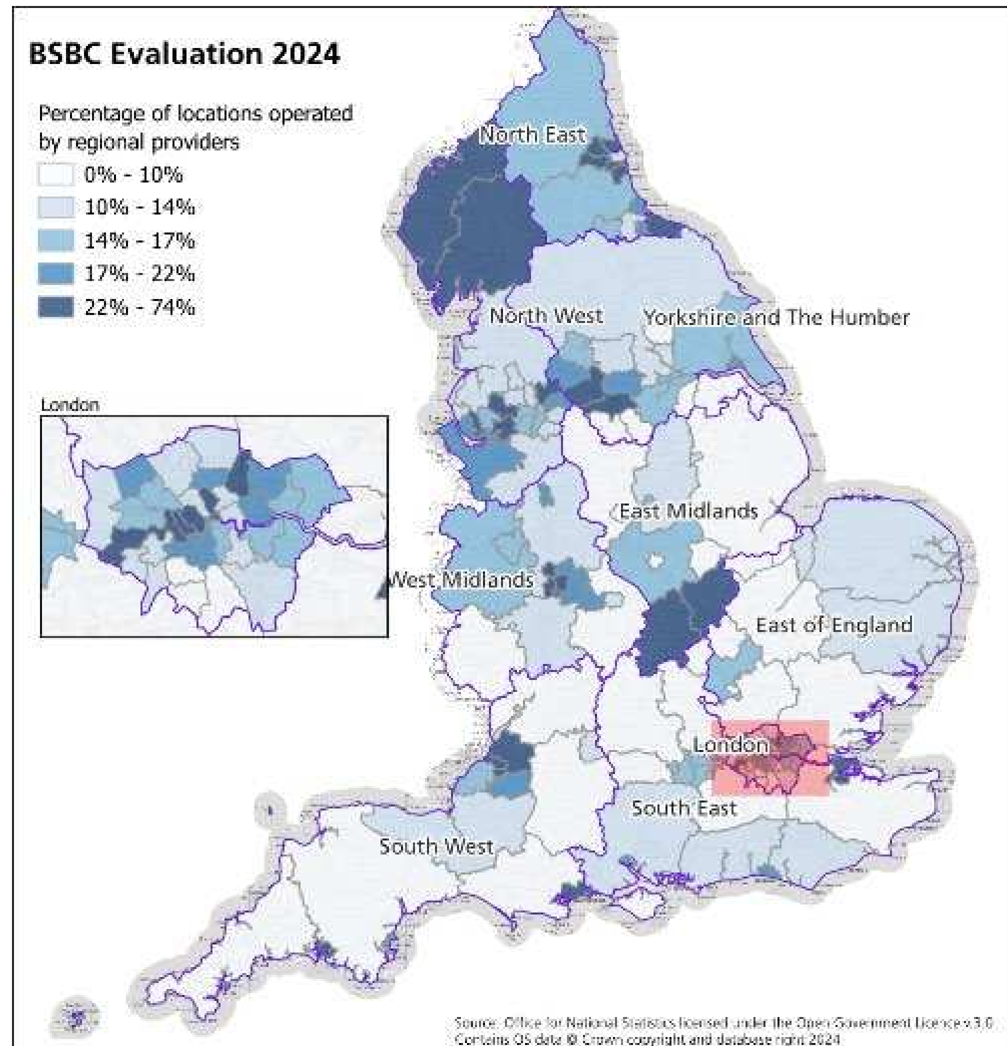
CQC Registration Category	Large	Medium	Small
Nursing Care	100%	90%	79%
Care Homes without nursing	100%	90%	72%
Supported Living	100%	88%	62%
Shared Lives	100%	83%	63%
Domiciliary Care	99%	84%	57%
Extra Care	97%	83%	56%

Figure 6 - Chart showing DSPT compliance July 2024 by provider size and CQC registration type



This table also highlights a point made in previous evaluations that the medium sized providers, who often operate at a regional level, are a good target for future engagement, because these providers are often of a scale where they have a centrally coordinated IT support function. There are concentrations of these providers in relatively few areas, as illustrated on the map below:

Figure 7 - Map showing the density of locations operated by medium sized regional providers in July 2024



3.1.3 Recommendations for future action

The data from April 2021 shows the scale of the increase in publications in the DSPT by social care providers, from 14.5% in April 2021 to 76.1% in August 2024. This has been achieved through a successful partnership of a small central team and support organisations operating at a local level which has created benefits across the health and care system.

Three key recommendations arise from this. The first, picked up in more detail below, is that engagement with the remaining small providers requires a structured approach to providers that LSOs may not traditionally have had much contact with. The success of the Northeast Region NHS Team in engaging with all providers, and the large increases in small provider engagement by some LSOs in the last year point to a valuable source of learning. It also confirms that although small providers are often more difficult to engage it is entirely possible to do so.

The next recommendation is one that has been made in previous evaluations: the value of engagement with the medium sized, regional providers. These represent around 35% of the market and often have a central IT Support / Head Office function that means that engagement with a head office team can result in DSPT compliance for multiple care locations in a region. These providers are concentrated in a relatively small number of areas, making targeting an easier task.

The final recommendation is to consider setting targets for DSPT completion by provider size (scale) to reflect the challenge of engaging with some provider types. There is already 100% compliance with large providers of some CQC registration categories and 100% compliance across all is a realistic target. For the medium size, regional providers, 95% compliance would be a challenging but achievable target. Finally, for small providers, a target of 75-80% compliance is probably close to the maximum achievable given the rate of turnover of these providers. Were the CQC to make DSPT compliance a requirement, the target would be closer to 100%.

3.2 Local Support Organisations

3.2.1 Overview of LSOs

Alongside the increase in DSPT compliance since April 2021 has been a change in the nature and range of functions of LSOs. The survey of LSOs undertaken in 2024 showed that for the majority, working on the BSBC programme led to an increase in their involvement in their local health and care systems and the range of services they now offer to local care providers.

The BSBC delivery methodology of working with local organisations to deliver support to providers in completing the DSPT has probably been the greatest success of the programme. It has enabled the programme to reach many of the 27,000 provider locations with a small central team coordinating the 28 local support organisations. As detailed below, this represents a positive return on investment on the primary aim of helping care providers avoid cyber incidents. It has brought much wider benefits to the health and care system that are harder to quantify in financial terms but support a much more effective engagement of ICSs and local authorities with the local care provider market.

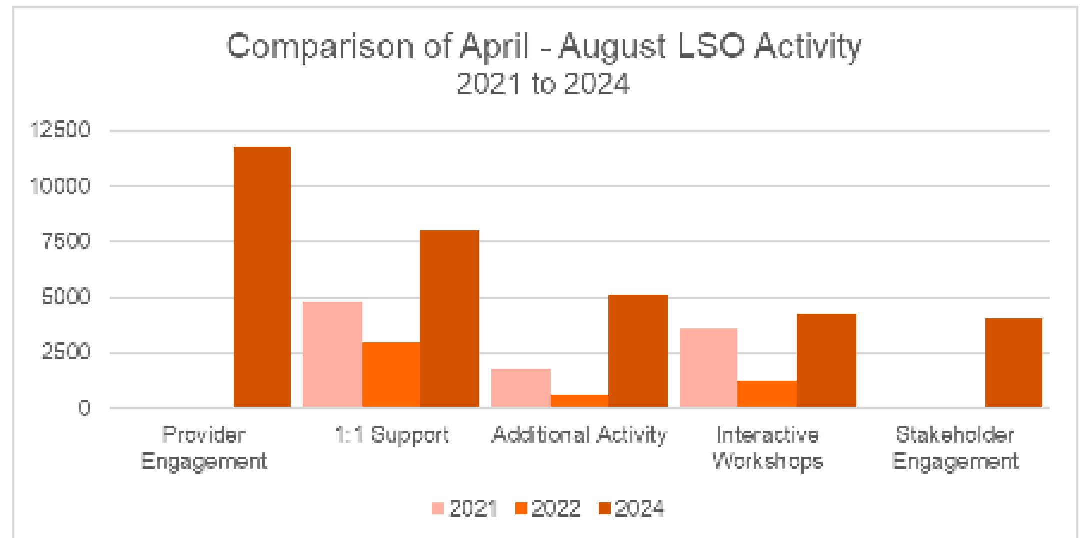
3.2.2 LSO activity

The biggest change that has taken place since 2021 has been the evolution of the nature of the activities undertaken by LSOs as part of the BSBC programme and in their direct work with their local providers.

One of the strengths of the BSBC programme has been its ability to adapt how the programme is operated based on reviews and feedback, and the moving of functions from LSOs to the central team is an example of this. The local helplines and the webinars, which represented a considerable proportion of LSO activity in 2021, are now delivered centrally, freeing up some LSO time to concentrate on engaging with individual providers. Feedback from LSOs in the evaluations that

took place in 2022 and 2023 noted the increasing importance of 1:1 support of smaller providers, so moving these functions to the central team allows LSOs to do this.

Figure 8 - Comparison of LSO Activity, April to August 2021 to 2024



One area where progress has yet to be made is on recording and monitoring LSO outcomes. Whilst LSOs complete a monthly report on their activity, at the time of the evaluation there is no data on the outcomes of their activity in terms of the number of providers engaged and subsequent completion of the DSPT. As the nature of engagement with providers changes, and most larger providers become DSPT compliant, the success of LSOs in engaging with providers and turning this engagement into a published DSPT becomes more important and necessary to monitor.

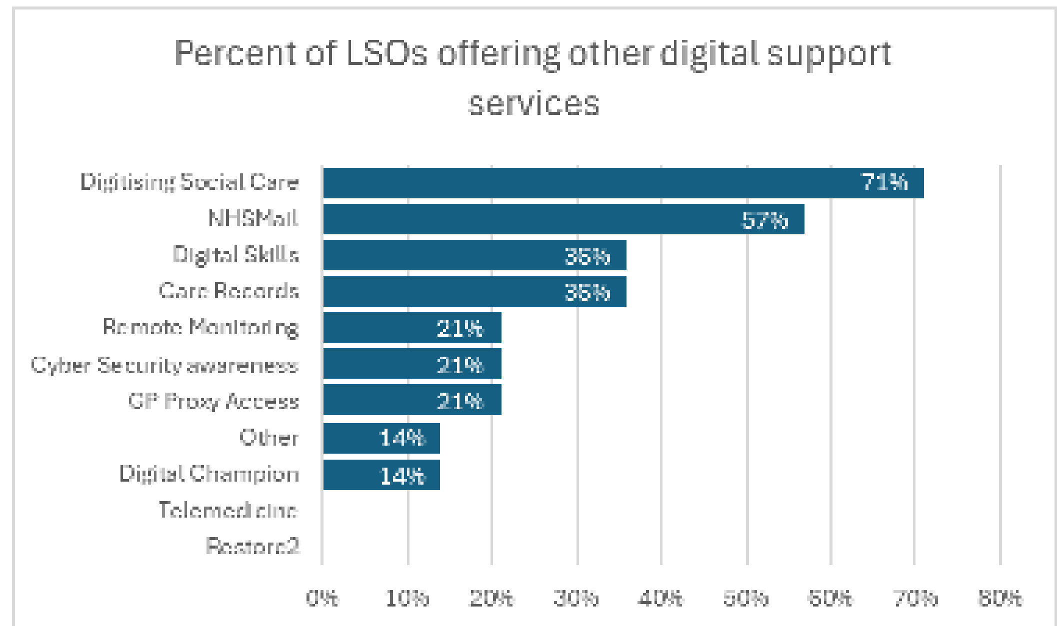
As noted in the value for money section below, the Ipsos / IPC survey found that DSPT compliance on its own had a limited impact on the risk of cyber incidents affecting providers apart from providers who published at Standards Exceeded, implying that it is a level of behaviour change that protects providers. Supporting providers to embed the principles of the DSPT in their operations and change their behaviours will be a key to unlocking the fuller benefits of cyber security for social care businesses. This will become a key task for LSOs in the future.

3.2.3 Maturing LSOs

The 2022/23 BSBC evaluation noted the increasing differences between LSOs as they have matured, highlighting the differences between the smaller LSOs that generally just offered BSBC commissioned support to providers, and the larger LSOs that were becoming important players in their local health and care systems, offering a range of digital and other support to providers, councils and ICBs.

This trend has continued in 2024, and the survey undertaken with LSOs highlighted the range of services provided by some LSOs. As well as BSBC, respondents offered a range of other digital services to local care providers, the largest proportion offering wider support around Digitising Social Care (71%) and NHSMail (57%)

Figure 9 - Percent of LSOs offering other digital support services

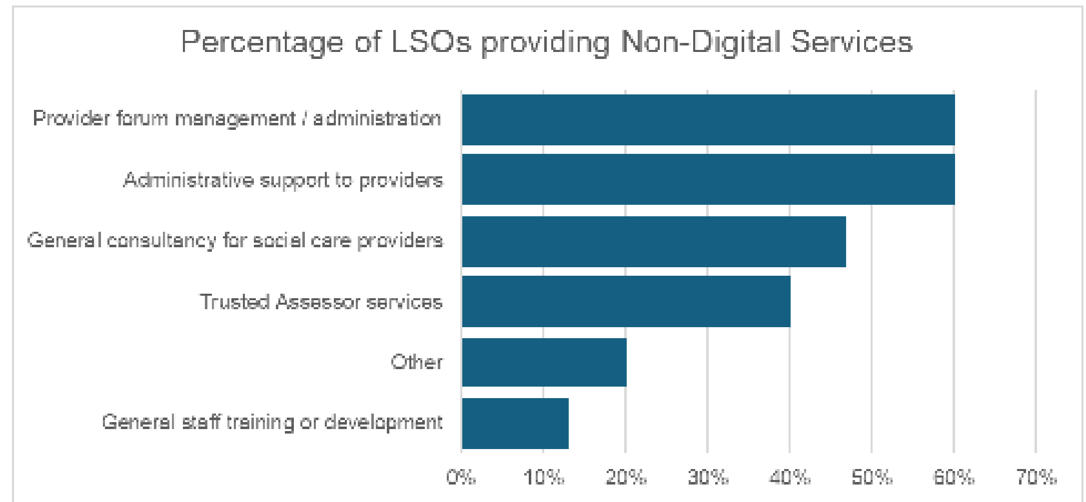


Almost all these other digital services were commissioned by ICBs or other NHS organisations, apart from one LSO which received some local authority funding to support Digitising Social Care.

Most LSOs said that that they had either not been providing these services before working on BSBC or that the quantity of these services had increased since being involved with BSBC.

The questionnaire also asked about the other services offered by the LSO/care association. Two thirds of respondents were offering general staff training or development services (not related to digital transformation), and a third provided a Trusted Assessor service. One LSO also provided DBS management services.

Figure 10 - Percentage of LSOs providing non-digital support services



Most of the LSOs received local authority funding for these services, although two thirds of the LSOs receiving money for staff training or development received ICB funding for this and a third of the Trusted Assessor services were funded by ICBs.

Most respondents said that the level of these services had increased since engagement with BSBC. This should be seen as a very positive contribution to the social care sector in the sense that the BSBC programme appears to have acted as a trigger for further involvement of LSOs in the wider health and social care system.

3.2.4 LSOs and health and care system engagement

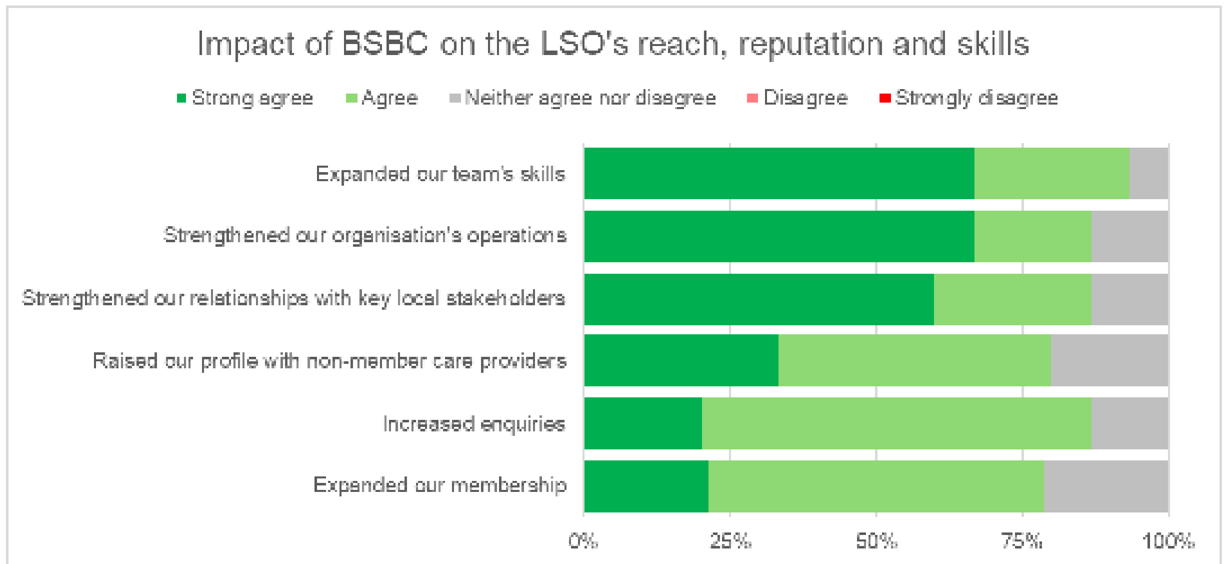
These trends highlight the increasing engagement of the larger LSOs in their local health and care systems. Most LSOs had regular, high-level contacts with local authorities and ICBs. Although most LSOs were also engaged with local Health and Wellbeing Boards and with the CQC, this was at a lower level and almost half of LSOs reported no involvement with their Health and Wellbeing Boards. 25% of LSOs reported attendance at key meetings within the CQC, but 40% reported contact half-yearly or less.

Some of these trends started before the BSBC in the immediate aftermath of Covid 19 when local authorities increasingly worked with care associations to reach out to providers in need of support. However, BSBC has enabled LSOs to develop these existing relationships.

86% of respondents to the survey said that their involvement in the BSBC programme had helped them win new work and additional contracts.

The questionnaire asked about specific areas where involvement in the BSBC programme had helped them develop as an organisation and most respondents felt that involvement in the programme had made a positive impact.

Figure 11 - Chart showing impact of the BSBC programme on LSOs



3.2.5 Recommendations for future action

The maturing LSOs and the development of the Digital Care Hub present opportunities to expand the BSBC methodology of working through LSOs to other social care developments. Individual LSOs have developed expertise that can be shared with others, whilst the national reach of the Digital Care Hub presents opportunities to support change beyond the DSPT.

The key recommendation to support this is to develop the measurement of LSOs performance to include outcome measures and not just activity, although it is understood that some work on this has already commenced.

As the Digital Care Hub extends its operations beyond BSBC, it presents opportunities to work with other organisations operating in the digital sphere that have links with social care delivery. There are many such organisations, and a key challenge will be the identification of the key partners and developing working relationships with these.

The diagram below shows the other programmes and organisations that provide digital and cyber services that are relevant to social care services and small businesses, grouped by the overarching organisation. For example, there are many relevant digital programmes that fall under the Department of Health and Social Care, shown in the orange shading.

Figure 12 - Diagram showing cyber-related programs and agencies in England and links to BSBC / Digital Care Hub

3.3 Programme Management

3.3.1 Central Government Policy

The change of government in July 2024 has yet to result in clear policy direction in the digitisation of social care, but the BSBC model of local action coordinated by a small central team is likely to be of interest to minsters aiming to transform delivery within significant funding restraints.

The government has shown an interest in the expanding use of data and AI to deliver improved healthcare. The government's proposed Digital Information and Smart Data Bill (DISD Bill) suggests that data and information security will be an important element in the expansion of digital approaches, including:

- **Data protection** – reform of some data laws to maintain and develop data protection to promote safe development and deployment of new technologies.
- **Strengthening the ICO** – new, stronger powers to give it a "more modern regulatory structure"

- **Digital Verification Services** – supporting the creation of secure digital identity products and services, supplied by certified providers. This is an area where the Digital Care Hub already has experience
- **Smart Data Schemes** – creating a legal framework for "smart data" allowing data to be shared securely with authorised third-party providers ("ATPs")

All these proposals overlap with work that the Digital Care Hub is already undertaking and where the experience of the BSBC programme provides the Digital Care Hub and LSOs an advantage in shaping the proposals in social care.

3.3.2 Central Team

Feedback from LSOs and other stakeholders about the central team has been consistently positive throughout the evaluations. There were some initial concerns about the plans for the development of the Digital Care Hub, but later communication from the central team allayed these concerns. LSOs have valued the small size of the central team and the relationships they have with the individual team members. The experience of the central team in providing social care services has been particularly important in maintaining these relationships.

3.3.3 Regional Management

There have been a few changes to the regional management structure since the first evaluation in 2022, with the main one being the loss of the Ageing Well Leads. One of the ongoing challenges for LSOs and the programme has been engagement with local authorities combined with a regular turnover of regional ADASS representatives in some areas. In local authorities where commissioners take a positive approach to DSPT compliance, engagement with providers and DSPT compliance levels are consistently higher. However, the number of local authorities engaged with the programme at this level is small. There is increasing engagement with the LGA, which is positive, but getting coordinated action from the 153 local authorities is always going to be a challenge.

Engagement with the CQC nationally and regionally will become increasingly important, but LSOs report a low level of engagement with the CQC locally. Uncertainty about the future role of the CQC represents a risk that standards development on cyber security will be put off and an opportunity to engage with the CQC to provide training to inspectors will be missed.

At the time of writing, it is unclear what changes the CQC will make to the Single Assessment Framework although initial comments in both the Dash Review and Richards Review imply that it will change significantly and indeed the reinstatement of specialist teams led by new Chief Inspectors suggests that new more specific standards are likely to apply to different types of health and social care provision.

3.3.4 Fit within the health and social care system and other initiatives

The Digital Transformation Fund, given to ISBs to encourage the digitisation of social care, has resulted in much greater levels of interaction between the larger

LSOs and the wider health and social care system. Some LSOs are funded by their local ICB to provide support to providers on Digital Social Care Records and other digital initiatives. This has a significant impact on the profile of social care providers in the wider system, with the LSO providing a bridge between ICB commissioners and care providers.

There is a risk that this results in a two-tier LSO system, with larger LSOs that are engaged with ICBs being able to offer providers support across a wide range of digital initiatives, with funding to back this up. In contrast, there is a risk that smaller LSOs without capacity for this type of engagement or in areas where the ICB is not effective at engagement, cannot offer this range of support.

3.3.5 CQC

After the inclusion of the DSPT in the new Single Assessment Framework, something that LSOs and stakeholders had felt important to securing higher provider engagement, both the Dash and the Richards Reports have suggested the scrapping of the Single Assessment Framework in a significant shake-up in the operation of the CQC.

Changes in the direction of the CQC mean uncertainty about their long-term stance on digital care services and cyber security, although it is unlikely that this won't receive attention in whatever shape the CQC takes in the future. In the meantime, there is an opportunity for the Digital Care Hub, alongside LSOs, to shape the discourse within the CQC on digital developments in social care. A CQC returning to an approach based on sector specialism rather than generic inspection teams creates more opportunities to engage with the CQC on what good cyber security standards look like in social care, measured not just on DSPT compliance, but the embedding of good cyber security practice in social care organisation behaviour.

LSOs did identify an opportunity to get involved with the CQC to a local level to train CQC Inspectors on cyber security issues and the DSPT. There were some suggestions that the Digital Care Hub and LSOs could develop a cyber security checklist based on the key things that Inspectors should look at to assess a provider's cyber and data security management. The LSO survey identified that 25% of responding LSOs have regular contact with senior regional CQC staff, and there is a window of opportunity for the Digital Care Hub to play an active role in the development of new standards and inspection frameworks on digital social care and cyber security.

3.3.6 Target Setting

The final recurrent theme in comments about the management of the programme was the setting of appropriate targets for future years. All those interviewed believed that most of the easier to engage providers had completed the DSPT or were working on doing so, and that it would be far harder to engage the remaining providers. The other concern was the need for providers to re-certify each year. The rate of turnover of staff in social care provider organisations means that in many cases, the original contact in the provider who had been engaged for the initial DSPT completion had moved on, and that re-publication

could require as much support as the initial publication. This particularly affects smaller organisations where organisational knowledge often rests with individuals rather than organisational structures and procedures.

There were several suggestions that targets for the next year should include specific targets for re-publication as well as new publications. As discussed in the value for money assessment below (see 4.1), there is also a strong argument for setting a new target for the percentage of providers publishing at Standards Exceeded, as this is an indicator of behaviour change within organisations which protects against cyber-related incidents. This would require additional investment to train LSOs to support providers to publish at Standards Exceeded and additional provider support resources would be required centrally.

The DSPT data suggests that the overall number of providers whose DSPT has expired remains fairly constant and may have dropped slightly over the last year, so this is not a major issue nationally, although there are issues in some specific local authority areas as identified above. There is an annual increase in expired DSPTs when the toolkit year changes over, although this is usually a temporary increase which is recovered over the following months.

3.4 Action Research Fund

Part of the 2024 evaluation included the Action Research Fund projects which were run in the early part of 2024 and presented their final reports in March 2024.

All the organisations running Action Research Fund projects were invited to have an interview to discuss their experiences of the process of commissioning, running and reporting on the projects. Of those invited, three LSOs took part in the interviews. The other LSOs and professional organisations did not respond to requests to schedule an interview.

All those who have participated in the projects felt that they had been a valuable experience. The research experience varied considerably, from organisations that had considerable research experience to those running research projects for the first time.

This evaluation does not consider the individual projects but looks at the lessons to be learnt from the exercise to inform future planning.

3.4.1 Feedback from the Research Projects

The quality of the final reports from the projects and the learning within them, varied considerably and this highlighted several issues with the projects:

- The organisations commissioned to run the projects felt that the process had been rushed and that they would have appreciated more time to complete the research and write up the results.
- Initial support could be improved with a 1:1 inception meeting to clarify aims, timescales and outputs

- The fixed budget meant that projects could not always do what they planned to.
- Those that had not run research projects in the past would have benefited from more help in setting up the project and ongoing support.
- It would have been very helpful to have a template for the report, setting out expected contents
- More input later in the process to help link the findings of the projects back to actionable recommendations for the BSBC project would have been welcomed.

All those interviewed would like to undertake further research projects and their projects had generated ideas for additional research they could undertake.

3.4.2 Recommendations for future Action Research Fund projects

The organisations running Action Research Fund projects that were interviewed all felt positive about the projects and felt that they had learnt from their experiences. Although the detail of the research clearly identified interesting findings, many of the reports failed to link these back to high level conclusions and recommendations that were relevant to the programme. This is in part a reflection of the lack of experience of some of the organisations. The lack of links back to the BSBC project makes it harder to justify some of the research projects in terms of the priorities of the BSBC project. As a result, there are a few recommendations:

- The initial specification of the request for proposals for research projects should be clearer about the expected outputs of the projects in relation to wider BSBC, specifically that the research projects should be generating findings that will help to improve the outcomes of the wider BSBC Programme – a “relevance check”
- The research experience of the organisations putting in proposals should be considered, and additional support should be provided if necessary to ensure that projects stick to their initial remit and produce actionable findings. It may be beneficial to offer support as organisations are developing proposals to help ensure that proposals are deliverable within the budget and timescales.
- There should be ongoing support of projects checking on progress and verifying that projects stick to their initial research remit. There should be a 1:1 inception meeting but also regular facilitated meetings between all the projects so that learning and experience can be shared. Those organisations with limited or no research experience would benefit from being paired with an organisation with more experience.
- There should be a clear report template for the projects which set out how the findings should be reported and guide research projects through the process

of producing actionable recommendations relevant to BSBC rather than just a list of findings.

Overall, the Action Research Fund projects have been a valuable exercise for both the organisations running the individual projects and the BSBC programme and they have increased the skills of the people participating. With some changes it is believed that cost effective action research projects can be developed that will allow LSOs and others to utilise their knowledge and experience whilst providing valuable insight for the BSBC programme.

4 Value for Money

There are four main areas were the BSBC programme demonstrates good value for money:

- Return on investment in terms of preventing costly cyber-attacks and data breaches to participating organisations. For 2024, there is data available on the frequency and impact of cyber-attacks affecting social care providers specifically, from research undertaken by Ipsos / IPC.
- Reduction in administration costs for both social care providers and for the NHS through access to NHS Mail, digital record-keeping and Proxy Access achieved as a result of publishing the DSPT and therefore being eligible to apply for these services.
- In some instances, delivering a strategic focus for engagement between social care providers and the ICS and ICB's which supports the wider agenda of integration and closer alignment between health and social care.
- Efficiency savings to the wider health and social care system arising from the digitisation of systems enabled by the completion of the DSPT.

A financial assessment can only be undertaken on the first of these, because the cost impacts of the other areas are not available.

4.1 Return on investment

Previous evaluations have calculated the return on investment on the programme from the **Cyber Security Breaches Survey** published by the Department of Digital, Culture, Media and Sport (DCMS). This covers all business types and does not specifically reference care provider organisations.

In 2024, Ipsos / IPC were commissioned to undertake research into cyber incidents affecting social care providers specifically, and that data has been used to calculate the return on investment for 2023/24.

The report shows that overall, 33% of providers surveyed experienced a cyber incident over the previous 3 years, which compares to an average of 40% of all UK businesses. This lower percentage may already reflect the impact of the DSPT and the supporting BSBC programme has had on the vulnerability of social care providers to cyber-attacks, given that average DSPT compliance over the previous 3 years was 57%.

48% of cyber incidents had a material impact on organisations, with an average cost of £9,528 over the last three years for those that reported a financial impact. Much of the cost of the impact related to staff time dealing with the consequences of the incident and training in response. For businesses, around 25% had a material impact from a cyber incident, at an average cost for small businesses over the last three years to £3,540. Therefore, although the rate of cyber

incidents is lower in care providers than businesses generally, the incidents are more likely to result in a material impact and the cost of dealing with it is likely to be higher.

We have recalculated our estimation of the cost of cyber incidents on care providers based on this new data. The Ipsos/IPC report does not look at the frequency or impact of incidents by provider size, so we have looked at all social care providers. These tables are repeated in a larger format at the end of this section.

Figure 13 - Estimated cost of cyber incidents on care provider

	Total registered with the CQC	Percentage of providers experiencing an attack or breach	Percentage of those experiencing an attack or breach with a material outcome	Estimate of providers experiencing an attack or breach	Estimate of providers experiencing an attack or breach with a material outcome	Average cost of attack or breach with material outcome	Estimated total cost
All social care providers	27,187	33%	48%	8,972	4,306	£9,528	**£41,031,577**

4.2 Estimating return on investment

Assuming the publication of the DSPT providers some mitigation for the both the probability and to some degree impact of a cyber-attack or breach we have calculated the return on investment as detailed below.

BSBC had succeeded in July of 2024 in supporting 75% of social care providers to complete and publish the DSPT.

The Ipsos / IPC sample found that over 50% of providers met DSPT standards in all locations, which is lower than the total DSPT compliance level of all social care providers. The report notes that there were few differences between providers who exceeded, met or did not meet DSPT standards, and that the DSPT has raised awareness but not significantly changed behaviour. However, providers that had published at Standards Exceeded reported fewer cyber incidents.

A significant finding is that providers who seek more general support in their cyber security, such as through BSBC and LSOs, are less likely to suffer incidents and where they do, these are less likely to have material impacts. It is therefore likely that the wider support activities of BSBC have an impact on cyber security in the sector than just completion of the DSPT in isolation.

As noted earlier, data on the number of providers engaging with LSOs is not available, but data from the BSBC central team gives an indication of the number of people who access wider support with cyber security when completing their DSPT. 8,462 people have attended BSBC webinars since April 2021. Some of

these will be repeat visits by people or locations from the same provider, but it is reasonable to assume that 25% of these are unique visits from the same provider, which would represent 7% of social care providers. Statistics from the BSBC website also suggest a high number of visits, and again it is reasonable to assume that this represents around 7% of providers.

Using this 7% of providers as a proxy measure of providers who engage with wider support from the BSBC programme and therefore exhibit some behaviour change that reduces the likelihood and impact of cyber incidents, the overall value of avoided cyber incidents is £15.5 million, giving a return on investment of £1.91 as detailed in the table in Figure 15 below.

There are several factors that make it difficult to report return on investment figure:

- Providers who have higher levels of awareness are more likely to identify and report incidents and assess the cost of incidents to be higher. This means that one would expect the number of incidents reported by social care providers to be at least equal to the rate reported by smaller organisations in the Cyber Security Breaches Survey and that the 33% rate reported in the Ipsos / IPC survey. This might reflect the impact that the growing rate of DSPT completion has had on cyber security since 2021.

- It is difficult to quantity the impact of increased knowledge and awareness. One might expect the rate of cyber incidents to remain similar regardless of the cyber security awareness of the organisation, but fewer of these should result in material impacts because of the security arrangements in place.

- The current effective measure for the programme is completion of the DSPT, but there is no data on engagement with providers at LSO level (which is a recommendation for future years).

The table below presents three scenarios:

- Without impact of BSBC – this uses the average percentage of all businesses experiencing a breach from the Cyber Security Breaches Survey (40%) and the impact of this from the Ipsos / IPC report

- Low impact – this assumes that the percentage of providers experiencing an incident is 33% based on the Ipsos / IPC report and that the percentage experiencing an impact from a breach is reduced by 8% to 40%

- Medium impact – this assumes that the percentage of providers experiencing a breach is again set at 33%, but the percentage experiencing an impact reduced to 35% (which could be a combination of avoiding an impact or reducing the value of the impact).

Figure 14 - Table showing estimated costs of cyber incidents by impact scenario (repeated in a larger format below)

	A - Total registered with the CQC	B - Percentage of providers experiencing an attack or breach	C - Percentage of those experiencing an attack or breach with a material outcome	D - Estimate of providers experiencing an attack or breach (B x A)	E - Estimate of providers experiencing an attack or breach with a material outcome (D x C)	F - Average cost of attack or breach with material outcome	G - Estimated total value of impact (E x F)
Without impact of BSBC	27,187	40%	48%	10,875	5,220	£9,528	£49,735,245
Low Impact	27,187	33%	40%	8,972	3,589	£9,528	£34,192,981
Medium impact	27,187	33%	35%	8,972	3,140	£9,528	£29,918,859

The estimated impact of the BSBC programme based on these scenarios is as below:

Figure 15 - Table showing calculation of return on investment of BSBC programme based on three impact scenarios

	Total expenditure on BSBC	Total saving	Saving less investment of BSBC expenditure	Return on £1 of expenditure
Without impact of BSBC	£5,337,120	£0	-£5,337,120	-£1.00
Low Impact	£5,337,120	£15,542,264	£10,205,144	£1.91
Medium impact	£5,337,120	£19,816,387	£14,479,267	£2.71

4.3 Comparison with similar digital programmes

Whilst an attempt was made to compare the costs of the BSBC programme with other digital programmes aimed at social care providers, it has proved to be frustratingly difficult to get comparative figures.

Anecdotal evidence from LSOs is that the implementation of Digital Social Care Records has been considerably more expensive with fewer positive outcomes that the BSBC programme. The implementation of the two programmes is very different and the barriers facing providers in implementing DSCRs are considerably higher (complex processes and high initial and ongoing costs) which undoubtedly make the implementation more costly than BSBC, but most LSOs were of the view that they could have been far more successful in implementing the DSCR programme if they had been involved in the same way as with DSPT support through the BSBC programme. Evidence from those LSOs that have been involved in implementing DSCRs with similar freedom to operate as with BSBC suggest that outcomes are better for lower cost.

The budget for the whole Digitising Social Care programme over 3 years is £150 million, with a wide scope. The only direct comparison that could be found was from NHS North East and North Cumbria ICS, which reported on their progress on the digitising social care records programme in October 2023. They reported that they had invested £1.8 million in the project, which had resulted in grants to 83 adult social care providers and 11 pilots for Future Care Technology or Independent Living Technology.

4.4 Overall Recommendations

The first recommendation is a repetition of a recommendation in relation to the recording of LSO activity and the need to record outcomes as well as activity (see 3.2.2 above).

The second recommendation relates to the Ipsos / IPC finding that organisations that exceed DSPT standards (as opposed to those that are approaching or meet the standards) are less likely to experience cyber-related incidents. We recommend that a new target is created based on the percentage of providers publishing at Standards Exceeded. 7% of providers currently exceed standards, and we recommend a target of 15-20% for the year to July 2025.

A target increasing the number of provider organisations publishing at Standards Exceeded will require additional resources for the programme. For LSOs, this will require additional training to support them to develop providers to Standards Exceeded level. At a national level, BSBC would need to develop additional tools and resources for providers to use to achieve Standards Exceeded. These would be an additional cost above the basic programme, although based on the Ipsos / IPC report, would probably generate an additional return on investment from avoided cyber incidents.

Figure 16 - Estimated cost of cyber incidents on care provider

	Total registered with the CQC	Percentage of providers experiencing an attack or breach	Percentage of those experiencing an attack or breach with a material outcome	Estimate of providers experiencing an attack or breach	Estimate of providers experiencing an attack or breach with a material outcome	Average cost of attack or breach with material outcome	Estimated total cost
All social care providers	27,187	33%	48%	8,972	4,306	£9,528	**£41,031,577**

Figure 17 - Table showing estimated costs of cyber incidents by impact scenario (repeated in a larger format below)

	Total registered with the CQC	Percentage of providers experiencing an attack or breach	Percentage of those experiencing an attack or breach with a material outcome	Estimate of providers experiencing an attack or breach	Estimate of providers experiencing an attack or breach with a material outcome	Average cost of attack or breach with material outcome	Estimated total value of impact
Without impact of BSBC	27,187	40%	48%	10,875	5,220	£9,528	£49,735,245
Low Impact	27,187	33%	40%	8,972	3,589	£9,528	£34,192,981
Medium impact	27,187	33%	35%	8,972	3,140	£9,528	£29,918,859

Figure 18 - Table showing calculation of return on investment of BSBC programme based on three impact scenarios

	Total expenditure on BSBC	Total saving	Saving less investment of BSBC expenditure	Return on £1 of expenditure
Without impact of BSBC	£5,337,120	£0	-£5,337,120	-£1.00
Low Impact	£5,337,120	£15,542,264	£10,205,144	£1.91
Medium impact	£5,337,120	£19,816,387	£14,479,267	£2.71

5 Summary of Recommendations

We have made several recommendations to further improve the programme, which are summarised below:

5.1.1 Recommendation 1 – Engaging small providers (section 3.1.3)

Several LSOs have had success in engaging small providers over the last year, including Bradford Care, Care & Support West, SE and SW London and Dorset PIC. Further work should be undertaken to understand what has driven this success and the extent to which it is due to the actions of the LSO or other factors (such as local authority commissioning practices) and the learning disseminated to other LSOs.

5.1.2 Recommendation 2 – Regional providers (section 3.1.3)

Regional providers, that is those that operate within several local authorities within a single region, should be identified and a plan for engagement developed. There are concentrations of these providers in a relatively small number of areas in the country, including Tyneside, Cumbria, West Yorkshire and Bristol.

5.1.3 Recommendation 3 – DSPT completion targets (section 3.1.3)

DSPT completion targets should be set for organisation sizes, with a recommendation that the target for large national organisations should be 100%, medium-sized and regional providers should be 95% and small providers 75%.

5.1.4 Recommendation 4 – Providers publishing at DSPT Standards Exceeded target (section 4.4)

There should be a new target for the percentage of providers exceeding DSPT standards. We suggest a target of 15-20% initially (currently 7% of providers exceed standards). The programme would require additional resources to support this recommendation so an initial step would be to quantify the cost of the resources required.

5.1.5 Recommendation 5 – LSO outcome measures (Section 3.2.5)

LSO performance should be measured on outcomes as well as activity. We recommend that the number and names of providers engaged each month should be recorded. These data would enable the central team to measure the percentage of engaged providers that subsequently achieve Approaching Standards, Standards Met or Standards Exceeded.

5.1.6 Recommendation 6 – Action Research Fund projects (section 3.4.2)

There are several recommendations related to future Action Research Fund projects which we have grouped under one overall recommendation:

- The initial specification of projects should clearly set out the expected outputs, specifically in terms of actionable findings
- There should be additional support for organisations that have limited research experience.
- There should be regular ongoing support for projects consisting of both 1:1 sessions and group sessions with other projects to share experiences and support.
- There should be a clear report template which sets out how findings and recommendations are to be identified and the benefits of these.

6 Appendix 1 - Data on DSPT Compliance – Size and Scope of the Programme

6.1 Introduction

This section of the evaluation looks at the data on DSPT compliance and the activity of the Local Support Organisations that were providing support to social care provider organisations to complete the DSPT.

Previous years' analysis has covered periods up to the end of March, which matches the period that the evaluations were commissioned for. This year's evaluation covered a longer period up to the end of the DSPT year at the end of June 2024. The figures from previous years have been re-based on the end of June each year for consistency. The comparative figures based on the previous evaluation periods have been included in an appendix for reference.

The analysis of the data on the Data Security and Protection Toolkit (DSPT) compliance is based on the period April 2021 to July 2024, which are months for which complete data on the DSPT and Local Support Organisation (LSO) activity is available. We have commenced the analysis from April 2021 and then July in each year 2021-2022 to give comparative years. The July date is based on the most recent data to the end July target date for DSPT completion.

The actual DSPT year ends in August or September, the actual date of which is set by the NHS England. Where appropriate, analysis of 2024 data has been extended to the end of August to include the full DSPT year.

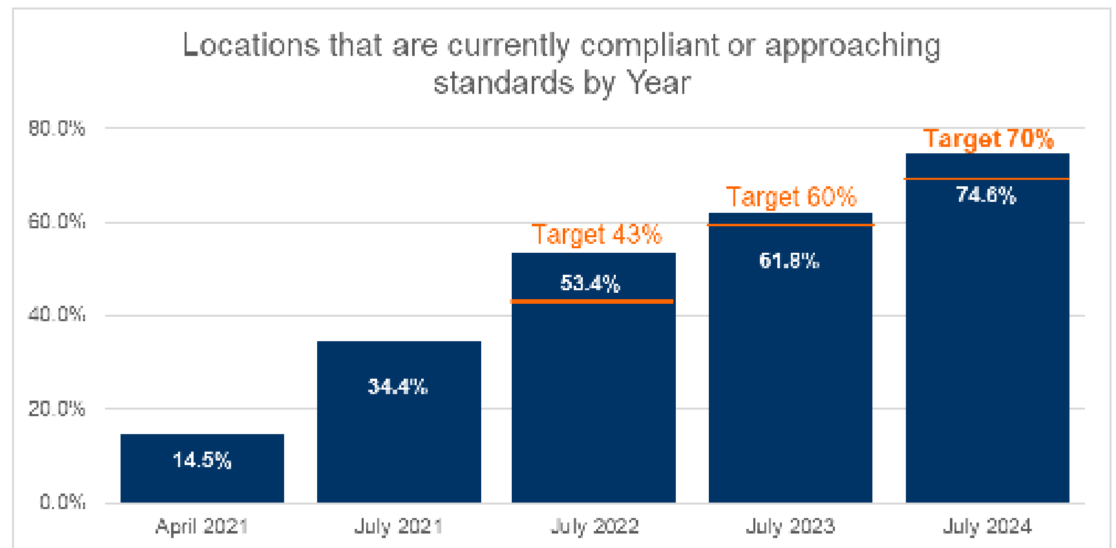
As noted, above, this evaluation covers adult social care services that are registered with the CQC provided by social care organisations (so excluding NHS bodies). These are registered by the CQC as locations, which are either the location where the personal care services are delivered (such as care homes or supported housing services) or where the staff providing the service are based in the case of domiciliary care services (home care). In April 2021 there were 26,439 such locations that could have been compliant with the DSPT. In July 2024, this had increased to 27,215 locations; an increase of 4%.

Overall, there has been a significant increase in compliance with the DSPT over the period, up from 14.53% in April 2021 to 76.1% at the end of August 2024. This represents an additional 17,036 locations that were DSPT compliant.

Figure 19 - Change in DSPT compliance 2021-2024

Compliance Level		April 2021	July 2021	July 2022	July 2023	July 2024
Locations that are currently compliant or approaching standards	No.	3,841	9,125	14,505	16,807	19,745
	%	**14.5%**	**34.4%**	**53.4%**	**61.8%**	**74.6%**
Locations neither compliant nor approaching standards	No.	22,598	17,357	12,656	11,237	7,447
	%	**85.5%**	**65.6%**	**46.6%**	**38.2%**	**25.4%**
Total	**No.**	**26,439**	**26,482**	**27,161**	**28,044**	**27,192**

Figure 20 - Chart showing compliance against target for each year



At a regional and local authority level there is considerably more variance in compliance with the DSPT. There is also considerable variance in compliance with the DSPT by the type of service that the location provides. This report looks in more detail at these variances over the following pages. These data will help increase understanding of the factors affecting DSPT compliance and should help LSOs and the national and regional BSBC teams target support in future years of the programme.

6.2 DSPT Compliance by Level

DSPT compliance is possible at 3 levels for 2021/22 onwards:

- Approaching Standards

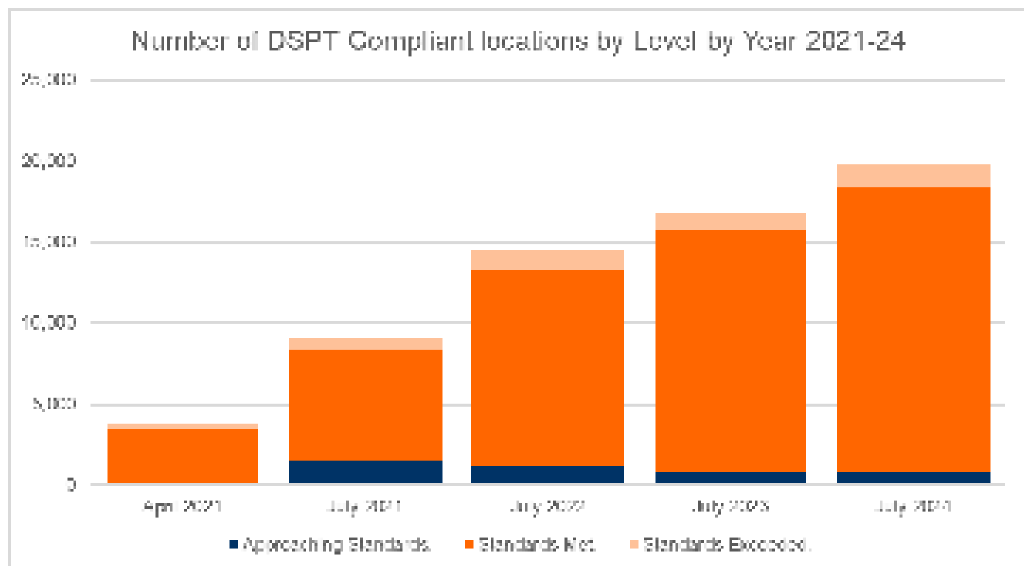
- Standards Met
- Standards Exceeded

The table below shows the percentage of providers that had achieved each level of compliance between April 2021 and 2024:

Figure 21 - DSPT compliance Level as a percentage of total compliance 2021-202

Level		April 2021	July 2021	July 2022	July 2023	July 2024
Approaching Standards.	No.	47	1,516	1,234	882	762
	%	1%	17%	9%	5%	4%
Standards Met.	No.	3,486	6,807	12,149	14,960	17,657
	%	91%	75%	84%	89%	89%
Standards Exceeded.	No.	308	802	1,122	965	1326
	%	8%	9%	8%	6%	7%
Total		**3,841**	**9,125**	**14,505**	**16,807**	**19,745**

Figure 22 - Number of DSPT compliant organisations by level of compliance and year

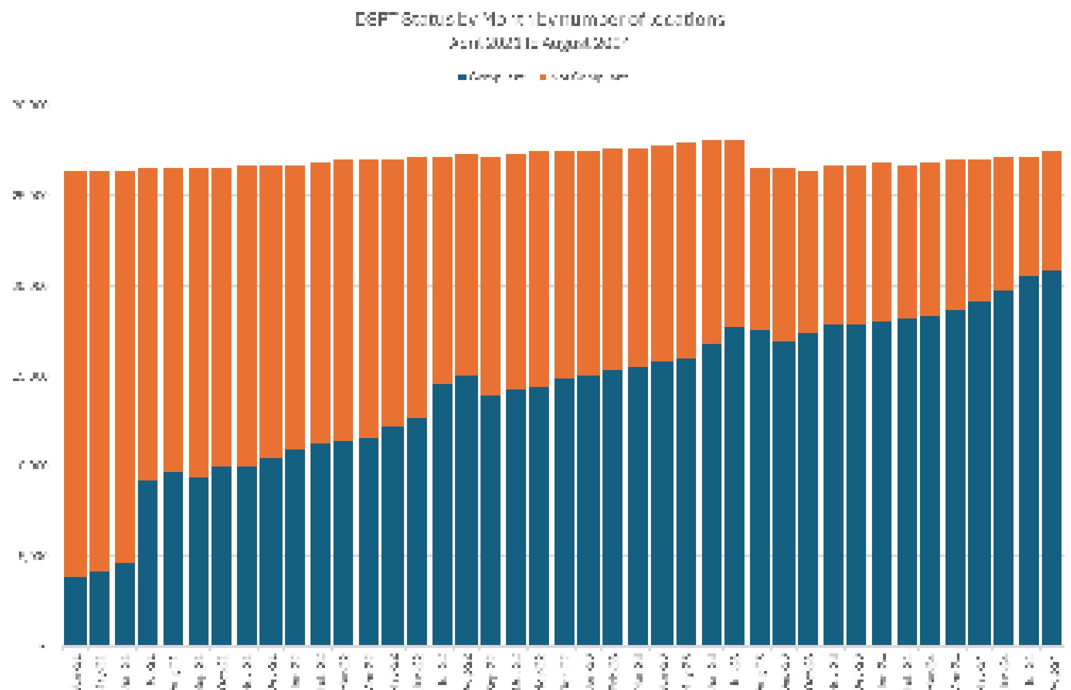


There was a large increase in compliance by location for all DSPT compliance standards, in line with the overall increase in DSPT compliance noted in the previous section.

6.3 DSPT Publication by Month

DSPT publications remain valid until the year after they are published, so for the DSPT year that ran from July 2023 to June 2024, DSPTs published in 2022/23 and 2023/24 were valid. There is an increase in DSPT publications in the months leading up to the end of the DSPT year. The chart below shows DSPT publications by month since April 2021.

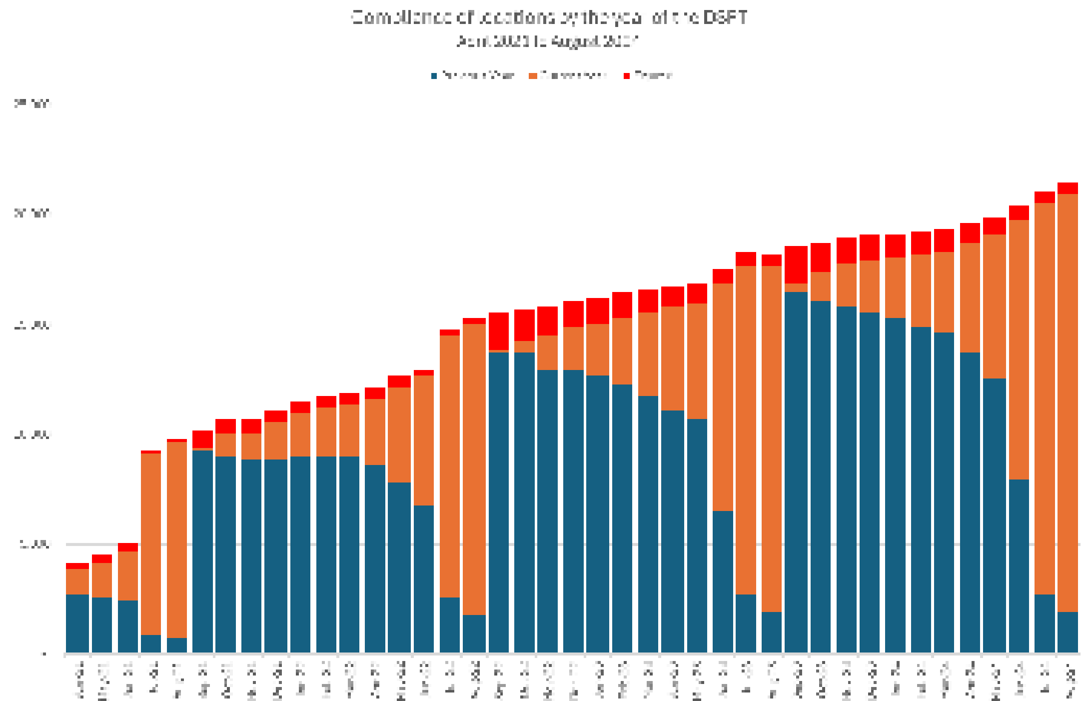
Figure 23 - DSPT status by month



There is a jump in the number of publications in July and August each year as the DSPT year ends, with the number of compliant providers falling in September as publications from the previous DSPT year expire.

There is a big change in the DSPT status of organisations publishing across the year, as illustrated in the chart below, which shows which year DSPT compliance is from. Current are locations that have published their DSPT in the current year, whilst Previous relates to DSPT compliance that arises from the DSPT published in the previous year.

Figure 24 - DSPT status of locations by the year of the DSPT



It is clear from the chart that much of the activity in July and August is from providers who held a DSPT from the previous year renewing before it expired, whist from September much of the activity relates to providers registering for the first time. The red shading indicates locations where the DSPT has expired, which jumps in September each year as 2-year-old DSPTs cease to be valid.

A growing number of new locations are registering in the first year of their operation, rising from 22% in 2021 to 42% in 2022. There has also been a slight reduction in the number of months from registering to publication for these providers. Both figures suggest a growing awareness of the importance of digital security amongst the many other tasks facing a new provider.

6.4 Regional DSPT compliance

As noted, there is a variation in DSPT compliance between regions in England.

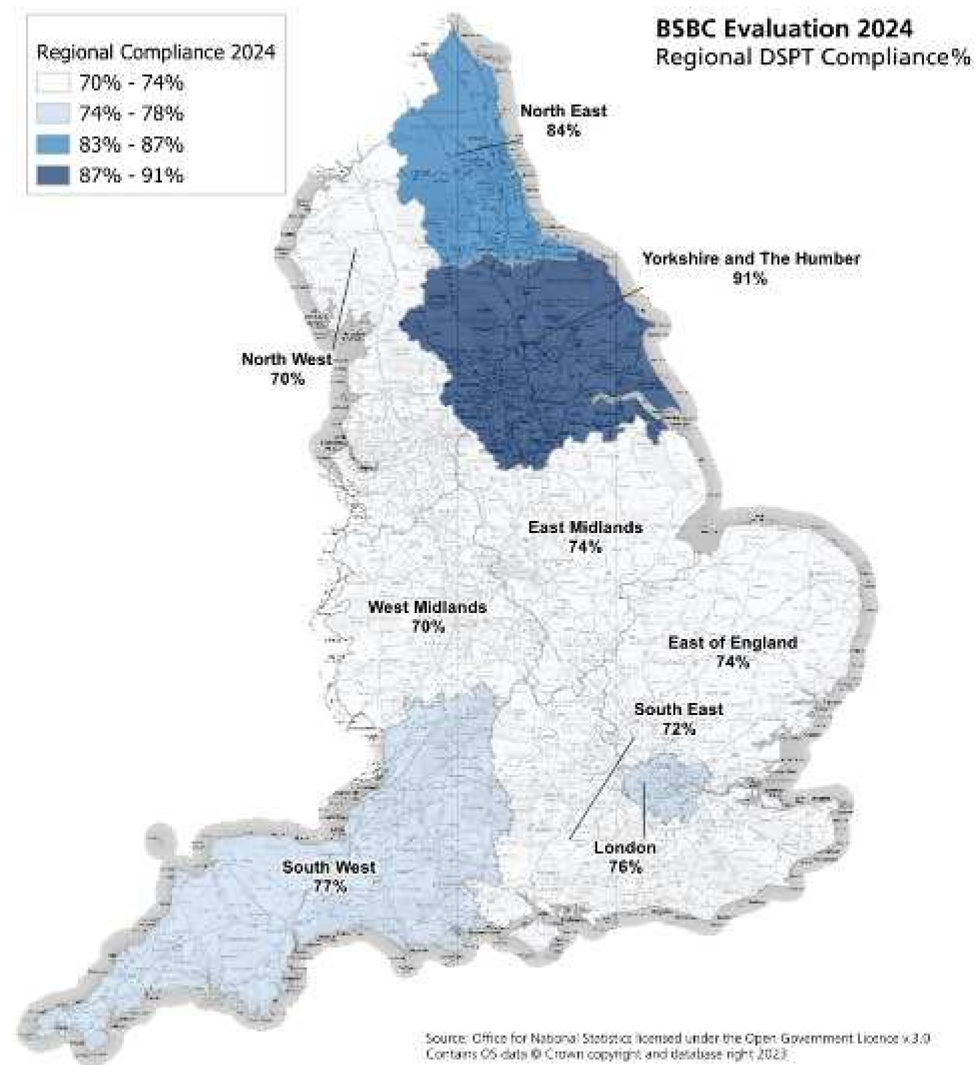
The table below shows DSPT compliance by region since 2021

Figure 25 - Change in percentage of DSPT Compliant Locations by Local Government Region 2021-2024

Region	April 2021	July 2021	July 2022	July 2023	July 2024
Yorkshire and The Humber	14%	38%	70%	81%	91%
North East	18%	47%	71%	81%	84%
South West	13%	37%	55%	62%	77%
London	8%	24%	43%	57%	76%
East of England	17%	36%	54%	62%	74%
East Midlands	19%	35%	48%	60%	74%
South East	13%	35%	55%	65%	72%
West Midlands	15%	31%	47%	55%	70%

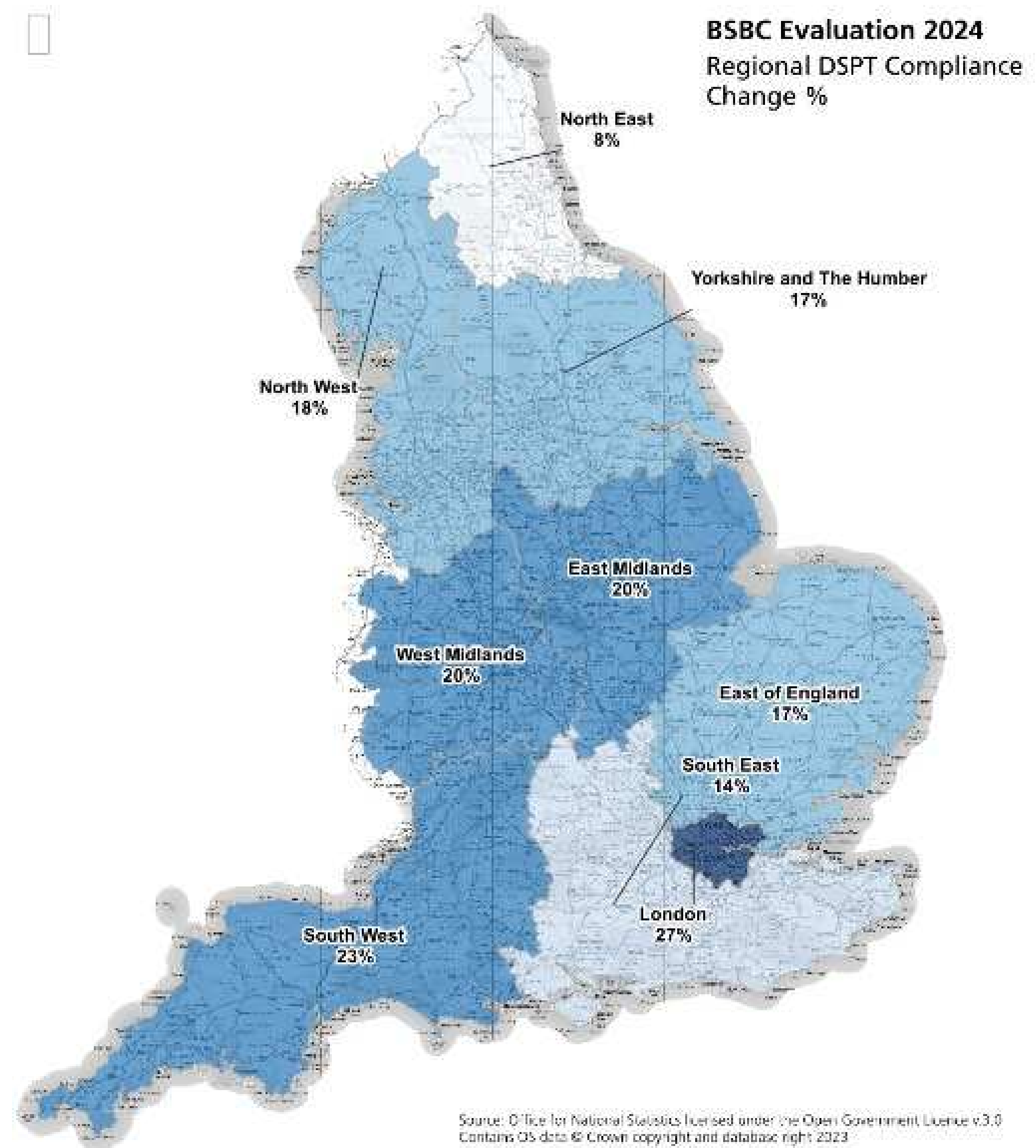
The map below shows the compliance by region, with darker shaded areas having greater compliance. It clearly shows that Yorkshire and the Humber has the highest compliance at 91%, with North East following at 84%, both of which are covered by the NHS-led North East and Yorkshire LSO.

Figure 26 - Map showing location DSPT compliance Percentage by Region



The following map shows the change in DSPT compliance from April 2021 to July 2024 again showing large increases in compliance in some regions. The higher initial compliance levels in the North East and Yorkshire and The Humber means that their overall percentage change has been lower, whilst London has shown a large increase in compliance of 27%

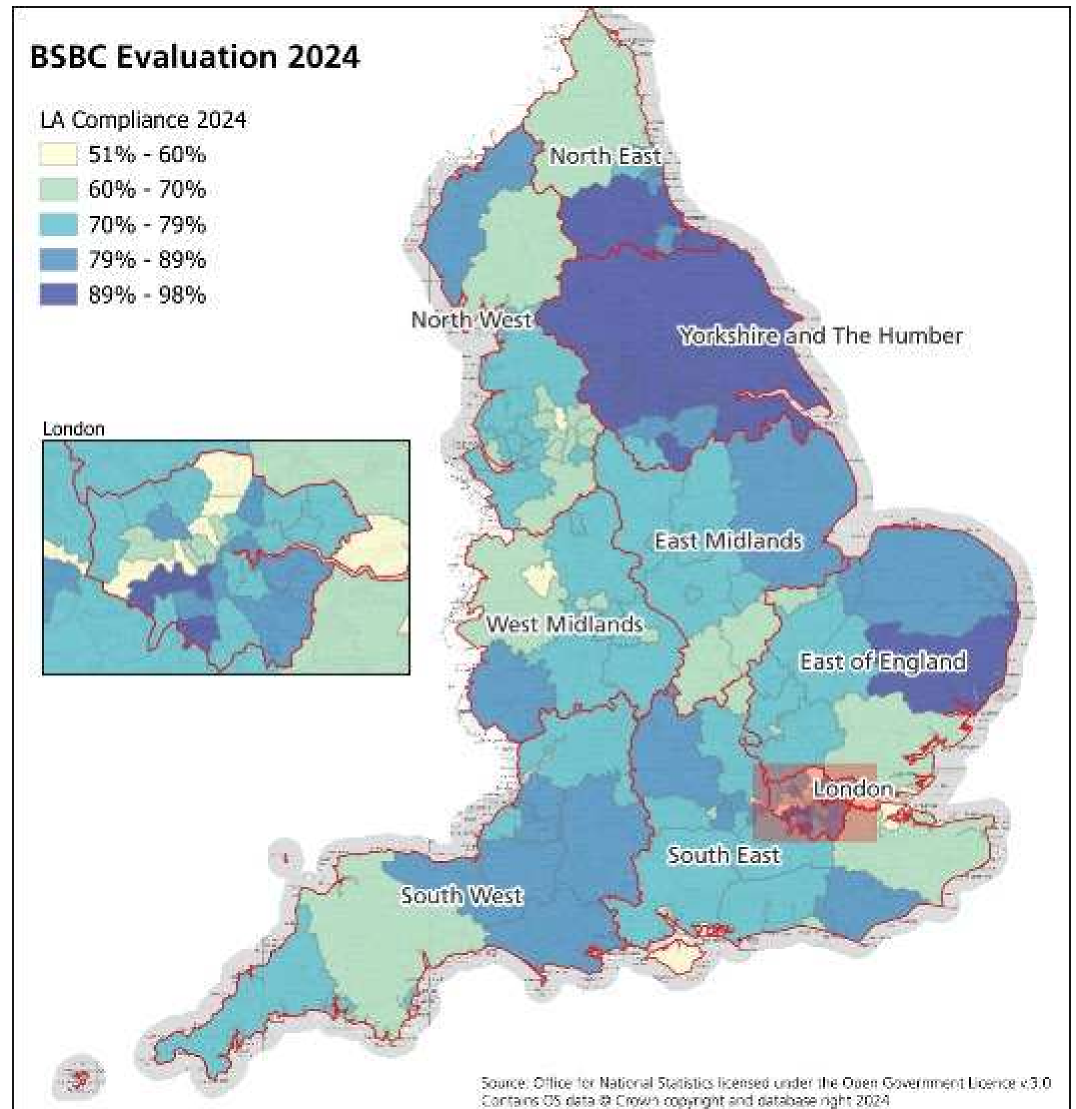
Figure 27 - Map showing location DSPT compliance change between July 2023 and July 2024 by Region



6.5 Local Authority compliance

At a local authority level, there is also substantial variation in compliance levels within regions. This is notable in the North East and Yorkshire region where the high DSPT compliance of locations within a small number of local authorities accounts for the good performance at a regional level. This is illustrated on the following map, which shows the DSPT compliance percentage by local authority:

Figure 28 - Map showing location DSPT compliance percentage by Local Authority and NHS Region



Conversely, compliance in Devon and Cornwall, parts of the West and East Midlands and the North West are below average, whilst in some authorities in London, DSPT compliance is less than 30%. The Isle of Scilly's 1 non-care home provider is not compliant, resulting in a 0% compliance rate.

There has been considerable change in DSPT compliance both over the last 12 months (July 2023 to July 2024) and for the period of the evaluation data (July 2021 to July 2024). This is shown in the maps below.

Figure 29 - Map showing location DSPT compliance change in percent

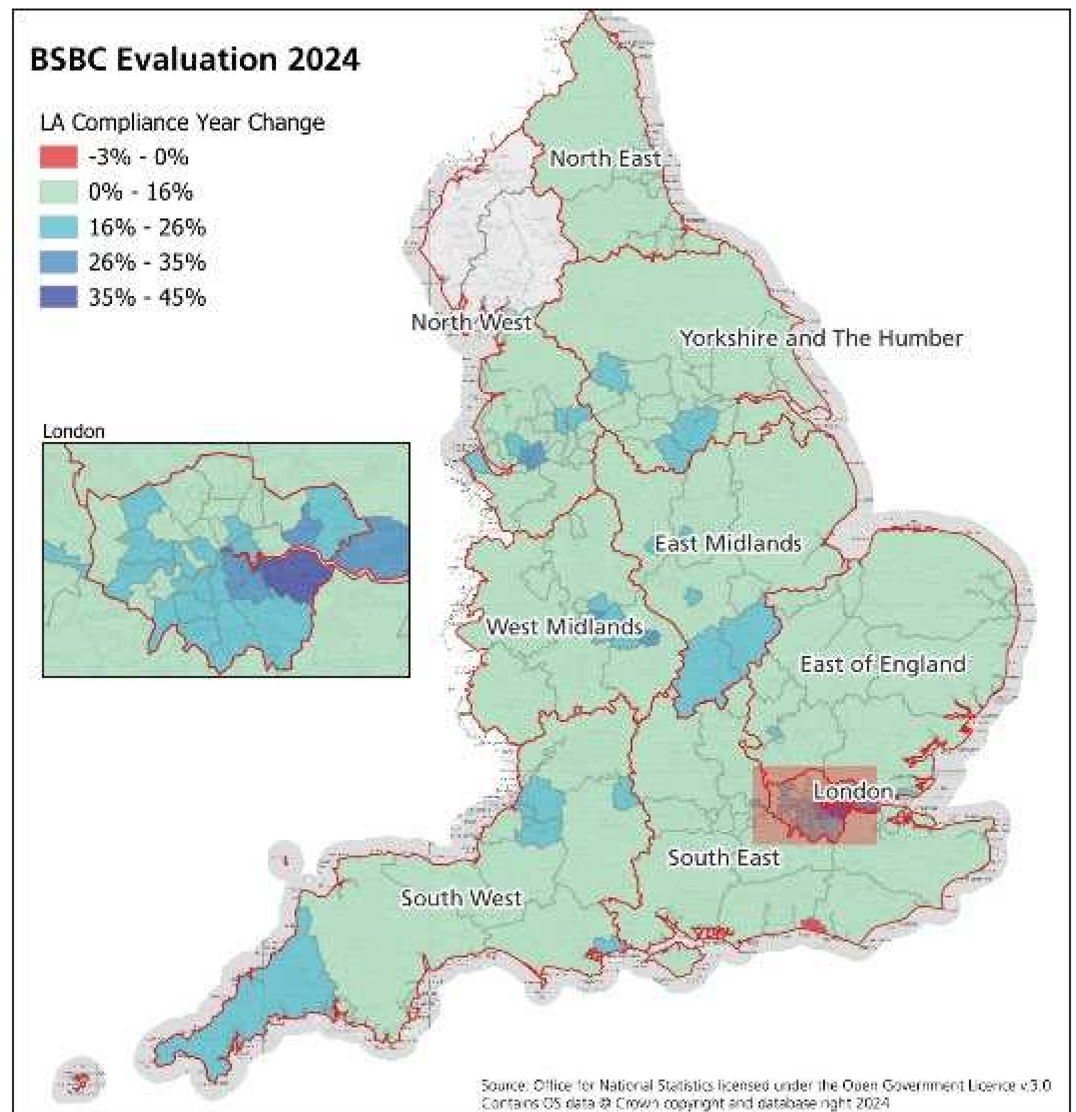
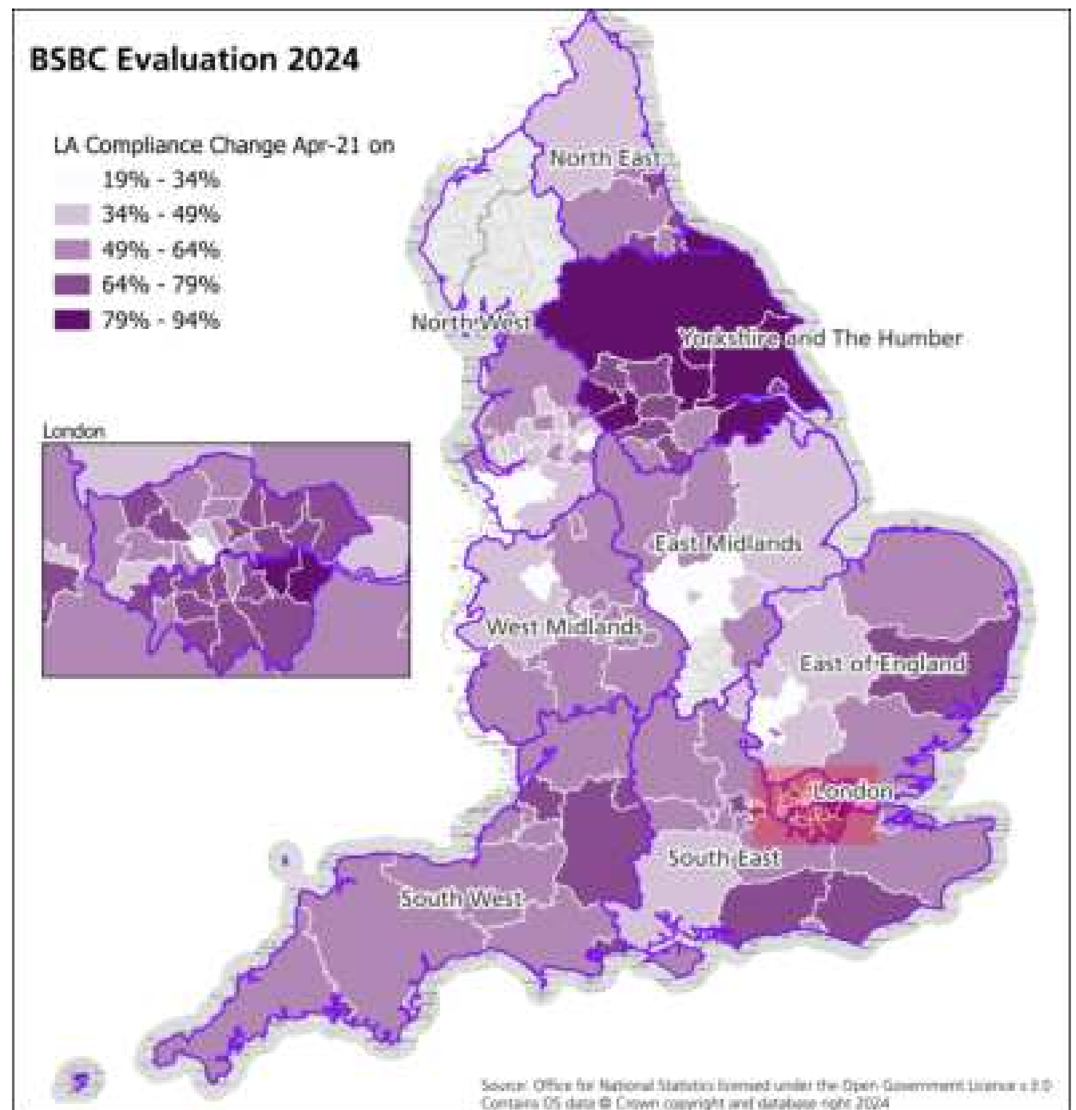


Figure 30 - Map showing DSPT compliance change in percent from April 2021 to July 2024

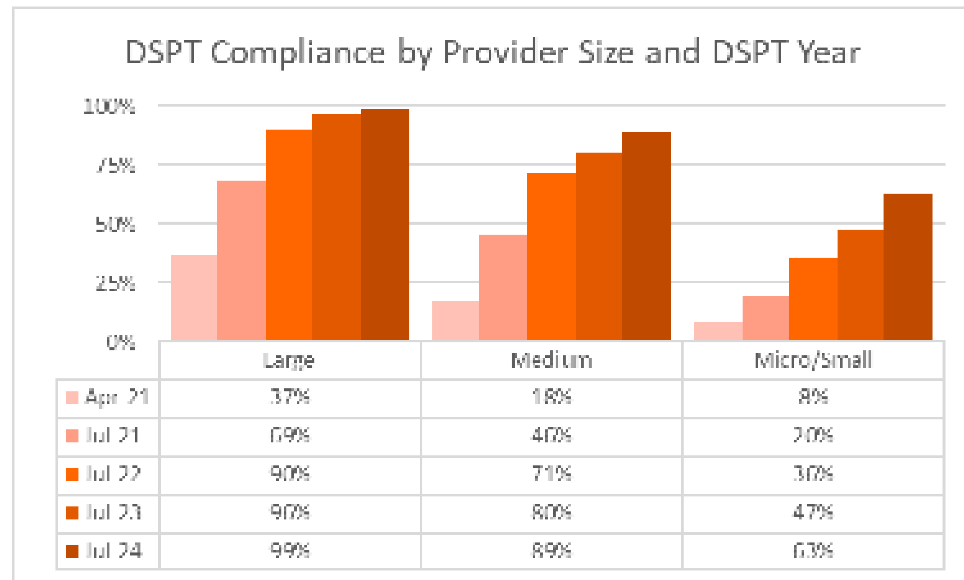


Greenwich has seen an increase of 45% (41% to 81%) since July 2023. One authority (Brighton and Hove) has seen a reduction in DSPT compliance of 3% compared to July 2023 (down from 70% to 67%). Two authorities have shown no change in compliance in the last year: Portsmouth (on 58%) and South Tyneside (on 88%). Over the period since July 2021, London and Yorkshire and The Humber have shown the highest levels of growth in compliance.

Care homes (including care homes providing nursing care) continue to have a higher level of DSPT compliance than non-care home locations, but there has been a notable increase in DSPT compliance in non-care home locations driving the overall increase in compliance. In July 2024, 84% of care home locations were compliant compared to 65%% of non-care home locations (mainly domiciliary care agencies). This represents an increase of 7% for care home locations and 18% for non-care home locations.

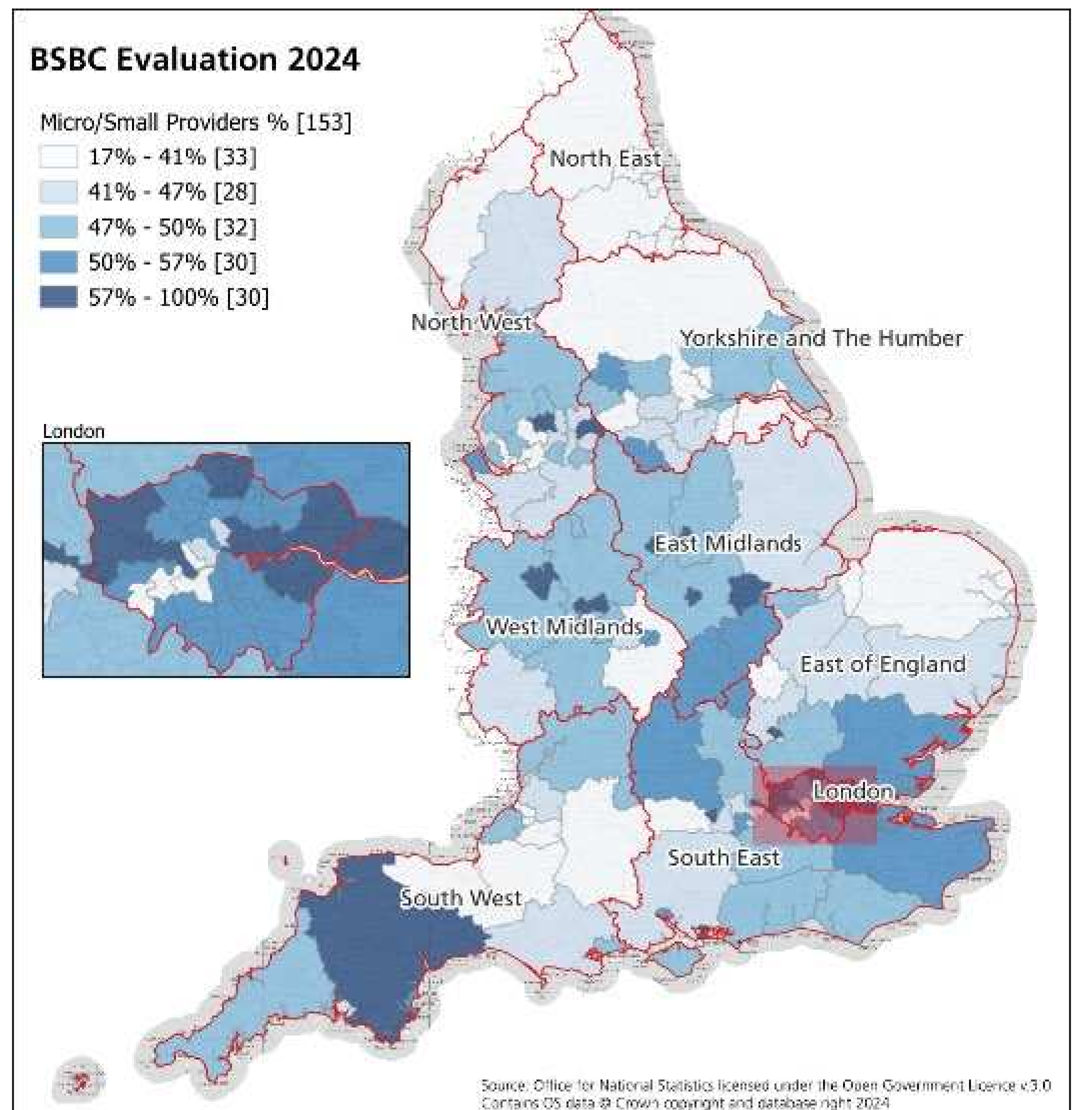
There continues to be a close link between the size of providers and DSPT compliance. 99% of large providers are now DSPT compliant, an increase of 3%. Micro/Small providers are now 63% compliant, an increase of 16% since last year. This suggests a growing awareness of the DSPT across the social care sector, including smaller providers who often remain hard to engage with.

Figure 31 - DSPT compliance by provider size and DSPT year



This relationship between the number of small providers in an area and DSPT compliance at an area level can be seen on the following map, which shows the micro/small provider percentage for each local authority area. When compared with the earlier map on DSPT compliance, the relationship between the two can be seen. In previous years there has been a strong relationship between the number of small providers and lower levels of DSPT compliance at a local authority level. This year, this relationship is less strong, reflecting the impact of growing engagement of smaller providers.

Figure 32 - Percentage of local authority care providers classified as micro/small



This also has implications at an LSO level, which will be explored shortly.

6.6 DSPT compliance by type of organisation

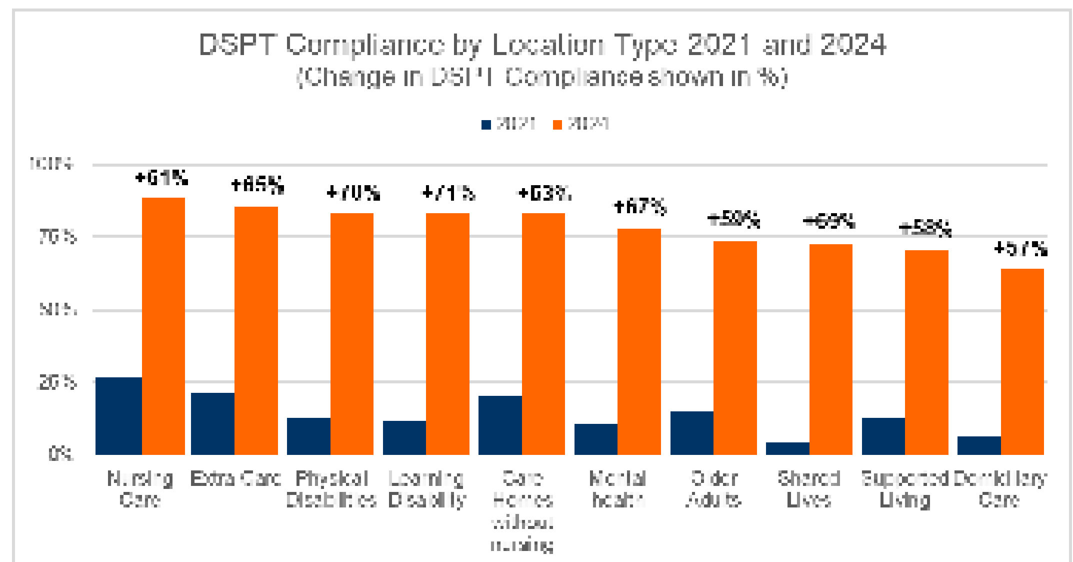
The data suggest that the size of organisation is key to DSPT compliance rather than the type of support that it provides. Large organisations of any type have good compliance, although different types of provider have different proportions of large providers.

The table below shows DSPT Status by type of CQC registration:

Figure 33 – Table showing location DSPT status by CQC registration type and the percentage of all locations that this location type represents

	Expired	Compliant	Not Compliant	Not Published	Not Registered	% of Locations
Nursing Care	2%	**88%**	1%	3%	6%	7%
Extra Care	0%	**86%**	0%	1%	13%	1%
Physical Disabilities	2%	**83%**	0%	2%	12%	2%
Learning Disability	2%	**83%**	1%	2%	12%	7%
Care Homes without nursing	3%	**83%**	1%	3%	10%	17%
Mental health	2%	**78%**	1%	3%	15%	2%
Older Adults	2%	**74%**	1%	4%	19%	38%
Shared Lives	2%	**73%**	1%	2%	22%	0%
Supported Living	2%	**71%**	0%	4%	23%	5%
Domiciliary Care	2%	**64%**	1%	5%	29%	20%

Figure 34 - Chart showing DSPT compliance by location type in 2021 and 2024



All location types have shown an increase in DSPT compliance (shown above the 2024 column), with domiciliary care locations showing the largest increase, Nursing care shows the lowest level of increase, from a high starting point.

The data seem clear that the key factor in DSPT take-up is the size of the provider and not necessarily the type of services. Large providers have much higher rates of DSPT compliance than smaller ones, with many location types provided by large providers being 100% compliant, the lowest level being Extra Care at 97%. The tables and charts below show DSPT compliance by provider size and the CQC service type and provider size and client group.

Figure 35 – Table showing DSPT compliance July 2024 by provider size and the CQC registration type

CQC Registration Category	Large	Medium	Small
Nursing Care	100%	90%	79%
Care Homes without nursing	100%	90%	72%
Supported Living	100%	88%	62%
Shared Lives	100%	83%	63%
Domiciliary Care	99%	84%	57%
Extra Care	97%	83%	56%

Figure 36 - Chart showing DSPT compliance July 2024 by provider size and the CQC registration type

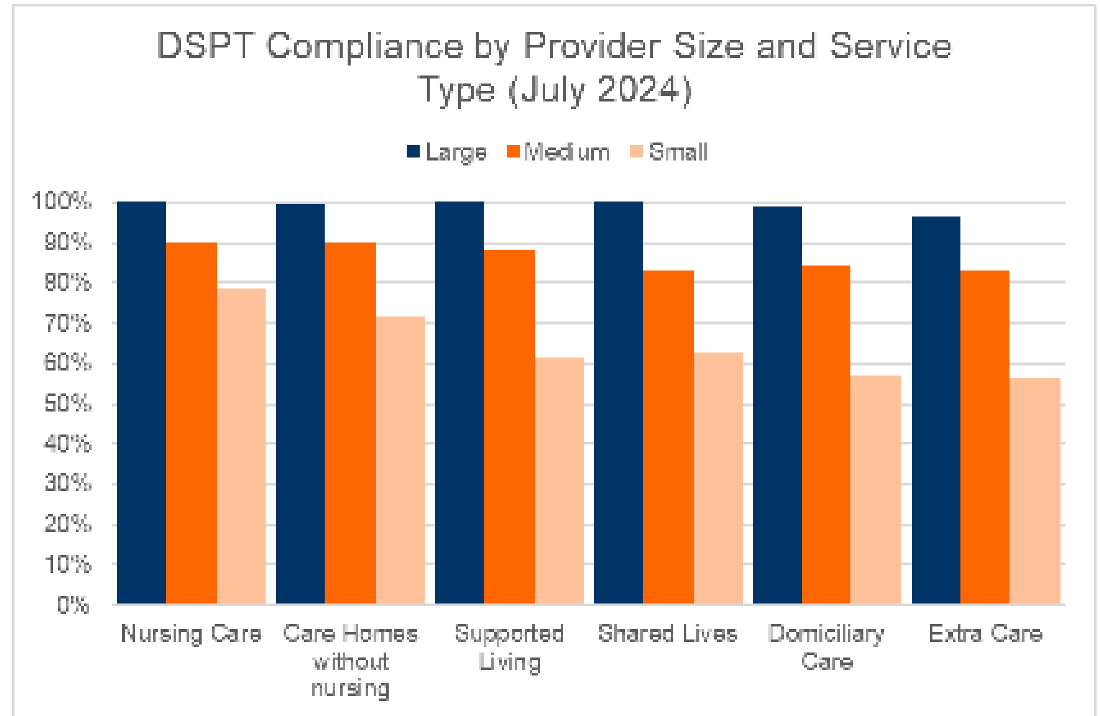
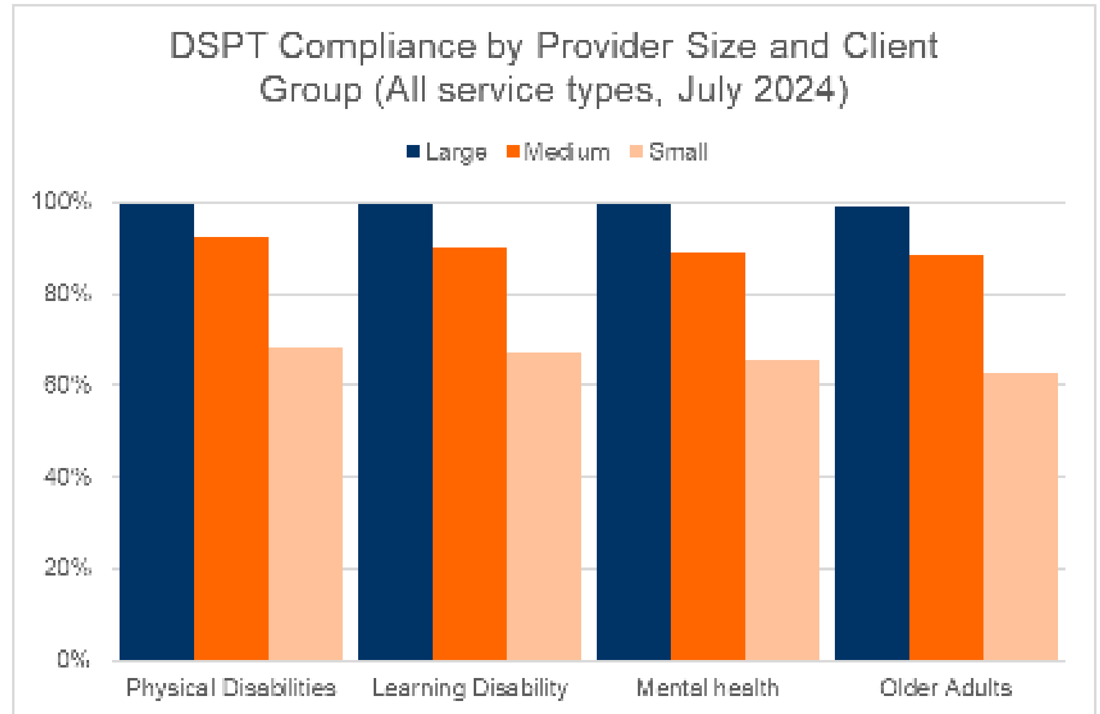


Figure 37 – Table showing DSPT compliance July 2024 by provider size and client group

CQC Registration Category	Large	Medium	Small
Physical Disabilities	100%	92%	68%
Learning Disability	100%	90%	67%
Mental health	99%	89%	65%
Older Adults	99%	89%	63%

Figure 38 - Chart showing DSPT compliance July 2024 by provider size and the CQC registration type



The make-up of the provider market at a local level explains a lot of the variation in DSPT take-up at a regional and local authority level. The following chart shows the split between small, medium and large providers for each CQC registration type, together with the percentage of the total care market that the registration type represents. It shows, for example, that domiciliary care locations are dominated by small providers, and represent 31% of the overall care market, reflecting the impact on DSPT take-up in areas with a high proportion of domiciliary care locations, such as London.

Figure 39 - Size of care providers by CQC Registration type with the percentage of the overall care market that the registration type represents

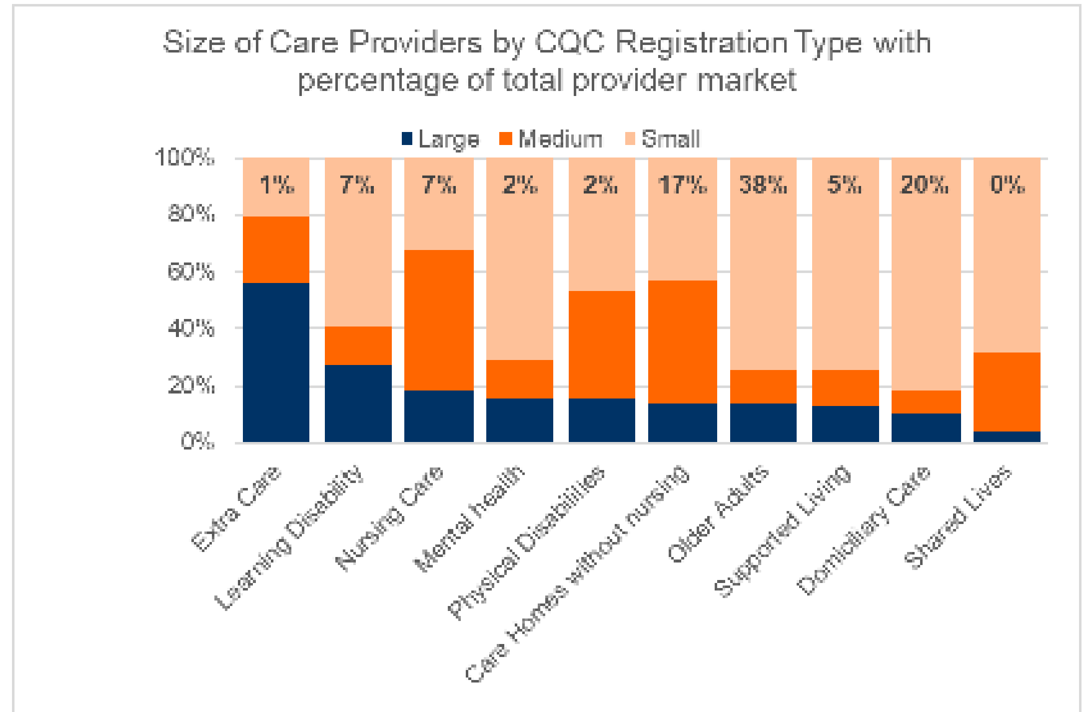
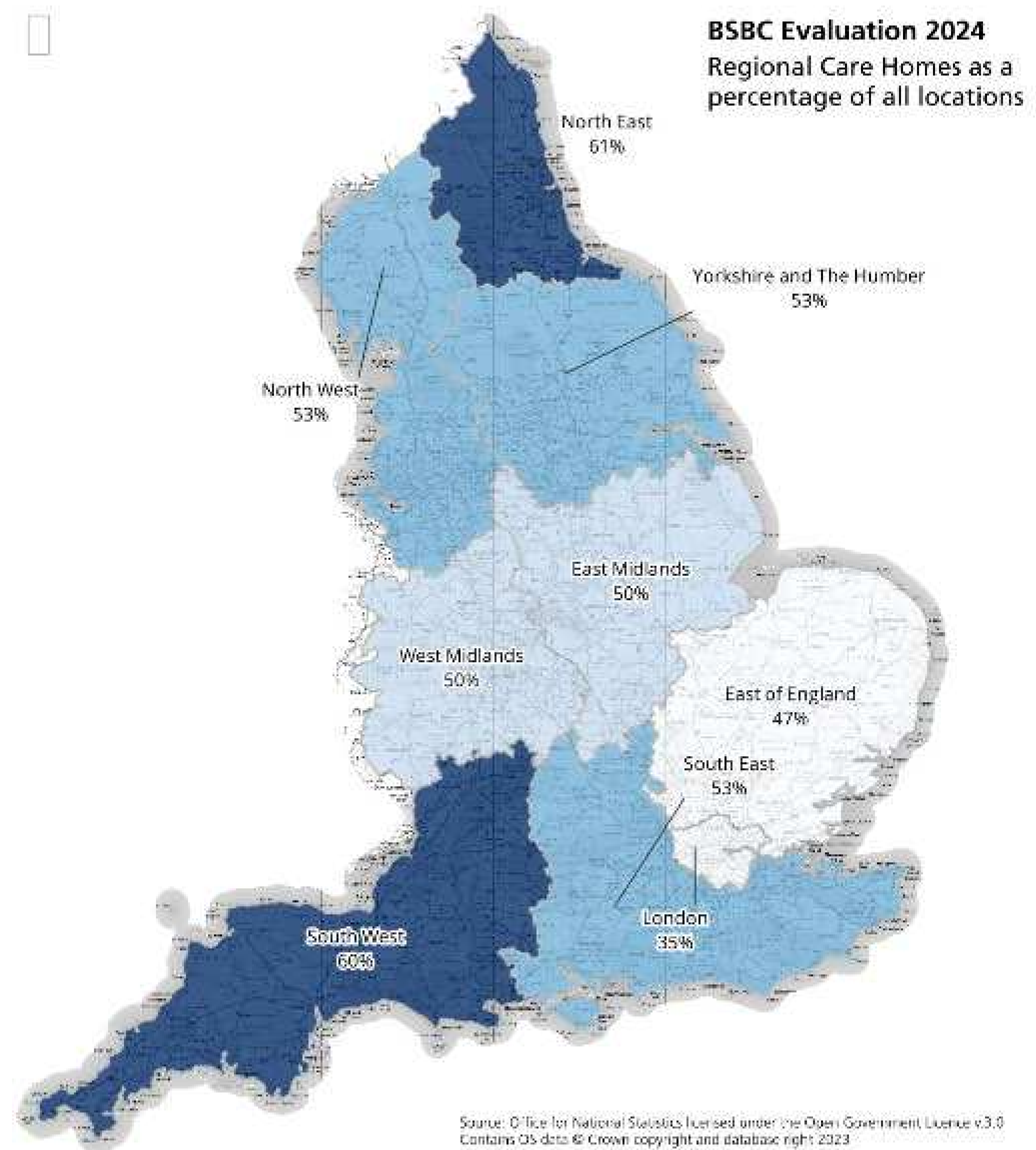


Figure 40 – Table showing Region care market provider sizes and DSPT compliance, July 2024

Region	Large	Medium	Micro/Small	DSPT compliance
Yorkshire and The Humber	14%	34%	52%	91.1%
North East	20%	41%	38%	84.4%
South West	14%	28%	58%	76.7%
London	10%	20%	70%	75.7%
East of England	16%	26%	58%	74.3%
East Midlands	12%	28%	60%	73.6%
South East	18%	24%	58%	72.0%
West Midlands	12%	28%	60%	70.3%
North West	14%	29%	57%	69.9%

In previous years there has been a clear link between the percentage of small providers in a region and the level of DSPT compliance, although the North East and Yorkshire and Humberside have been exceptions to this. In the last year, this link has become a lot less apparent, particularly in Yorkshire and Humberside where there are high levels of compliance despite relatively high percentages of small providers.

Figure 41 - Percentage of CQC registered locations that are care homes, August 2024. Darker shading shows higher compliance



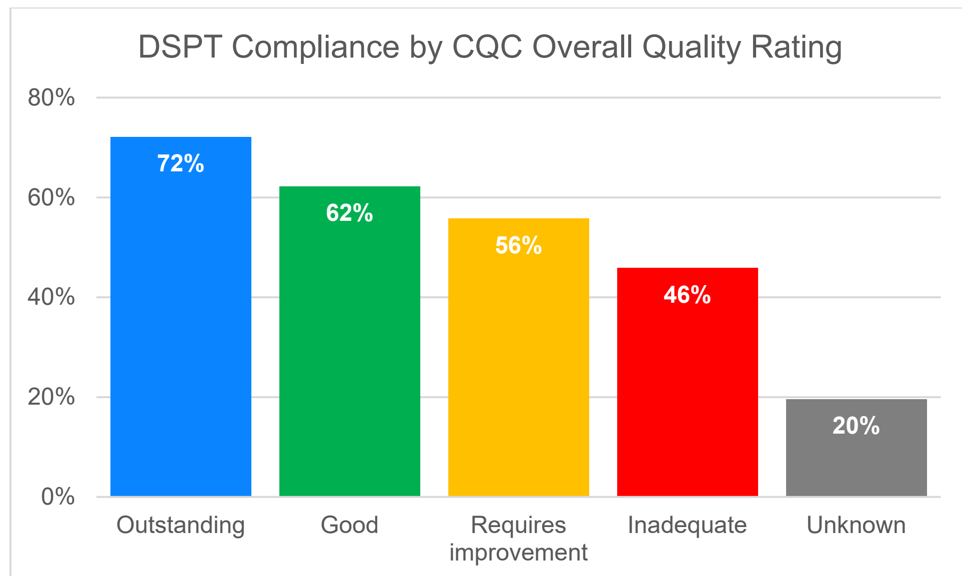
6.6.1 Quality

There is a clear relationship between the quality of a location and its DSPT compliance. The higher the quality of the location, the more likely it is to have DSPT compliance.

Figure 42 - DSPT compliance status by Location Latest Quality Rating (CQC Data 1/07/2024). Services rated as "Unknown" are generally newly registered services.

Compliance	Outstanding	Good	Requires Improvement	Inadequate	Not Rated
Compliant	**2.1%**	**72.3%**	**20.4%**	**0.7%**	**4.5%**
Expired	19.9%	69%	2%	2%	7%
Not Compliant	22.6%	72%	0%	2%	2%
Not Individually Registered.	0.2%	52%	44%	1%	2%
Not Published.	0.2%	65%	31%	2%	2%

Figure 43 - DSPT compliance by CQC Quality Rating (July 2024)



This shows that services are more likely to be DSPT compliant the higher the quality rating. Services with a rating of "Unknown" are generally those that are newly registered and have not yet been inspected. Those services are also less likely to have completed the DSPT process. Nationally, in July 2024, 82% of

locations are rated as Good or Outstanding, and 17% are rated as Requires Improvement or Inadequate, with the remainder being Unknown or unrated.

6.6.2 Size and Scale of Providers

A significant determinant of DSPT compliance is the size of the provider. In general, the larger the provider, the more likely they are to have completed the DSPT. The size and scale of providers is calculated from publicly available CQC data. Whilst the size in terms of client numbers is not available for homecare providers, this can be inferred from the number and geographic spread of care locations (offices).

Scale of operations

As noted in the sections above, the scale (size) of the provider is the overall size of the provider in terms of the number of locations (services) that they operate, although for Care Homes, this can also be the number of care home beds they manage.

Scale is broken down into Micro/Small, Medium or Large:

- **Micro/Small** – 1 to 3 locations or 1 to 60 beds
- **Medium** – 4 to 10 locations or 61 to 999 beds
- **Large** – 11 or more locations or 1,000 or more beds

Again, the greater the number of locations that the provider has, the more likely they are to be DSPT complaint.

The table below shows DSPT compliance by the number of locations for non-care home locations:

Figure 44 - Table showing DSPT compliance by the scale of the non-care home provider (July 2024)

Not Care Home	Compliant	Not Compliant	Not Individually Registered.	Not Published.
Large	**98%**	0%	2%	0%
Medium	**84%**	1%	14%	1%
Micro/Small	**57%**	1%	34%	6%

Small providers (those with 1-3 locations) have the lowest level of DSPT compliance at 11%, whilst most large providers (54%) are compliant.

For care home locations, there is a similar picture, but levels of compliance in care homes are higher in general.

Figure 45 - Table showing DSPT compliance by the scale of the care home provider (July 2024)

Care Homes	Compliant	Not Compliant	Not Individually Registered.	Not Published.
Large	**100%**	0%	0%	0%
Medium	**90%**	1%	6%	1%
Micro/Small	**73%**	2%	14%	6%

Figure 46 - Table showing scale of providers by region with the percentage DSPT compliance (July 2024)

Region	Large	Medium	Micro/Small	DSPT compliance
Yorkshire and The Humber	14%	34%	52%	91.1%
North East	20%	41%	38%	84.4%
South West	14%	28%	58%	76.7%
London	10%	20%	70%	75.7%
East of England	16%	26%	58%	74.3%
East Midlands	12%	28%	60%	73.6%
South East	18%	24%	58%	72.0%
West Midlands	12%	28%	60%	70.3%
North West	14%	29%	57%	69.9%

Geographic scope

The first factor is the geographic scope of the provider. This is sub divided into three groups of providers:

- **Local Providers**, operating within a single local authority area
- **Regional Providers**, operating within several neighbouring local authority areas within a single region.

- **National Providers**, operating across several regions.

National providers, which will generally be the largest ones, have the highest levels of DSPT compliance. Local providers, which are often also the smallest, have the lowest level of compliance

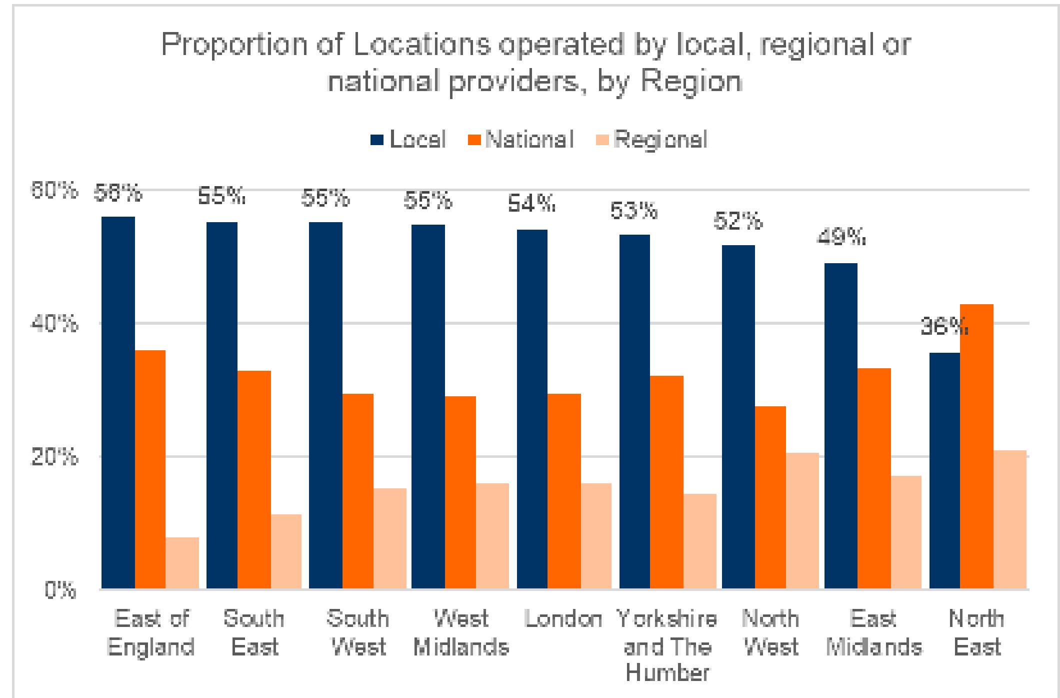
Figure 47 - Table showing DSPT compliance by geographical scope of provider (July 2024)

DSPT compliance	Local	National	Regional
Compliant	**67%**	**89%**	**77%**
Expired	3%	1%	2%
Not Compliant	1%	0%	1%
Not Individually Registered.	23%	8%	17%
Not Published.	6%	1%	4%

The chart below shows the breakdown of locations by provider scale by region, showing the percentage of locations operated by local providers.

The figures for the North East are very different to the rest of the country, with a much higher proportion of locations operated by regional and national providers.

Figure 48 - Chart showing the proportion of locations operated by local, regional or national providers. The percentage figures show the percent of locations operated by local providers. (CQC Data July 2024/)



6.6.3 Type of Non-Care Home Provision

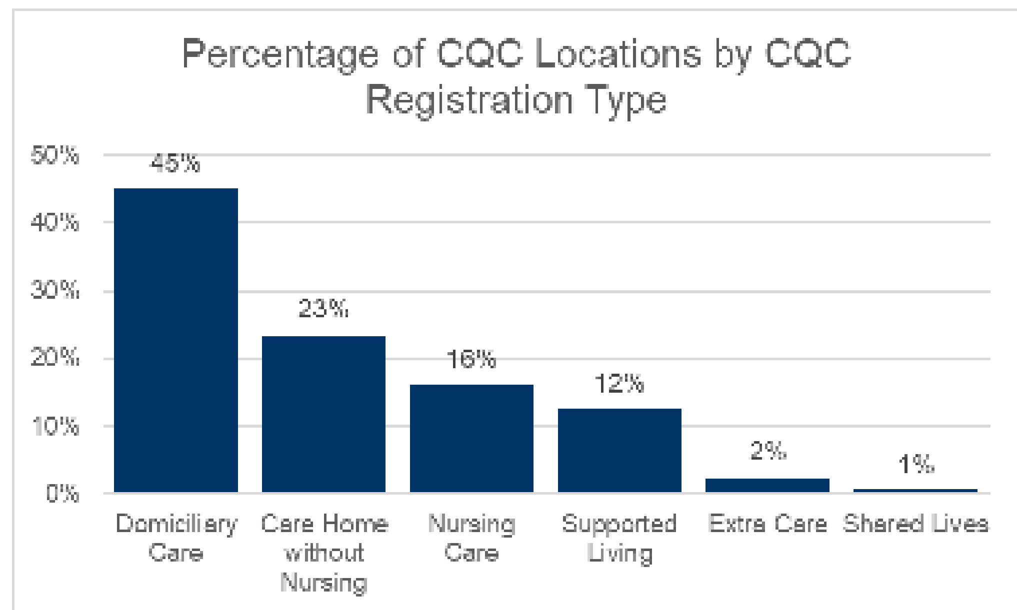
As noted earlier, the type of provider is a significant factor in determining DSPT compliance. The data earlier in this section shows that compliance is lower in non-care home locations. These locations are made up of several types, which are detailed below:

- **Domiciliary Care** – home care provided in people's own homes, available for all client groups and all ages.
- **Extra Care** – supported housing for mainly for older adults with personal care services available from a care provider. Extra Care housing usually consists of flats or housing available within a single site.
- **Shared Lives** – support to mainly working age adults with support need to live with a family who provide care and support.
- **Supported Living** – housing for working age adults, usually with a small group of people or a self-contained accommodation within a cluster of other housing for people with support needs.

To be CQC registered, the support provider must provide personal care alongside other support. For some services, such as shared lives, some may not be registered because they don't provide personal care.

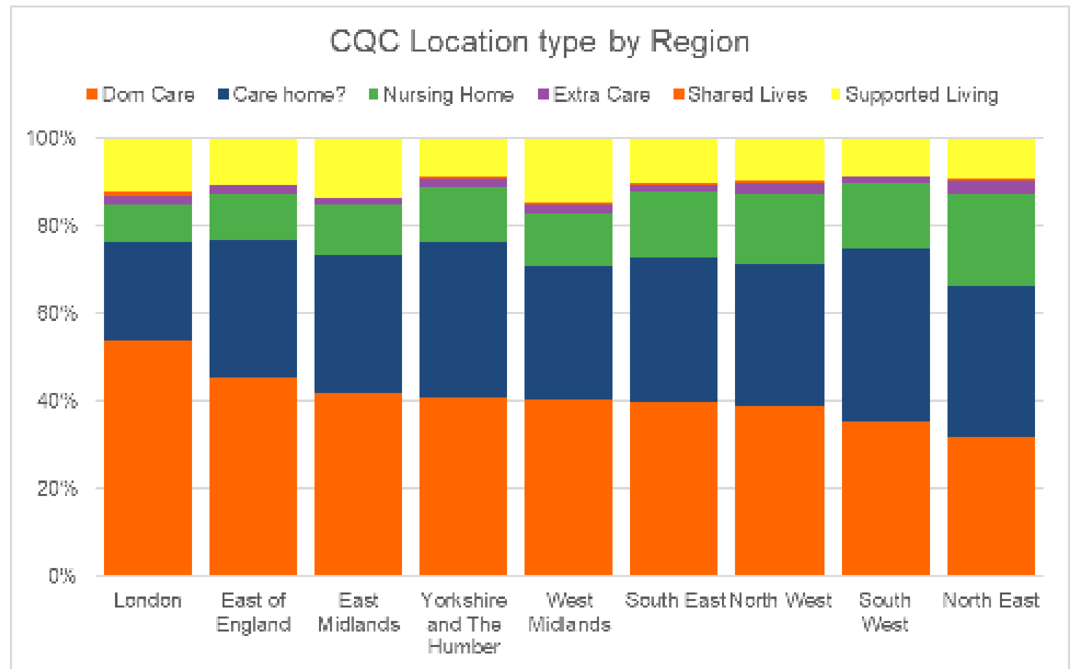
CQC locations can be registered for multiple services (for example a care home location might also be registered to provide domiciliary care) so to avoid double-counting services and mixing up registration types, the tables below are based on location that only provide the relevant services (for example, just locations that provide extra care, not locations that provide extra care alongside domiciliary care services. This results in fewer locations in the data but more accurate results for the service types.

Figure 49 - Locations by Type of Service as a percentage of all locations (July 2024)



At a regional level, there is little difference in the split of location types except for London, where the percentage of locations that are care homes is lower than the other regions:

Figure 50 – Chart showing location type by Region (July 2024)



6.6.4 Conclusions – Regional variation in provider compliance

The data suggest that similarly to the previous evaluation, most of the regional variance in provider compliance is due to the mix of provider and location types across the regions. Whilst there is some variation in the mix of support activities undertaken by LSOs, as detailed below, most of the variation in compliance seen arises from wider market factors.

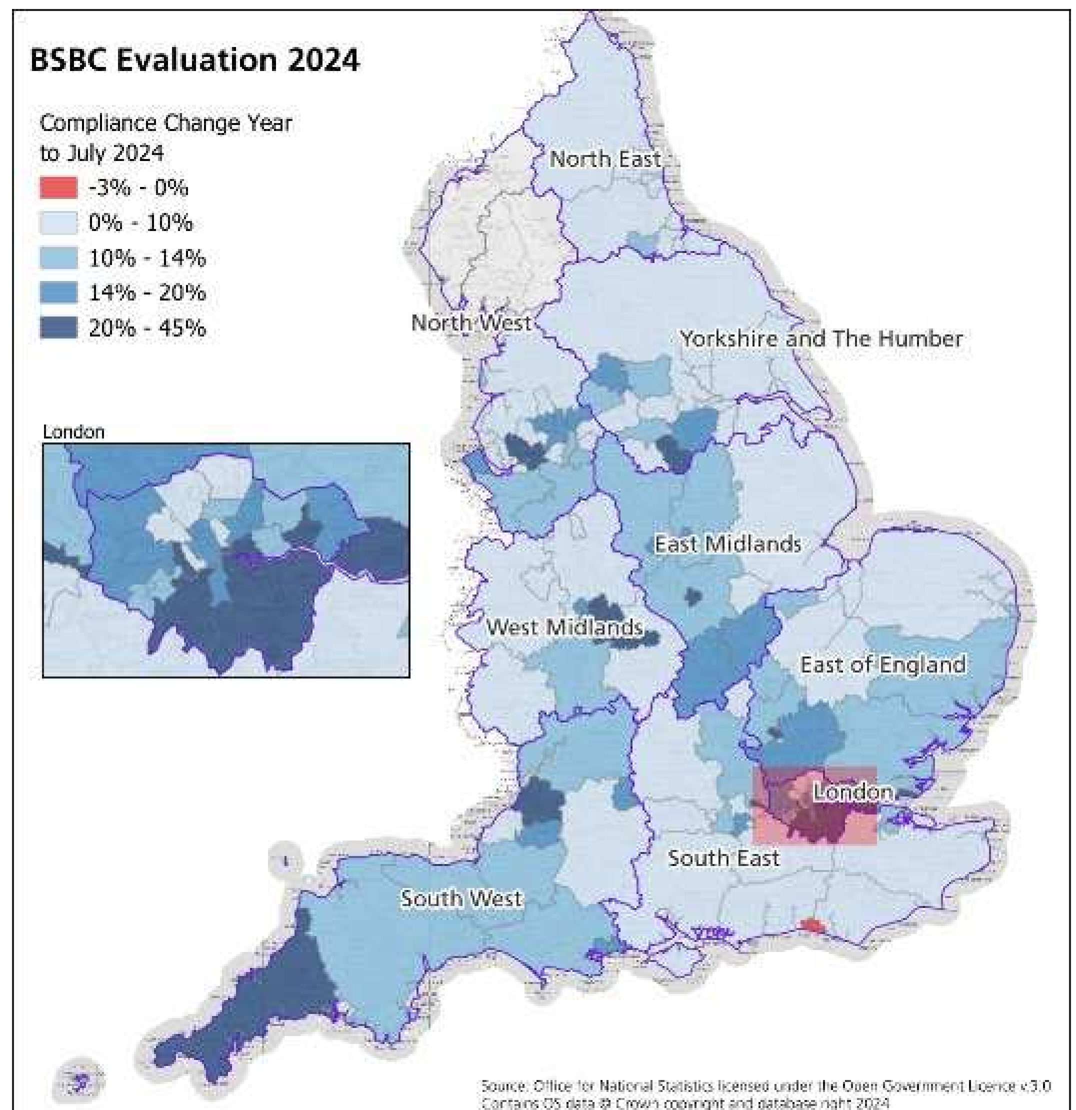
6.7 Change in DSPT compliance July 2023 to June 2024

In line with the overall increase in DSPT compliance between July and March 2024, there have been large changes at a regional level, as illustrated earlier.

At a local authority level, there have also been significant changes in overall DSPT compliance.

The map below shows these changes:

Figure 51 - Map showing percentage change in location DSPT compliance by Region July 2023 to June 2024

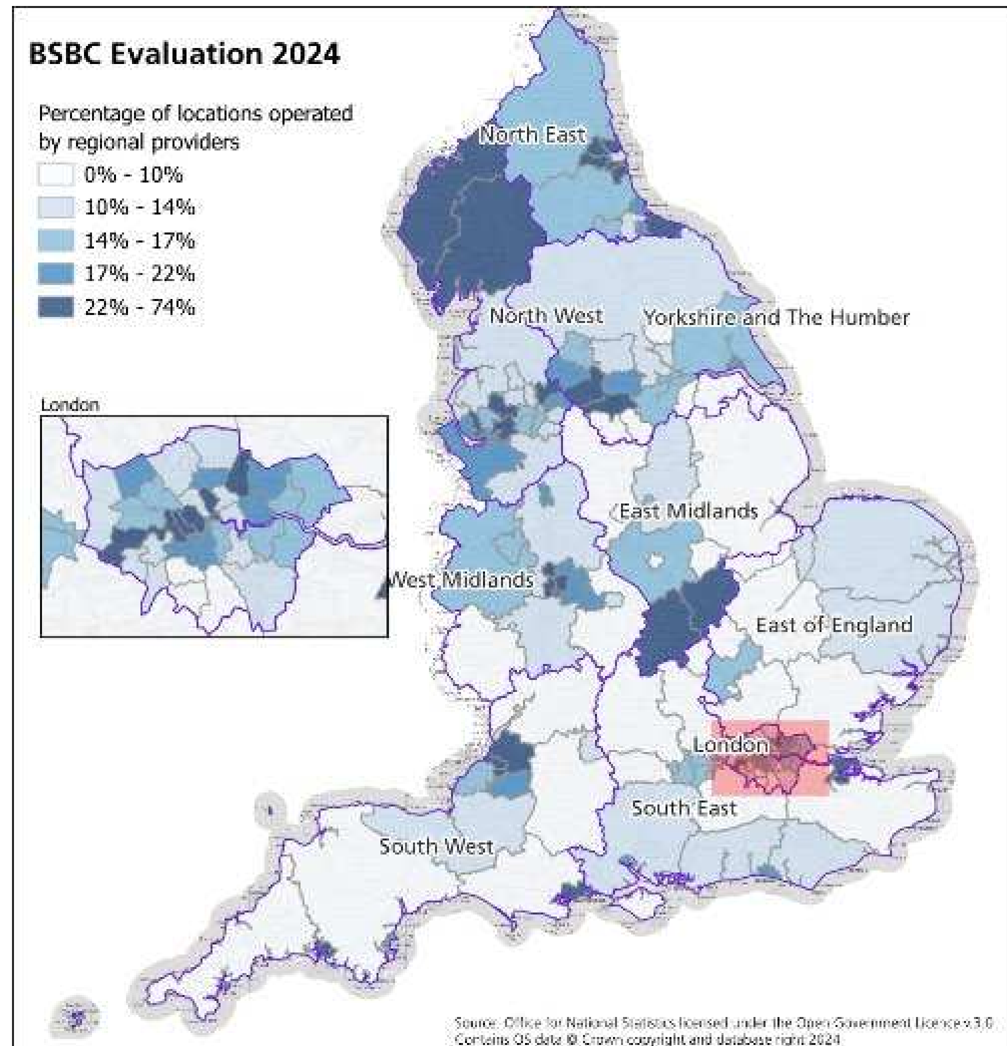


One local authority—Brighton and Hove—had an overall decrease in DSPT compliance in the locations around 3%. Several London councils showed significant increases in compliance.

6.7.1 Regional Providers

The map below shows the density of locations operated by medium sized regional providers. There are particular hot-spots of these locations in the North East (Tyneside), West Yorkshire, Merseyside and Bristol.

Figure 52 - Map showing the density of locations operated by medium sized regional providers in July 2024



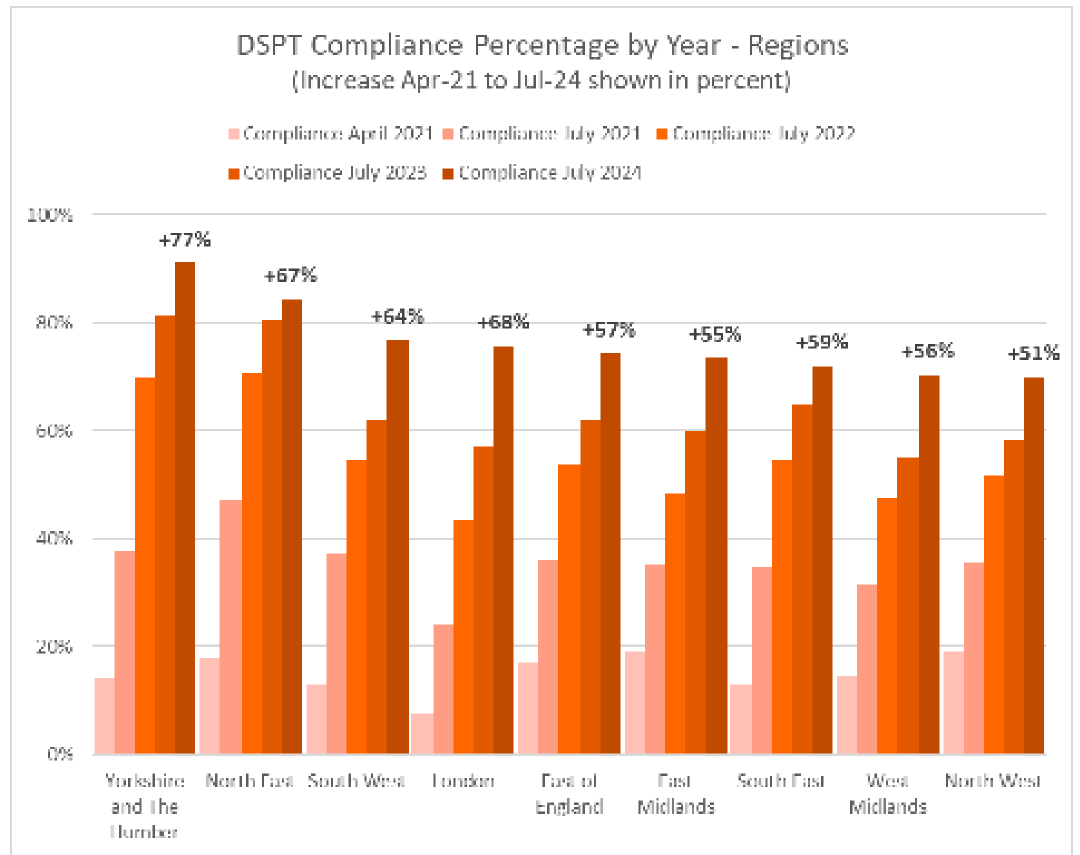
As detailed in the recommendations, targeting these medium-sized providers in the next year of the programme in a similar approach to the Large Provider programme would bring several benefits because they are geographically concentrated in a small number of areas and intervention in these areas would have a large impact on overall DSPT compliance. These providers account for 10% of locations overall, and compliance currently stands at 65% overall. As relatively large providers, they potentially bring big gains from a targeted programme.

6.7.2 Change by Previous DSPT compliance

The chart below shows the change in DSPT compliance since July 2021, with the percentage change in compliance in the year to July 2024 shown in percent.

The data shows an average increase in compliance of 18%, with London showing the largest percentage increase at 27%, followed by the South West at 23%.

Figure 53 - Chart showing DSPT compliance status by region from April 2021 to March 2023



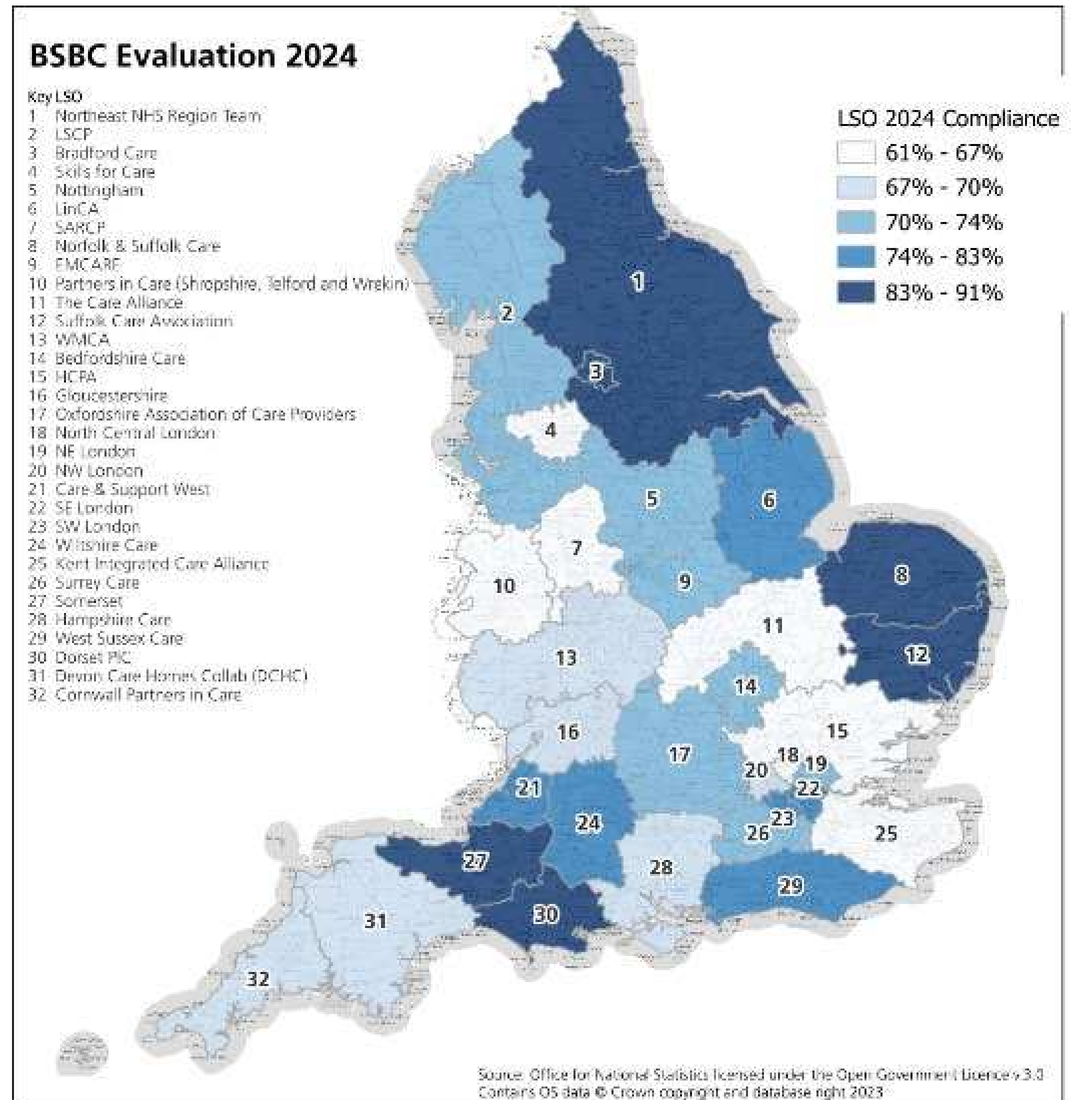
6.8 Local Support Organisations

6.8.1 LSO activity and DSPT compliance

As noted earlier, the main driver of variance in DSPT compliance across the country is the make-up of the care market rather than the activities of the LSO or other organisations. The main exception to this is the North East, where actions by Durham County Council to reward DSPT completion, for example, has driven up compliance rates to 96%.

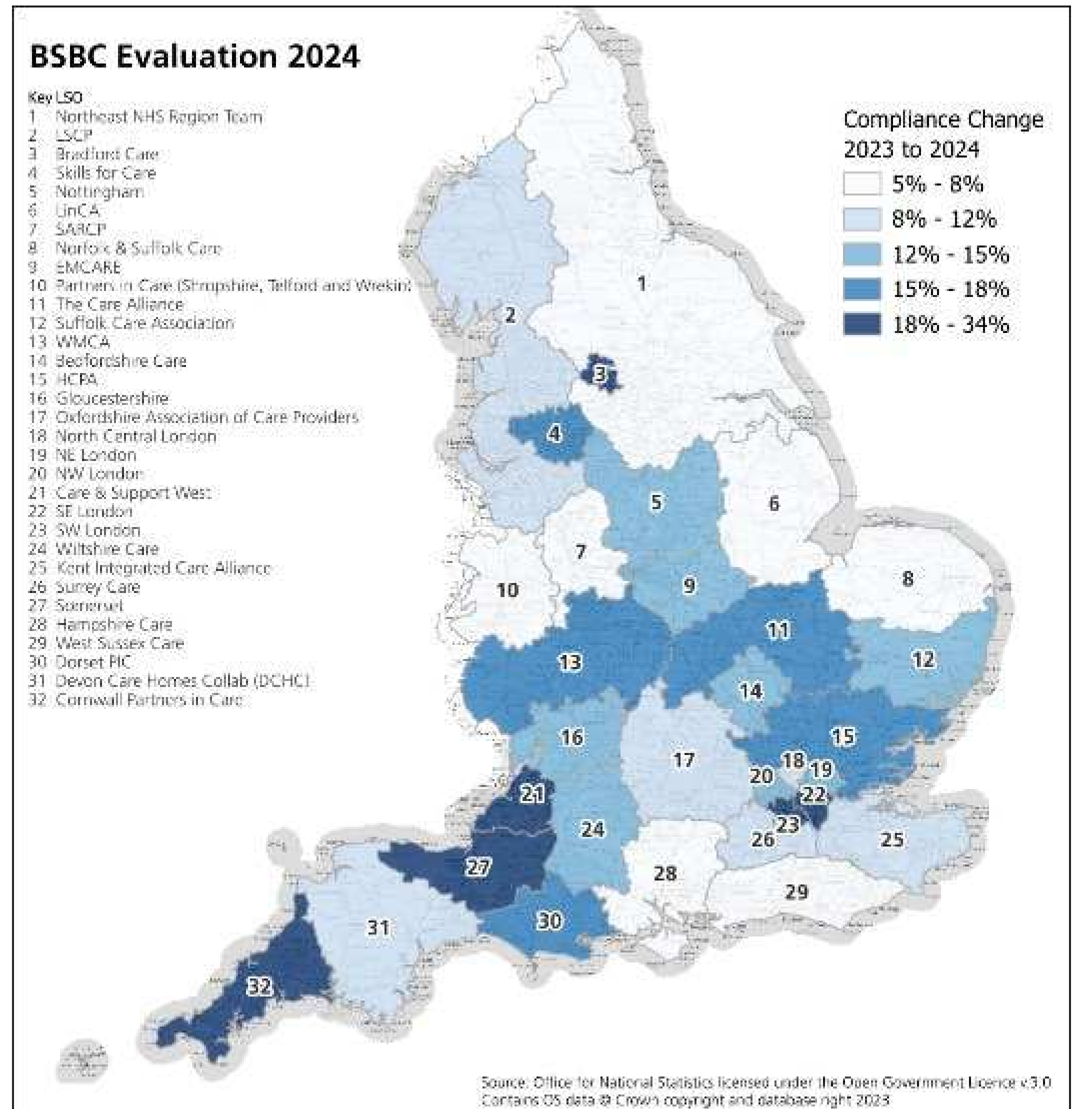
The map below shows the level of DSPT compliance based on July 2024 data:

Figure 54 - Map showing DSPT compliance in March 2023 at LSO level



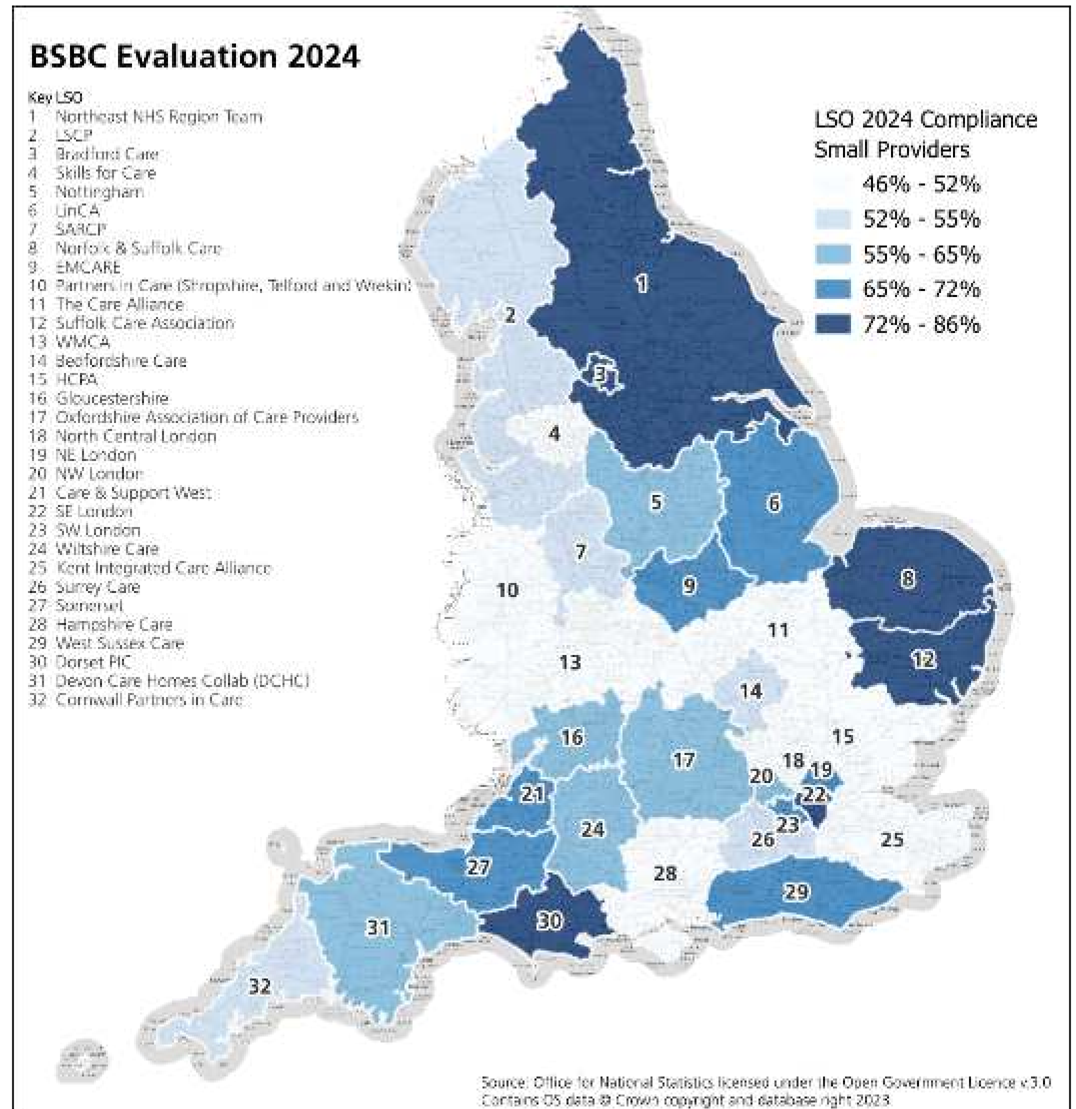
There have been large changes in DSPT compliance at an LSO level since 2023, as well as some changes to LSOs, particularly in London, where there are now 4 LSOs operating. The map below shows the change in DSPT compliance between July 2023 and July 2024:

Figure 55 - LSO Compliance Change 2023-2024



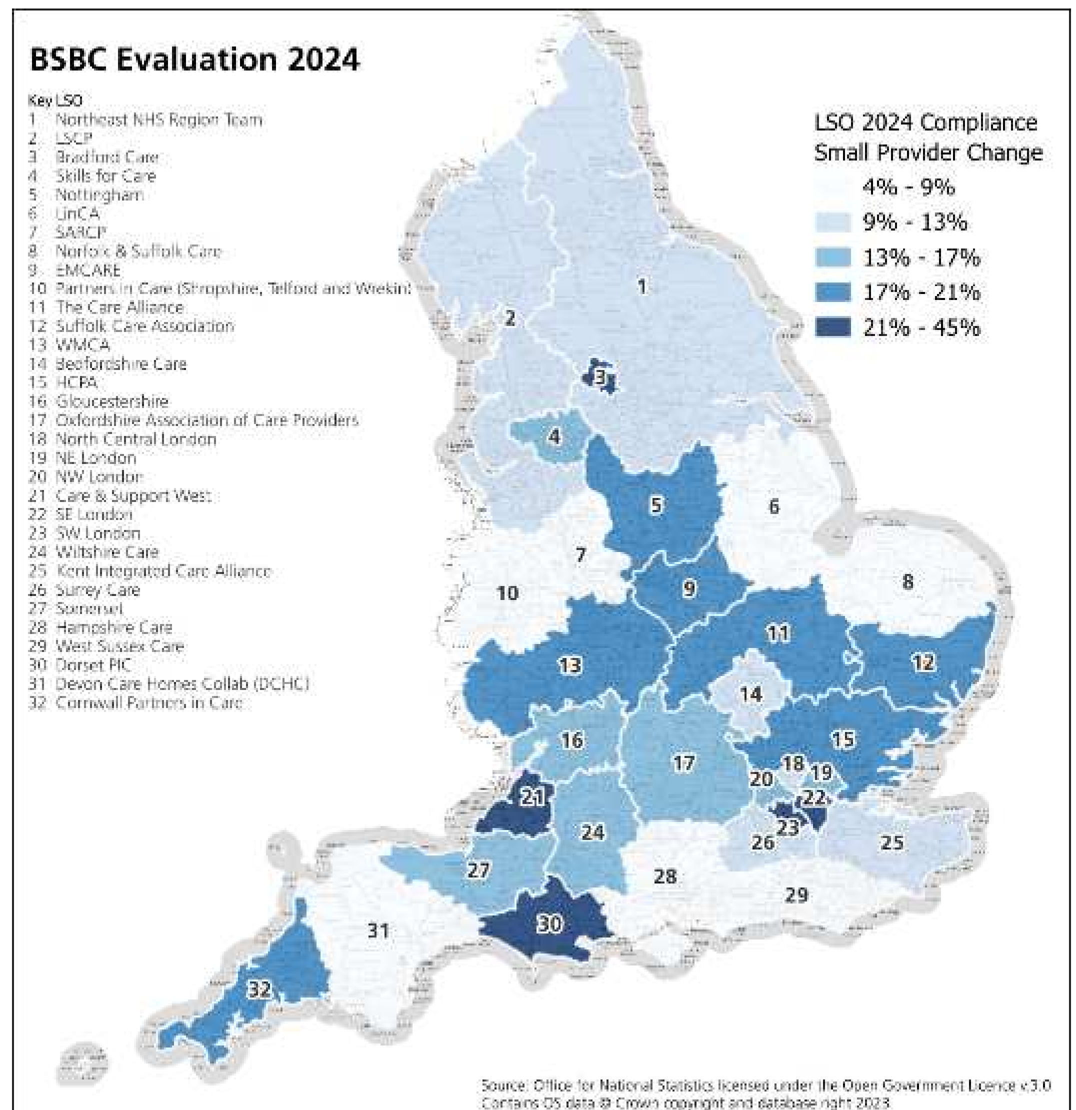
There have also been significant changes in the DSPT compliance of micro/small locations at LSO level, with the following two maps showing the 2024 compliance and the change between July 2023 and July 2024.

Figure 56 - LSO DSPT compliance of small providers 2024



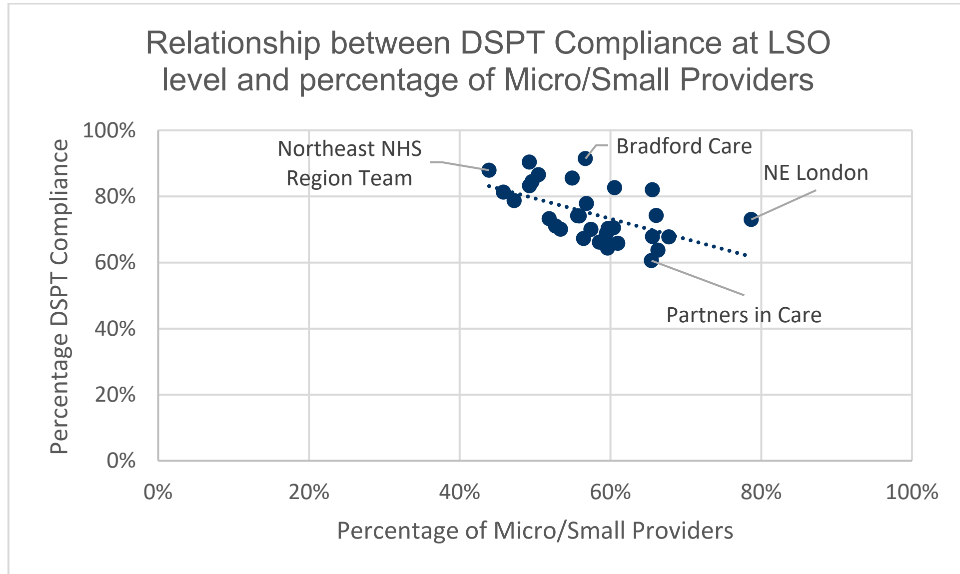
The LSOs with higher overall DSPT compliance in July 2024 also have higher compliance amongst the smaller providers, although compliance with small providers is at a lower level. The big changes are in the level of DSPT compliance by small providers since July 2023:

Figure 57 - LSO Change in DSPT compliance of small providers 2023-24



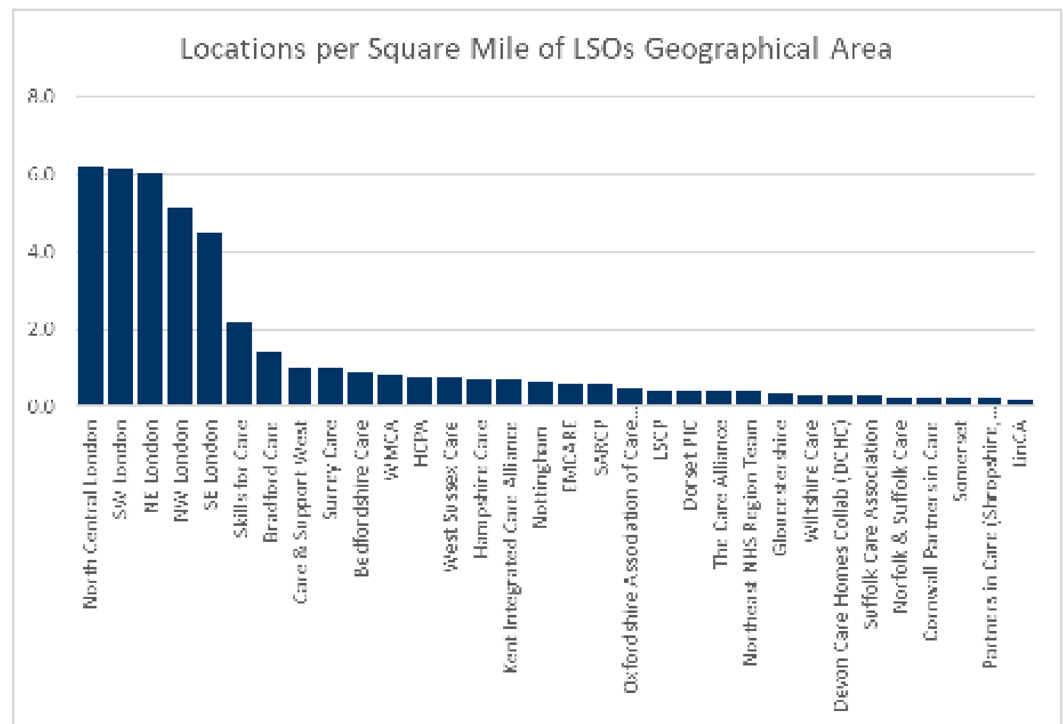
Bradford Care, Care & Support West, SE and SW London and Dorset PIC all show increases in small provider DSPT compliance of 21% to 45% between July 2023 and July 2024, with SE London having a 45% increase in small provider compliance (32% in Bradford Care, 29% at SW London, 26% at Care and Support West, and 23% at Dorset PIC).

Figure 58 - Relationship between DSPT compliance and micro/small providers (July data)



Compared to July 2023, there are much higher levels of small provider compliance overall, and there is less difference in performance between LSOs.

Figure 59 - Number of locations per square miles by LSO area. Source: CQC Data July 2024



LSOs continue to note the challenges in engaging with small providers, and particularly those that require in-person support to help them complete the toolkit. Where in-person support is required, the size of the area and number of small providers has an impact. The chart above shows the number of locations per square mile based on LSOs operating areas. The London LSOs have the greatest number of providers per square mile, followed by Greater Manchester (Skills for Care). This may have assisted the London LSOs in the effective engagement with smaller providers, but the Northeast NHS Region Team have a low number of providers per square mile and effective engagement with small providers, demonstrating that an efficient process for making regular contact with providers, in the case of the Northeast NHS Team by phone, does result in higher levels of engagement and DSPT compliance.

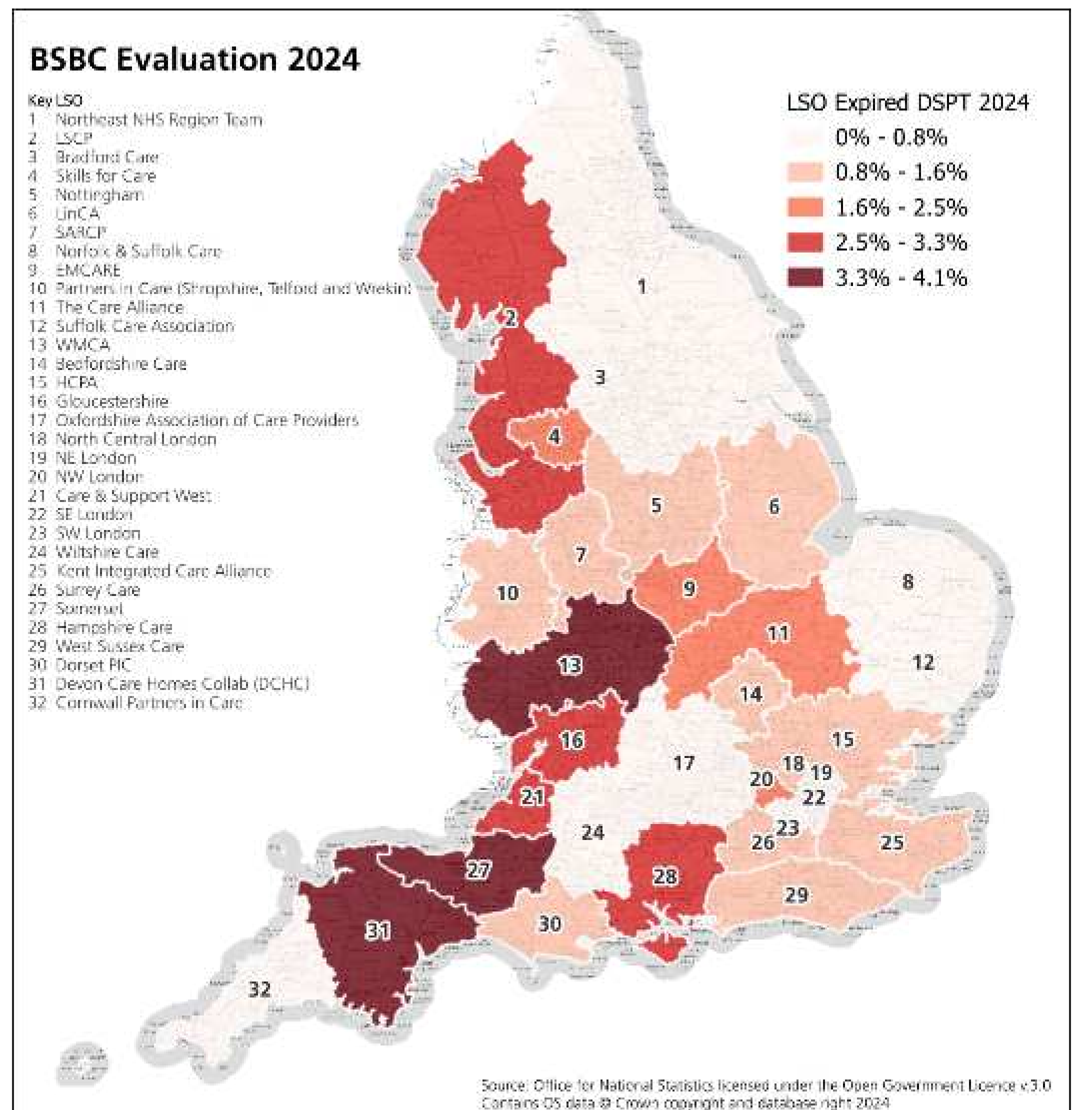
One area where LSOs are likely to have a greater impact is the renewal of DSPT, and the table and map below looks at the percentage of DSPTs that expire at an LSO level. There continues to be a relatively high variance in DSPT expiry at an LSO level, and this appears to be a useful area to concentrate on for LSOs with higher levels of locations with expired DSPTs. In the case of WMCA, for example, the 3.6% of locations with expired DSPTs equates to 81 locations.

Figure 60 - Table showing percentage of expired DSPTs by LSO

LSO	Expired DSPT %
Somerset	4.1%
Devon Care Homes Collab (DCHC)	3.9%
WMCA	3.6%
Gloucestershire	3.2%
Care & Support West	3.0%
LSCP	2.8%
Hampshire Care	2.7%
Skills for Care	2.4%
NW London	2.3%
EMCARE	1.9%
The Care Alliance	1.7%
Surrey Care	1.6%
SARCP	1.6%
LinCA	1.4%
North Central London	1.4%
Partners in Care (Shropshire, Telford and Wrekin)	1.3%
Nottingham	1.2%
Kent Integrated Care Alliance	1.2%
HCPA	1.2%
Dorset PIC	1.2%
Bedfordshire Care	1.1%
West Sussex Care	0.9%
Wiltshire Care	0.8%

LSO	Expired DSPT %
Oxfordshire Association of Care Providers	0.8%
SE London	0.8%
Northeast NHS Region Team	0.6%
Norfolk & Suffolk Care	0.6%
Cornwall Partners in Care	0.6%
Bradford Care	0.5%
SW London	0.4%
NE London	0.2%
Suffolk Care Association	0.0%

Figure 61 - Map showing percentage of expired DSPTs by LSO



The providers with higher levels of DSPT expiry are similar to the 2023 figures. There has been some improvement in the East Midlands and Lincolnshire, but the West Midlands and Somerset have got worse since last year.

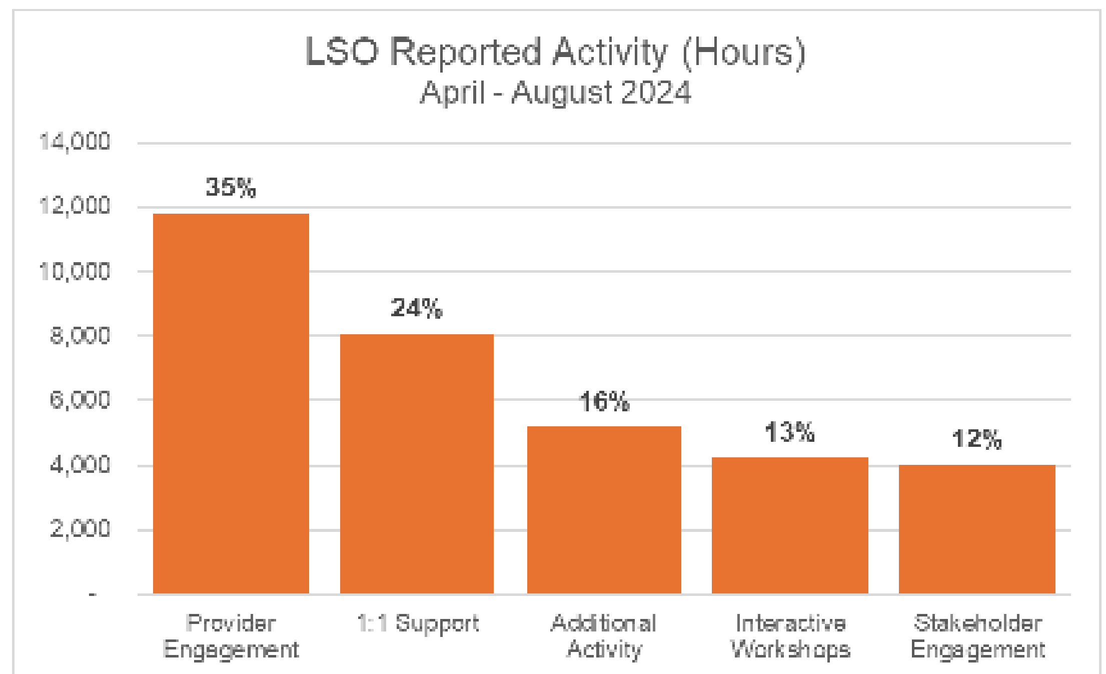
In general, it would be expected that providers who initially complete the DSPT do so because they feel there is a value in it, so the variance in the percentage of expired DSPTs is unexpected. It would be expected that expiry would be more likely in areas where there are high levels of initial take-up, because it is more likely that some of the providers who have completed the DSPT will decide it is not worth re-certifying.

6.8.2 Local Support Organisation Performance

There have been significant changes in the activity of LSOs since the last activity data that was assessed, which related to 2022-23. Since then, the local helplines

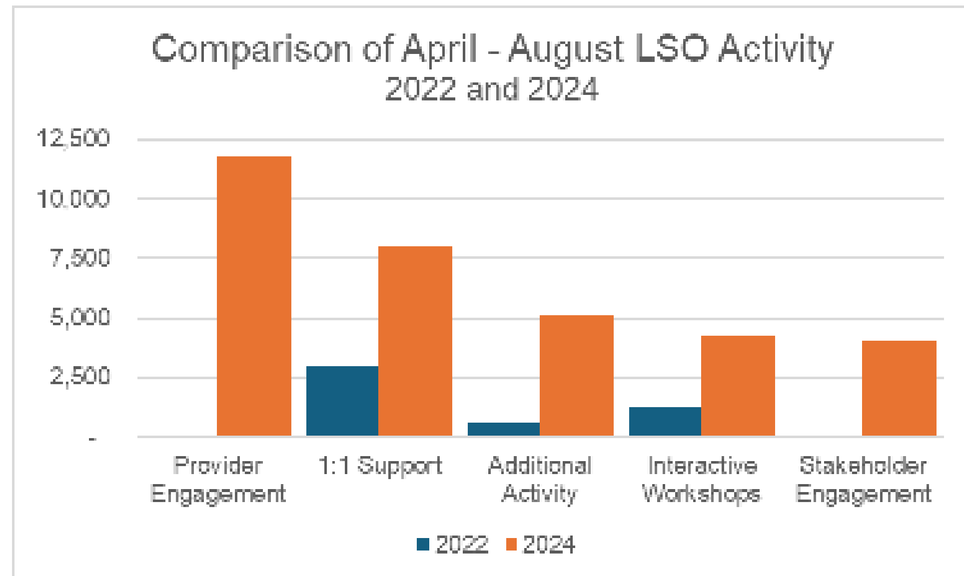
and webinars have been taken over by the central team, leaving LSOs to focus on engagement with local providers through interactive workshops, 1:1 support and through promotional work. In the period April to August 2024, LSOs reported a total of 33,400 hours of activity related to BSBC, broken down as follows:

Figure 62 - Chart showing LSO Activity in Hours, April to August 2024



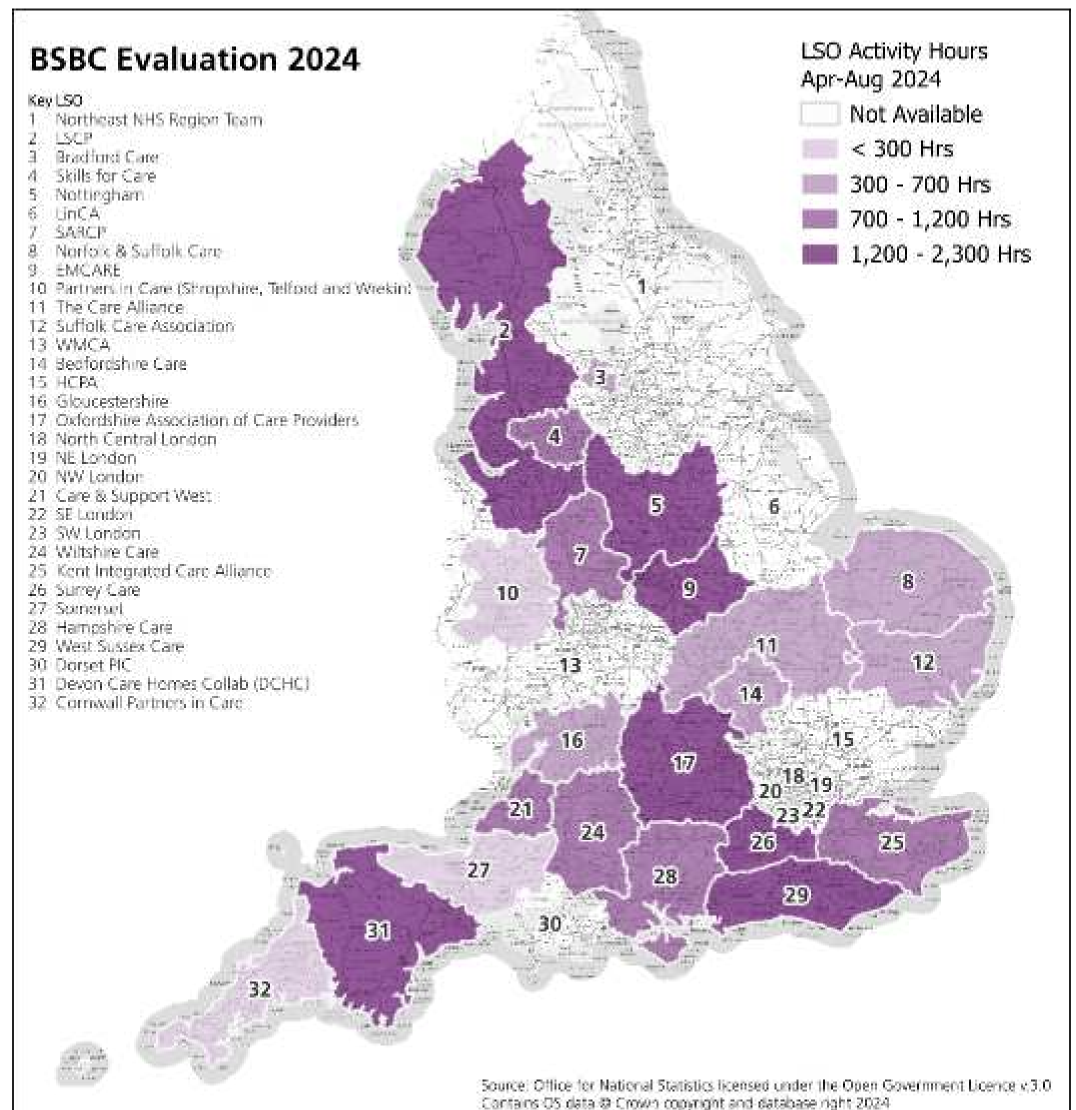
Direct comparisons with previous years are difficult, because the number of categories or activities are different, and some activity was not previously reported. Overall, however, there has been a significant increase in the hours of 1:1 Support and Interactive Workshops delivered:

Figure 63 - Comparison of LSO Activity, April to August 2022 and 2024



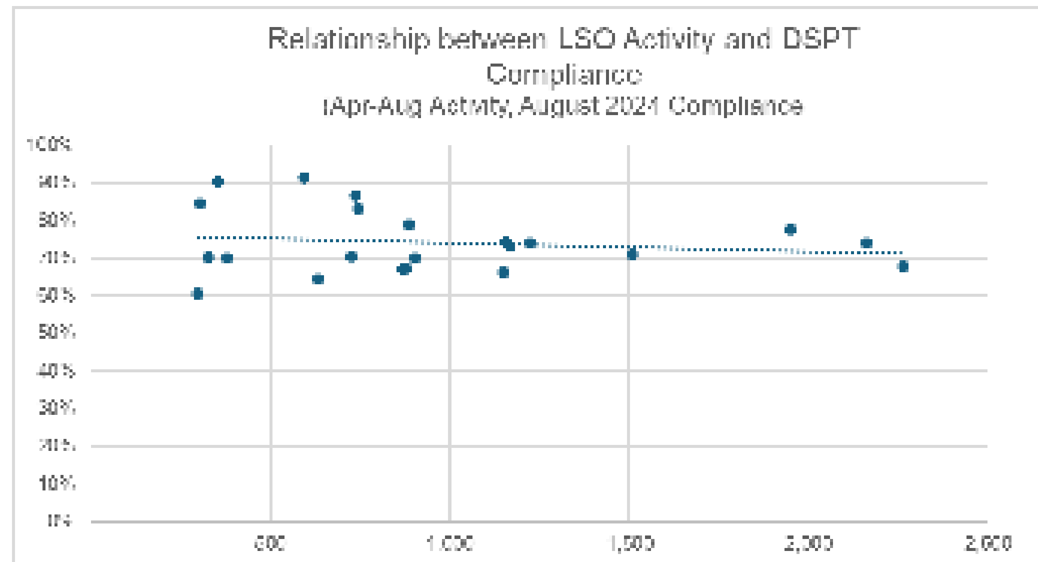
The map below shows the total LSO activity, in hours, for the period April to August 2024. Only those areas where there are data available are shaded.

Figure 64 - Map showing LSO Activity Hours (Total) April to August 2024



The data on DSPT compliance at an LSO level does not suggest a direct relationship between the number of activity hours and the compliance level, but the different size of LSO areas and the number of providers operating in those areas means that there is unlikely to be a direct correlation between the number of hours of LSO activity and DSPT completion.

Figure 65 - Chart showing relationship between LSO activity (hours) and DSPT Compliance Percentage 2024



There is no data collected on the number of providers that LSOs are engaging with. We suggest that as a minimum the number of providers engaged with through all LSO activity is recorded. A more comprehensive performance monitoring approach would look at the number of providers engaged through Interactive Workshops, 1:1 Support and Provider Engagement. The most effective measure of LSO performance would be through the recording of the names of the individual providers / locations participating in Interactive Workshops,1:1 support or other provide engagement so that the rate at which providers complete the DSPT following engagement could be assessed. We suggest as a minimum that the number of providers / locations engaged be recorded.

LSO actual activity in the period April to August 2024 is 88% of the planned activity, compared to 75% the year 2022-23 and 70% for the equivalent period in 2022.

6.9 DSPT Compliance Data Conclusions

The Better Security, Better Care programme had set a target of 75% which was narrowly missed at the end of June 2024 but met shortly afterwards, still within the 2023/24 year. There has been a notable increase in compliance by small organisations, whilst compliance by large organisations is almost 100%

Whilst the make-up of the local care market in terms of the split between small, medium and larger providers continues to play a significant role in determining overall levels of DSPT compliance at a Local Authority, LSO and Regional level, is clear that other factors play a role, for example in London and the North East where there are proportionally higher levels of small provider compliance.

The data suggest that most pf the larger providers are now DSPT compliant. These national providers account for almost 50% of care home beds, meaning that a large proportion of people living in care homes benefit from the increased data security that DSPT compliance brings. The challenge for the next years of the programme will be extending DSPT compliance to smaller providers and increasing the number of providers that achieve Standards Exceeded.

A second challenge for future years of the programme will be ensuring that providers republish their DSPTs to ensure continuing compliance. The data from 2021 onwards suggests that 3% of providers ceased to be compliant because the DSPT had not been renewed, which has decreased slightly. There is a more significant local variation in DSPT expiry levels, as highlighted.

Finally, LSO activity is now much closer to targets. A lack of data on the outcomes of the support provided makes it difficult to objectively measure the impact of LSOs and ultimately the impact of the financial support they receive from the programme. Such data that do exist suggest that LSOs have a positive impact on providers and on DSPT compliance.

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