

Provider Newsletter

June 2026



Welcome to our Summer 2026 Edition.

In this issue:

- 1 *Safeguarding Provider Survey Link – we would appreciate if you could complete.*
- 2 *NCL – COS Displaced Worker Pool – funding available for CQC registered providers.*
- 3 *Change to DOLS – Deprivation of Liberty*
- 6 *LGBTQ+ Learning Framework – helpful guidance for us all.*

Hello Providers

Summer has finally arrived and I am sure we are hoping that this heatwave goes as quickly as it came and we return to some “normal” summer temperatures. You are all aware on how to support your staff and residents but please reach out to us if you need any extra support or guidance.

Provider Forum – one is now booked for the 9th July for Mental Health and LD providers only between 10am and 1pm at Park Avenue we look forward to seeing you there. When the others are booked you will be notified by Brokerage.

Enfield continues to offer **free Infection Control Training** to all our Providers please do not hesitate to contact me to arrange at Beverley.Goldhawk@enfield.gov.uk

Please let me know if you have anything you would like to see in our September Newsletter.

And finally have an amazing summer, looking forward to seeing you all soon and remember if you need us please reach out we are here to work together to improve quality, knowledge and delivery of care in Enfield.

Safeguarding Provider Survey Link

Click here for the link to the [Provider Survey - Safeguarding Adults processes \(July 2026\)](#)

Fill in form and it should only take 5 minutes.

NCL – COS Displaced Worker Pool

Dear Provider,

This is a reminder that limited funding is available to help cover Immigration Skills Charge and CoS costs when recruiting displaced international social care workers.

Funding & Benefits

- ▶ Up to 2 years for small and charity organisations
- ▶ 1 year for medium to larger organisations
- ▶ Access to experienced, job-ready candidates already in the UK, faster recruitment experience, and improved workforce stability

Eligibility

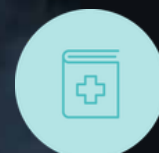
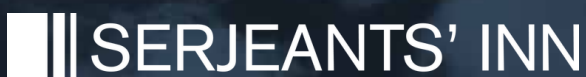
- ▶ CQC registered
- ▶ Registered on Companies House
- ▶ Rated "Good" or above
- ▶ No revocations or suspensions within the last 2 years

If eligible, please contact our programme lead, Charles Duyile @ Charles.Duyile@camden.gov.uk to discuss your recruitment needs and access this support.

Change to DOLS – Deprivation of Liberty

Following the Supreme Court judgment on 2 June 2026, the approach to identifying a deprivation of liberty has changed significantly. The Court confirmed that the previous “acid test” should no longer be applied in isolation and instead a multifactorial assessment is required, considering the person’s individual circumstances, including the type, duration, effects, and manner of any restrictions. It also clarified that a person’s wishes, feelings and level of acceptance may be relevant when determining whether there is a deprivation of liberty, even where they lack capacity. As a result, residential care providers should ensure that care arrangements are reviewed on an individual basis, with clear evidence of how restrictions are necessary and proportionate, rather than relying solely on supervision and control or whether a person is free to leave.

Updated guidance will be issued from the DHSC shortly but please see attached information provided by a legal firm to help in the interim. Please call the DoLS team on **0203 855 6299** if you would like to discuss further.



SUPREME COURT JUDGMENT

A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 UKSC16

Emma Sutton KC, leading Rhys Hadden, appeared on behalf of the Official Solicitor

Snapshot Guidance for Practitioners

Judgment given on 2 June 2026: following oral hearing on 20, 21 and 22 October 2025, before Lord Reed, President, Lord Hodge, Deputy President, Lord Lloyd-Jones, Lord Sales, Lord Stephens, Lady Rose and Lady Simler.

Question asked: whether the Minister of Health for Northern Ireland can lawfully issue a revised Code of Practice under the Mental Capacity Act (Northern Ireland) 2016 to allow some people who lack legal capacity under domestic law to, nonetheless, be treated as giving valid consent to their care arrangements through the expression of their wishes and feelings. If so, they would not be treated as being deprived of their liberty for Article 5 ECHR purposes, and the statutory deprivation of liberty safeguards would not apply.

Answer of the Supreme Court: the Minister *would* be acting in accordance with Article 5 ECHR in issuing the revised code. In reaching that conclusion, the Supreme Court concluded that *Cheshire West and Chester Council v P* [2014] UKSC 19 (“*Cheshire West*”) was wrongly decided, and should be overruled (para 207), applying the 1966 Practice Statement. This was the unanimous decision of the Supreme Court.

Why? - the 4 key reasons

1. A multifactorial test, and not an “acid test” is required;
2. There is an overlap between objective fact and the subjective absence of valid consent;
3. The type of setting is important;
4. “Liberty” means physical liberty.

1. A multifactorial test not an “acid test” is required

The Supreme Court concluded that *Cheshire West* went beyond Strasbourg jurisprudence and departed from the long-standing multifactorial approach to determining when a person is deprived of their liberty (see para 183). The question depends on the person’s concrete situation and take account of a whole range of factors, including:

- the type of restrictions;
- their duration;
- their effects;
- the manner in which they are implemented (see para 184 & 186, for eg), and
- the purpose for which the measures are imposed (see para 200).

Cheshire West had reduced the approach to an “acid test” (i.e. whether the person is under continuous supervision and control and not free to leave”) that was too rigid and wrongly ignored other relevant factors (see para 184).

The Court held that the introduction of a bright-line test was “*too crude*”, “*policy-driven*” and put “*the cart before the horse*” on the basis of “*a misplaced policy concern*” that safeguards in relation to vulnerable people have to be provided pursuant to Article 5, when other legal regimes and other Convention rights apply (see para 185).

2. Overlap between objective fact and a subjective absence of valid consent

A person’s compliance or lack of objection *may* be legally relevant to the question of objective confinement, and the 4:3 majority in *Cheshire West* were wrong to conclude otherwise. Strasbourg jurisprudence shows that confinement must be established as an objective fact and subjectively there must be an absence of valid consent (*Storck*, para 74), but the jurisprudence also shows that these are “*not hermetically sealed concepts and there is inevitably some overlap*” (para 187). If an individual is able to, and does, express their wishes and preferences about their living arrangements, and is happy with them, “*it will ordinarily be difficult to see how they are being coerced*” (para 189). In borderline cases, the Strasbourg jurisprudence makes reference to the closeness of the situation to the paradigm case of deprivation of liberty – confinement in a prison cell (para 190).

To treat a lack of mental capacity as an inability to express valid consent confuses the analysis. A person may lack capacity to make decisions regarding their residence and care arrangements, but if they can meaningfully express their wishes and indicate acceptance to their situation, that *may* amount to valid consent – meaning the subjective element of deprivation of liberty is not present (para 151 & 201, *for eg*).

3. Type of setting is important

The normality of the circumstances in which an individual is cared for is a relevant factor. For example, the effect of the restrictions on an individual living in their own home, with opportunities for leaving that home (for recreation, education or social contact, etc), is likely to be very different from the effect on an individual held in a psychiatric hospital or a prison (para 193). An individual living in their own home, in accordance with their wishes and feelings, *may* be deprived of their liberty within the meaning of Article 5, but the restrictions imposed would need to be more severe or extensive - *for eg*, by way of a combination of restraint, medication, and seclusion (ibid).

4. “Liberty” means physical liberty

This includes the freedom to go where one pleases, and for those who are *unable* to do this because they are unconscious, in a minimally conscious state, or so profoundly disabled that they cannot conceptualise leaving let alone physically achieve this, they are not being prevented by a third party from doing something and are not being deprived “*of anything*” (para 198).

The future ...

The decision of the Supreme Court, very unusually via the Reference procedure (*ie*, without a specific individual case or set of facts before it), will undoubtedly lead to a sea change in approach and inevitably give rise to a number of cases now being reviewed by the Court of Protection where the circumstances had, by application of *Cheshire West*, been found to constitute a deprivation of liberty. There are also likely to be a spate of “test cases” as to what is/is not a deprivation of liberty in this brave new world. Watch this space!



Emma Sutton KC

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Rhys Hadden

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LGBTQ+ Learning Framework

As you know, following the publication of the **Ms C SAR** in September 2025, the Enfield SAB has been interested in looking for tools and ways of working that may enhance the work of all our partners around working with the LGBTQ community. One such resource, recently published, is the new **LGBTQ+ :Learning Framework** recently published by Skills for Care and developed by Dr Trish Hafford-Letchfield in collaboration with the LGBT Foundation.

The toolkit is described as a ' New learning framework for knowledge, skills and values for working affirmatively with LGBTQ+ people in later life.' But the tools and principals will apply across the life course in all of our settings. The framework sits within **a wider webpage which includes research and videos** to support this work. CQC also published guidance of its own in 2020 around **Relationships and Sexuality in Adult Social Care services (although this covers a broader range of topics including consent and capacity around sexual relations).**

Research clearly demonstrates that LGBT+ people in later life report poorer health than the general population and have worse experiences of care. This can lead to a distrust of services going forward (the anticipation of prejudice at times) – with devastating outcomes in the case of Ms C and others. Ensuring an educated workforce is a first step around trying to combat this and demonstrates that you are working to be an inclusive provider!

