



Referral criteria – from 1 July 2026

North London Hospice provides comprehensive palliative care services both in the community and is currently operating a 12-bed inpatient unit for specialist care at [Jade Ward, at Edgware Community Hospital](#). This is a temporary location whilst the main hospice unit at 47 Woodside Avenue is rebuilt. It is expected to re-open in autumn 2027.

North London Hospice will continue to operate a hospice at home service for hands-on care. Additional services include symptom management, emotional and spiritual support, bereavement services, and a helpline for patients and healthcare professionals.

From 1 July 2026 new referral criteria for all referrals were introduced:

Referral criteria for all referrals to North London Hospice from 1 July 2026

Referrals for adults (aged 18 and over) and their families or carers who are living with **an advanced, progressive, life-limiting illness**. Our aim is to enable people to live and die well. **Referrals must meet the criteria for Specialist Palliative Care.**

Referral process remains unchanged and further information can be found on [our website](#) along with [the Pan London referral form](#).

Eligibility Criteria

Inclusions

- Referrals for adults (aged 18 and over) and their families or carers who are living with **an advanced, progressive, life-limiting illness**.
- for community services registered with a Barnet, Enfield or Haringey GP or living in one of those boroughs (including care homes)
- for inpatient and overnight advice services registered with an NCL-based GP
- patients with a diagnosis of a life-limiting illness with unresolved needs that cannot be met by the referring team (needs may be physical, psychological, social and/or spiritual)
- patients with life-limiting illness and likely to be in the last year of life, wanting support with advance care planning
- families and carers of patients who meet the above criteria and reside within North Central London.



Definitions: What are Specialist Palliative Care needs?

Where a person is living with an advanced, progressive, life limiting condition and has complex needs related to this condition (physical, psychological, spiritual or social) which haven't been resolved through interventions provided by frontline services e.g. GPs, community nurses.

To ensure patients are offered care transparently and equitably the hospice uses the Responding to the Urgency of Need (RUN) score tool, alongside the date of referral to support triage and prioritisation. Patients can then be re-referred at any time via their GP or other healthcare professional.

What can we offer:

- Symptom management, where symptoms are directly related to the person's life limiting condition and have not responded to standard first line symptom control measures.
- Support with conditions with which the core team are unfamiliar and need support with managing and understanding the expected symptoms and trajectory.
- Support to the person regarding psychological or social aspects of their life limiting condition.
- Support in recognising when someone is dying to ensure a dignified, comfortable and compassionate death.
- Assistance with advance care planning and carer support where the decisions to be made are beyond the scope of the frontline teams e.g. decisions around treatment, best interest decisions or other decisions requiring a specialist.
- Transition of the care of young people with life limiting conditions under children's palliative care services to adult services who meet the criteria above.
- Inpatient care for complex symptom control or care for the last days of life.

What we are unable to offer:

- Symptom management for chronic pain in line with NICE guideline NG193 (Chronic pain – assessment and management).
- Fast Track Assessments where there are no Specialist Palliative Care needs.
- Respite inpatient care.
- Long term nursing care for people who are stable and likely to be needed for greater than 2 weeks.
- Management of Mental Health conditions where we do not have the clinical capabilities to meet their needs, please call and discuss before submitting referral.
- Referrals from care homes for residents with low complexity where advance care planning and anticipatory medication are already in place- we are happy to provide telephone advice so please call.



Discharge criteria

Sometimes patient conditions/symptoms improve and they no longer have specialist palliative care needs. Under these circumstances we may discharge patients from our service and signpost to other organisations if appropriate.

Patients can then be re-referred at any time via their GP or other healthcare professional.