University of Southampton

ENHANCING PARAMEDIC CARE AT END OF LIFE

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EXECUTIVE SUMMARY

Paramedics play a vital role in end of life care, attending patients and families at home via ambulance calls, often during moments of acute crisis. This research conducted across England highlights critical challenges that hinder their ability to provide effective care to individuals in the last year of life. Key barriers include limited training in palliative and end of life care, poor integration with wider health and social care systems, and restricted access to patient records, essential medicines and clinical advice. These issues can lead to less than adequate care experiences for patients and distress among families and paramedics alike.

This policy brief outlines key findings and recommendations to improve paramedic preparedness, build professional confidence and foster stronger system-wide collaboration. Addressing these will enable ambulance paramedics to better support individuals at end of life.

CONTEXT

The UK is experiencing rising demand for palliative and end of life care, driven by an ageing population and an increase in people living with multiple long-term conditions. Annually, **over 670,000** people die, many with complex and evolving healthcare needs in their final months [1]. Even if demand remains stable, projections estimate a minimum **25%** increase in individuals requiring palliative care at the time of death over the next 20 years [2].

This demographic shift places growing strain on ambulance services. In England and Wales, more than half (**55%**) of those who died used ambulance services at least once during their last three months, with some patients making up to 38 calls [3]. In Scotland, **77%** of people in their last 12 months of life made ambulance calls [4]. The financial burden in the UK is substantial with ambulance care for people at end of life costing an estimated **£425 million annually** [5].

Despite their professionalism, paramedics face substantial challenges when responding to end of life cases [6]. These challenges lead to avoidable hospital conveyance, which can be distressing and contrary to patient preferences for home-based care. Ensuring consistent, integrated, and patient-centred end of life care via ambulance services should be a policy priority.

KEY FINDINGS

1. Fear and uncertainty undermine paramedic confidence

→ Fear of doing the wrong thing at end of life is widespread: **78%** of paramedics reported at least sometimes fearing doing the wrong thing; **39%** reported this often or always. This fear is in part related to difficulties distinguishing active dying and reversible issues. **71%** reported at least sometimes encountering this difficulty; **26%** reported this often or always.

→ Fear of wrongdoing is intensified by concern over review of care provision by employers, the professional regulator, police and coroners.

→ Confidence and competence in supporting patients during their last year of life are limited: **11%** of paramedics felt not at all or only slightly confident; **44%** felt only somewhat confident. Similarly, **9%** felt not at all or only slightly competent; **42%** felt only somewhat competent.

"...We're all afraid of being reviewed... So, it's a threatening thing to worry about if I get this wrong on this job, that's going to come back and visit me in three weeks' time when the coroner's statement has to be written, or, in a month's time when they ask for a police statement..."
(Paramedic)

2. Limited education and training contribute to skill gaps

→ Fear and uncertainty in providing end of life care are underpinned by limited training and education.

→ Pre-registration education in palliative and end of life care is restricted: **81%** said that a lack of education impacted their ability to meet the needs of individuals at least sometimes; **45%** reported this was often or always the case.

→ Continuous professional development (CPD) opportunities are limited: **77%** said lack of CPD affected their ability to meet the needs of individuals at least sometimes; **39%** reported this was often or always the case. Mandatory training in palliative and end of life provided by ambulance trusts was often absent or a superficial "breeze through". CPD appeared reliant on paramedics seeking out courses hosted elsewhere, accessed informally and in personal time.

"...More training would help because one [mandatory] training day a year, if I didn't have the drive to do it [palliative and end of life care training] myself I would [be] four years in [and] still be like: 'what do we do?'..."
(Paramedic)

3. Gaps in access to healthcare professionals undermine shared decision-making

→ Access to healthcare professionals for clinical advice or referral is variable, particularly outside standard working hours. This limits the ability of paramedics to engage in shared professional decision-making and deliver responsive care.

In-hours access: **76%** of respondents could always or often access a GP, **66%** for community nursing teams, **58%** for specialist palliative care teams, and **36%** for advanced/specialist paramedics.

Out-of-hours access: being always or often able to access a GP dropped to **60%**, **31%** for community nursing teams, **29%** for specialist palliative care teams, and **29%** for advanced/specialist paramedics.

→ Access to specialist palliative care advice is hindered by patchy service coverage and inconsistent availability of advice lines. Not all services operate 24/7 or maintain a dedicated advice line. Paramedics frequently lacked awareness of local advice lines or contact details, particularly when working out-of-area.

"...I know most of [county] quite well because it's pretty well covered [by specialist palliative care services]. [Another county] is where it gets a bit spottier, and a bit more confusing... I don't know which one I would contact..."

(Paramedic)

4. Challenges with medicines access and administration impede symptom control

→ Paramedics face multiple barriers to administering essential end of life medicines, undermining their ability to manage symptoms effectively.

→ Access to medicines: **80%** reported at least sometimes lacking necessary medicines; **41%** said this occurred always or often.

→ Policy variation: Not every ambulance trust in England permits administration of patients' own just-in-case medicines.

→ Documentation dependency: **74%** cited lack of access to a medicines administration and authorisation record as a barrier to administration at least some of the time; **40%** reported this occurred always or often.

"...This is a regular occurrence. This happens a lot where they send the patients home with anticipatory meds but no paperwork for it..."

(Paramedic)

"...We can't use them if there isn't a dosing sheet there for us, we are not allowed to use them, end of discussion..."

(Paramedic)

→ Training gaps: **59%** at least sometimes felt unconfident with medicines; **23%** always or often felt unconfident.

"...In terms of administering anticipatory medications, that's not something I've ever done before, and it's certainly not something that we've been specifically shown or trained how to do..."

(Paramedic)

"...A lot of paramedics don't realise they can give those drugs, because they're not comfortable with these subcutaneous injections..."

(Paramedic)

→ Advanced paramedic support: Some ambulance trusts equip advanced paramedic practitioners with key just-in-case medicines. These practitioners typically provided remote advice rather than attending in person to administer medicines.

→ Morphine misconceptions: Despite universal access and a greater willingness to administer morphine as opposed to other just-in-case medicines, some paramedics hold inaccurate beliefs that morphine use will hasten death.

→ Experience promotes confidence: Experienced paramedics are more confident administering just-in-case medicines. However, there is widespread uncertainty and reluctance to administer patient's own just-in-case medicines.

80%

reported at least sometimes **lacking necessary medicines**

59%

at least sometimes felt **unconfident with medicines**

5. Service shortages and challenges in interdisciplinary collaboration limit quality of care

→ Service gaps drive paramedic attendance: Paramedics were frequently called to manage situations resulting from breakdowns elsewhere in the healthcare system, often when individuals had "slipped through the net". Patients and carers reported inconsistent support from core services such as GPs and community nursing teams.

→ Limited access to patient records: Paramedics operate with limited electronic records access, relying on their own detective work, family insights, or searching homes for documentation. 45% reported never or rarely knowing end of life status prior to arrival (42% sometimes knew), 56% often or always lacked patient medical history, and 77% often or always lacked access to existing advance care planning documentation.

"...Once we're at scene, we can look back on our ePCRs [Electronic Patient Clinical Records] and see if we've ever been out to them before, and whether we've been out for similar things or not and we can read previous crews paperwork... The only thing we can look at before we get to scene is the [ambulance record system] summary... that's dependent on whether the patient has discussed with the GP to get a summary completed..."

(Paramedic)

→ Role misunderstanding undermines collaboration: There is misunderstanding across the healthcare system regarding the evolved scope of paramedic practice, this hinders collaboration and shared professional decision-making.

"...There's a massive misunderstanding within other areas of healthcare as to what we do, and what our scope of practice is... GPs potentially aren't as aware as to what our scope is and that we don't just put people on an ambulance and drive them in anymore..."

(Paramedic)

→ Differences in clinical perspectives hinder communication: Paramedics often act as "eyes and ears on the ground" for other services, but whilst paramedics may prioritise vital signs, palliative care professionals rely more heavily on visual and behavioural assessments. These differing lenses lead to communication challenges and undermine shared professional decision-making.

"...They see it as very much as A, B, C, D... and I'm saying to them: "what do they look like?", "are they talking to you?" I'm just looking at it in a completely different lens..."

(Specialist palliative care clinician)

"...All [hospital haematology, community nursing service, hospice service] said to us: 'ring us if you need us', but they didn't come very easily, anybody... we certainly felt the impact... a lot of hospices are struggling financially and reducing their services. We had district nurses. But, even in the worst week we had, they only came in once..."

(Bereaved carer)

RECOMMENDATIONS

1. Provide palliative and end of life care education and training to all paramedics (Finding 1 & 2)

Plan and deliver comprehensive education and training on end of life care provision for the paramedic workforce, focusing on recognition and management of palliative care needs, potential interventions and supporting family and friends in often highly charged, crisis situations.

Outcomes: Improves knowledge and confidence; improves care provision and efficiency; enhances patient and family experiences; reduces complaints and incidents; increases access to appropriate professionals and services for advice and referral; enhances communication with patients and families, and palliative care professionals (generalist and specialist).

Specific recommendations:

1.1. Forthcoming 10 Year Workforce Plan should include proposals that palliative and end of life care training is provided to all paramedics.

1.2. Ambulance trusts to incorporate regular palliative and end of life care training as part of CPD requirements, accessible irrespective of shift patterns and not reliant on paramedics participating in their own time. Ambulance trusts should include palliative and end-of-life care training within trust strategic learning and development plans to underpin this CPD requirement.

1.3. College of Paramedics to review palliative and end-of-life care related assessment and management in the pre-registration curriculum to ensure it includes necessary subject content, for example identification and management of palliative care emergencies and use of anticipatory medicines with focus on building confidence to recognise symptom management needs and administer medicines.

1.4. Health and Care Professions Council to ensure undergraduate courses adhere to the College of Paramedics curriculum, and that proposed content (including palliative and end-of-life care) is validated against this curriculum, as for other healthcare professions.

1.5. Health and Care Professions Council to embed core palliative and end-of-life care competencies within its standards of proficiency for paramedics.

2. Fund 24/7 access to specialist palliative care advice lines for all paramedics (Finding 3)

Single points of access are required to offer 24/7 advice to paramedics in all localities throughout England, providing expert advice whilst on scene, irrespective of whether the patient is known to specialist palliative care services or not. Service specifications to include: call taking by trained palliative care clinicians with access to shared digital healthcare records, rapid home-visiting support services, and technology to support digital consultations.

Outcomes: Provides paramedics access to specialist knowledge and skills for advice and shared professional decision-making; improves decision-making; reduces avoidable hospital conveyance; improves symptom management near the end of life; improves coordination of care; and amends current inequities in access.

Specific recommendations:

2.1. Integrated Care Boards to ensure existing 24/7 advice lines are available to paramedics, whether the patient is known to the specialist palliative care service or not.

2.2. Integrated Care Boards to commission 24/7 advice lines where there are gaps in provision. Consider use of NHS 111 option 4 (for palliative care) to avoid confusion and promote consistency across England.

2.3. Ambulance trusts should signpost paramedics to, and ensure they have digital access to, the NHS Service Finder for accurate contact details of 24/7 advice lines while on scene, regardless of location.

2.4. Providers of 24/7 advice lines should arrange healthcare professional-only (bypass) contact numbers to ensure paramedics can readily access advice while on scene.

3. Ensure access to and ability to administer (anticipatory 'just-in-case') medicines by all paramedics (Finding 4)

Ensure individuals who have just-in-case medicines in the home have a medicines authorisation and administration record easily accessible by paramedics to facilitate administration of patient's own just-in-case medicines when needed. Support paramedics to carry key just-in-case medicines when patient's own medicines are not available. Support all paramedics to receive sufficient training to be confident in administering just-in-case medicines without fear, to effectively manage symptoms.

Outcomes: Improves symptom management (increases administration of just-in-case medicines by paramedics); reduces unnecessary time on scene (spent liaising with community nurses to make home visits and give medicines); improves knowledge and skills around medicines; reduces fears related to administering medicines; reduces risk of avoidable hospital conveyance.

Specific recommendations:

3.1. All ambulance trusts to allow paramedics to administer patients' own just-in-case medicines.

3.2. Prescribers and healthcare teams to ensure medicines authorisation and administration records are completed as near as possible to the time of prescription and are available for paramedics to access in the home.

3.3. Ambulance trusts to ensure all paramedics have knowledge and expertise to administer these medicines via CPD training.

3.4. Ambulance trusts to develop policies to ensure that when symptom alleviation is necessary, and patient's own just-in-case medicines are not available in the home, there is no delay in the administration of such medicines. All paramedics to carry key just-in-case medicines (for sedation, nausea/vomiting and respiratory secretions) accompanied by a training package so they have knowledge and confidence to administer these as required.

4. Support interdisciplinary collaboration between paramedics and the wider healthcare team (Finding 5)

Create a supportive culture of respect and communication across the healthcare system, recognising paramedics as skilled generalists who need to collaborate with other end of life providers such as specialist palliative care and primary/community-based providers (general practitioners and community nurses). Provide clear and comprehensive information about paramedic skills and evolved scope of practice into complex home-based care at end of life, to enable improved interdisciplinary working and shared professional decision-making.

Outcomes: Improves care delivery via inter-disciplinary working, improves decision-making via shared professional decision-making; improves coordination of care; improves access to the right information; reduces avoidable hospital conveyance, Emergency Department attendance and hospital admissions.

Specific recommendations:

4.1. Ambulance trust control centres should recognise that time pressures placed on crews to leave scene whilst on end of life calls are unhelpful and lead to paramedics feeling pressured to convey to hospital.

4.2. Ambulance trusts to lead work with system partners including primary care, community and specialist palliative care services to increase appreciation of what paramedics can provide when attending an end-of-life call.

4.3. In line with the 10 Year Health Plan [7] commitment to share care plans for individuals at end of life with paramedics, Integrated Care Boards should lead a review of processes to ensure there are digital means to:

- **a.** Identify individuals who are in the last year of life, and ensure there is a mechanism to flag this as part of the information paramedics receive at the point of call and
- **b.** Ensure when paramedics are the first to identify an individual as being at end of life there is a mechanism for sharing this back into community healthcare teams or primary care and
- **c.** Ensure advance care planning documents (including ReSPECT forms or similar) are shared with the ambulance service and can be accessed by paramedics whilst on scene.

5. Integrate records systems to ensure paramedics have the right information at the right time (Finding 5)

Ensure ambulance services have access to digital patient healthcare records to facilitate appropriate care provision. Integrate the necessary records systems to enable access to required information, including medical history and advance care planning related documents, to ensure patients known to be in the last year of life can be identified from the point of call.

Outcomes: Prevents paramedics 'working in the dark'; improves care delivery; reduces duplication of information giving by patients and reliance on family members to be on scene; reduces unnecessary time on scene searching for physical copies of information in the home; facilitates integration across primary, secondary, and community services.

Specific recommendations:

5.1. In line with the 10 Year Health Plan [7] ambition enabling workforce access to the best digital tools, ambulance trusts and IT system commissioners and suppliers to work collaboratively to integrate the necessary digital patient record systems so paramedics are able to access sufficient information to facilitate care delivery.

5.2. Primary, secondary and community-based healthcare providers to work with local ambulance trusts to ensure that where advance care planning documents have been generated these are shared digitally with ambulance services.

5.3. Ambulance trusts to ensure procedures are developed so that advance care planning documents can be accessed and used to identify and triage those in the last year of life at the point of 999 call.

CONCLUSION

Paramedics are uniquely placed to provide timely and effective care to individuals in the last year of life. This research highlights an urgent and compelling need to invest in the training, integration and support of paramedics in end of life care. A coordinated, system-wide approach is required to ensure paramedics are well-connected to the wider healthcare team. This also requires a fundamental cultural shift within the ambulance service *"...to accept that primary care, palliative and end of life care are significantly more prevalent now and we are not an emergency only service any more... If we can't support someone properly in their last year what does this say about our service and NHS ethos..?"*

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