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West Midlands Adult Critical Care Network

Martha's Rule Pilot Support Pack

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PREFACE

Introduction

In the ever-evolving landscape of healthcare, the recognition and timely treatment of deteriorating patient remains critical to preventing avoidable deaths. In 2022, there were 251,595 deterioration related deaths in English NHS hospitals, of which around 3% may have been avoidable (Hogan, et al ,2019). A thematic review of over 2,000 deaths seen to be as a result of unsafe care identified contributary factors relating to variations in the management and monitoring of deterioration in nearly 70% of these (Donaldson et al 2014). Recent investigations into barriers preventing timely escalation and response have pinpointed three key factors: organisation culture, professional hierarchies, and leadership dynamics within healthcare environment. These factors often lead to a reluctance to raise concerns about deteriorating patients. Addressing these barriers requires clear leadership that models multidisciplinary teamwork, values the expertise of all stakeholders, and emphasises a person-centred approach. Such leadership can cultivate psychologically safe working cultures where raising worries and concerns is encouraged and supported.

The Martha's Rule pilot, commissioned by the Secretary of State for Health and Social Care in response to the tragic death of Martha Mills and other similar cases, aims to ensure that critical concerns from patients and those who know them best are acknowledged and acted upon. The pilot includes three key elements designed to improved patient safety and care:

1. **24/7 Access to Rapid Review:** All staff in NHS trusts must have around the clock access to a Critical Care Outreach Team for rapid review if they have concerns about a patient's condition.
2. **Patient, Family and Loved Ones Access to Rapid Review:** Patient's families, carers, and advocates must also have 24/7 access to a Critical Care Outreach Team, through clearly advertised mechanisms.
3. **Daily Wellness Information Gathering:** The NHS must adopt a structured approach to gather information about the patient's condition directly from the patient and their family at least once a day.

(NHS England, 2024)

The West Midlands Adult Critical Care Network encompasses 20 acute sites, 11 of which have been enrolled, through expression of interest, in the NHS England Martha's Rule pilot 2024/25.
These sites offer a diverse range of services, specialities, bed counts and cater to a wide spectrum of patient demographics.
All pilot sites have established 24/7 Critical Care Outreach Teams available for all NHS staff to access for rapid reviews when they have concerns about a patient's condition. Therefore, this support pack will focus on elements 2 and 3 of Martha's rule. Midlands Adults Critical Care Network will be working in partnership with Midlands Health Innovation Networks and Midlands Paediatric Critical Care Networks to provide support to phase one Martha's Rule sites; ensuring the successful implementation of Martha's Rule across all areas of the site (excluding Maternity, Neonatal care and Accident & Emergency unless the site opts to also cover these areas).

Aim of Support Pack

This support pack aims to compliment resources and information produced and shared by NHS England regarding Martha's Rule. This support pack aims to support the nursing, medical, operational teams and executive teams in the planning, implementation, monitoring, and evaluation of Martha's Rule pilot. The aim is to foster a healthcare environment where the voices of clinical staff, patients, carers, and family members are heard and acted upon promptly, ensuring the highest standards of safe patient care. This support pack should act as a guide outlining the steps to effectively implement these components, aiming to create an environment where every concern is heard, evaluated, addressed with the utmost urgency and care. By prioritising multidisciplinary collaboration and valuing the insights of all involved parties, we can enhance patient outcomes.

The support pack is specifically aimed at the implementation of Martha's Rule in relation to the adult inpatient demographic. However, it could be adapted for use in paediatric and maternal services where an organisational system is not already in place.
Currently, this guide does not cover paediatrics services, as this area is more complex and requires further thought and planning in collaboration with paediatric healthcare experts. There will be a requirement for Martha's Rule phase one sites to explore the implementation in Paediatrics. West Midlands Paediatric Critical Care Network have been accepted into the NHS England pilot focused paediatrics and therefore separate workstreams are being developed to further support the application of Martha's Rule in paediatric services.

We hope this guide serves as a valuable resource in our collective mission to safeguard patient health and well-being, fostering a culture of openness, responsiveness, and continuous improvement. Together, we can ensure that the legacy of Martha Mills drives meaningful change in our healthcare practices, ultimately improving care for all patients and preventing avoidable deaths.

NB: It is acknowledged that the sites enrolled in the pilot are at different stages of implementing Martha's Rule. Therefore, this support pack should be used as a guide relevant to each organisation's specific context and progress.

ELEMENT TWO OF MARTHA'S RULE: OVERVIEW

Patient, Family and Loved Ones Access to Rapid Review

The causes of missed deterioration are complex but have been attributed to a failure to assess the patient and monitor vital signs promptly, alongside potential time pressures, workload constraints, inadequate staffing or a lack of available equipment (L. Cornell & K. Datson, 2023)

One resource that has been largely overlooked in the identification and escalation of deteriorating patients are patients themselves and their families. The early signs of deterioration can be subtle. Given that patients and their families have an intimate understanding of their condition, they can alert healthcare providers to any changes and seek escalation earlier. However, the healthcare provider may sometimes be more inclined to await more objective signs, resulting in delayed escalation (Bucknall, et al, 2021; Chua et al, 2022).

A patient and relative activated Critical Care Outreach service recognises the value and significant contribution that patients and relatives can make. It empowers them to alert health professionals to subtle changes which can support the aim to prevent patients' further deterioration, avoid ICU admissions, improve patient and relative experiences, and reduce avoidable deaths. These initiatives have a proven track record of providing an extra level of safety within a hospital, resulting in many benefits to patients and their families (L. Cornell & K. Datson, 2023).

Patient/relative-triggered rapid response systems have been widely adopted within NHS trusts in the UK, but they remain an infrequent additional service. Alongside having a rapid response or critical care outreach team available in every NHS trust, a patient and relative activated Critical Care Outreach service should be available to address variations in standards of treatment, provide additional patient safety netting and raise the quality of care being provided (NHS England/NHS Improvement, 2021).

ELEMENT THREE OF MARTHA'S RULE: OVERVIEW

Patient Wellness Checks

Effective communication between healthcare professionals, patients, and their families is paramount in ensuring high-quality patient care. A structured approach to achieving this involves the implementation of element three of Martha's Rule. This emphasises direct and routine engagement with patients and their families. This approach mandates that healthcare staff obtain information about the patient's condition directly from the patient and their family at least once a day. Studies have shown that encouraging more staff to genuinely engage with patients is crucial for improving detection of deterioration. By routinising conversations that illicit communication about changing wellness, this method fosters a more open dialogue between staff and patients.

Regular communication and conversations with patients and their families about the patient's clinical condition can significantly aid in the early identification of deterioration. This, in turn, prompts timely prevention, identification, escalation and response (PIER)potentially preventing critical illness. Implementing these measures may deter the need for escalation by healthcare professionals, patients or their relatives to refer to Critical Care Outreach teams. Moreover, there is clear evidence that communication failures are one of the most common reasons why patients and their relatives directly refer to Critical Care Outreach teams (M. Odell, 2019; L. Cornell & K. Datson, 2023). Therefore, improving communication between ward staff, patients and their relatives may reduce the need for secondary help, enhancing overall patient and relative experience, preventing deterioration, and reducing avoidable deaths.

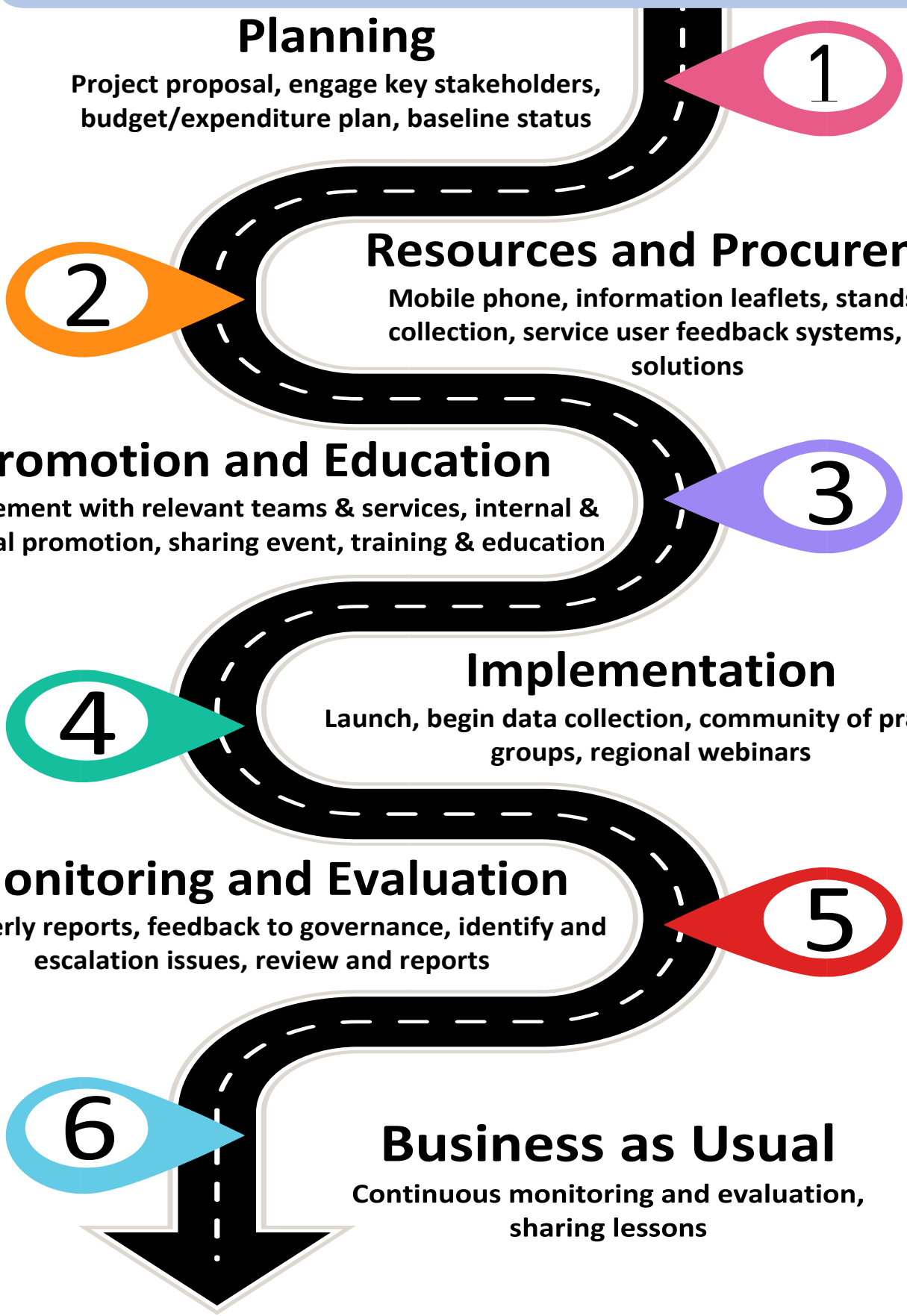
Studies where patients were routinely asked about how they felt and whether they felt better or worse have demonstrated that self- reported wellness can be a direct predictor of their clinical condition. For instance, patients who self-reported feeling better tended to improve, while those who reported feeling worse often experienced clinical deterioration (A. Albutt et al, 2021). This aspect of Martha's Rule underscores that patients know their bodies best and that relatives can detect subtle changes early in deterioration.

Although healthcare professionals routinely ask about how the patient is feeling, the aim is to formalise this process, thoroughly investigate the answers, and provide guidance on subsequence actions. It is important to note, however, that patient self-reported wellness has limitations, particularly regarding the patient's capacity and ability to answer questions accurately. In such cases, ward staff must assess the patient's capacity and document when wellness checks cannot be conducted, potentially relying on family input to complete these assessments.

(NHS England, 2024; A. Albutt et al., 2021)

Martha's Rule Pilot

Project Roadmap



PHASE ONE - PLANNING

Ownership of Projects

Element two of Martha's Rule involves implementation of a patient and relative activated Critical Care Outreach or Rapid Response team. Given that this element is highly associated with Critical Care, it is suggested that this aspect of the pilot be managed by the organisations Critical Care Service Leads and/or Deteriorating Patient team.

Element three of Martha's Rule involves implementation of a structured approach to check in on patient's wellness daily, which should be established as routine practice at the ward level. This process extends to all adult inpatient areas. Given the projects impact across all adult inpatient departments and divisions, the project owners must have comprehensive oversight. Thus, it is recommended that this aspect of the pilot be managed by the organisations Deteriorating Patient team and/or Quality Improvement team, depending on the organisation's structure.

While the ownership of the project should be considered, it is equally important to foster a collaborative approach between relevant services and teams.

Project Proposal

The project proposal is a detailed plan which can be submitted to stakeholders outlining objectives, scope, methods and anticipated outcomes, aiming provide oversight and secure support for its execution. Martha's Rule is part of a wider Managing Deterioration programme where the Prevention, Identification, Escalation and Response (PIER) Toolkit is due to launch in Q2 2024/25. We would encourage Martha's Rule phase one sites to explore how the PIER Toolkit can be embedded into your project proposal and as part of your Martha's Rule escalation pathway.
All elements of Martha's Rule should be included to form the sites project proposal.

A project proposal template is available for download and can be easily edited to suit your team and organisation's needs. Accessible via the following link -
https://www.mcctn.org.uk/marthas-rule.html

Budget/ Expenditure Plan

The Treasury is providing a supportive budget of approximately £40,000 (non-recurrent funding) to each site who submitted a successful expression of interest. Although this funding cannot be used to uplift the workforce, there are no other spending restrictions. The funding allocation is to support phase one sites to successfully implement Martha's Rule across the site (apart from Maternity, Neonatal and Accident & Emergency). Below are some suggestions and considerations for its allocation.

- Purchase of a mobile phone with voicemail application
- Dedicated project manager role/ hours
- Data collection support
- New/ update data reporting system
- Promotional resources (banners/ leaflets/ posters/ stands etc.)

Key Stakeholder Engagement

Key stakeholder engagement is crucial for the successful implementation and embedding of change within healthcare. Investment and engagement can be secured from key stakeholders by presenting the project proposal, which outlines the project methods, aims and shared goals.
Suggested key stakeholders -

- Critical Care Leadership team
- Nursing and Medical Leads for all adult and paediatric inpatient areas
- Divisional Leads for all adult paediatric inpatient areas
- Deterioration Patient/ Patient Safety/ Resuscitation Steering Groups
- Director of Nursing team
- Medical Director team
- QI/ Innovation/ Transformation team
- Patient Safety team including Patient Safety Specialists and Patient Safety Partners
- Communications team
- Switchboard team
- Patient Advice Liaison team (PALS)/ Patient Experience team
- Organisation CEO /executive team
- Local Integrated Care Board (ICB)

Baseline Status

To effectively measure improvement and assess the impact of changes, establishing a baseline is crucial. The pilot sites should agree on specific measures and baselines, considering current services and available data.

Suggested key measures to consider include:

- **Staff Experience:** Use surveys to assess staff perceptions of safety culture pre- and post-change.
- **Prevalence of In-Hospital Cardiac Arrests:** Track the incidence rates to evaluate if there is a reduction post implementation.
- **Unplanned Transfers to Higher Levels of Care:** Monitor these events as an indicator of prevention of unplanned admission to Critical Care following change.
- **Incident and Complaint Reports:** Analyse reports and complaints relating to failure to rescue deteriorating patients, collaboration with patient experience teams would be beneficial.

PHASE ONE - SUGGESTED CHECKLIST

- [ ] Agree on service name for element two.

  (Call 4 Concern© is a well-established and recognisable name for the service and should be considered to standardise terminology across the Midlands however would need to include the copyright sign and be attributed to its originators – The Royal Berkshire)

- [ ] Establish dedicated roles for pilot.

  (Project lead/ project manager/ data analyst)

- [ ] Complete predicted activity calculation for element two.

  (Pg. 5 in Project Proposal template, however, should note due to the press and public awareness of the pilot this may be more)

- [ ] Agree on referral/ triage escalation pathways for element two.

  (Suggested pathway on pg.8. Triage of calls can be undertaken by CCOT, alternatively could consider utilising switchboard however, this would require their buy in, support and education for switchboard staff) (Understand how the elements of PIER become embedded in your referral/ triage escalation pathways)

- [ ] Agree on budget/ expenditure plan.

- [ ] Agree on the platform for patient wellbeing checks (digital/ paper).

- [ ] Establish launch date.

- [ ] Complete project proposal.

- [ ] Present project proposal to key stakeholders and executive team.

PHASE TWO - RESOURCE and PROCUREMENT

Mobile Phone

Obtain procurement of mobile phone in liaison with organisation IT services. Ensuring the mobile phone offers a voicemail facility will allow the team to record a personalised voice message. This will help manage the referrers expectations of the service, particularly when the Critical Care Practitioner holding the phone is unable to answer the call straight away. The voice message should outline that the team are unavailable at that time to take the call due to assisting deteriorating patients and will return the call as soon as able, and that the caller should leave their contact details alongside a brief description of concern. The mobile phone number should be shared with the organisation, in particular PALS and switchboard. The mobile phone number should be advertised on promotional material and platforms.

Data Collection Systems

Pilot sites should consider their current data collection system and evaluate their effectiveness for inputting additional data in relation to Martha's Rule (in particular element two). There will be a minimum data set required, defined by NHS England, for evaluation purposes. Furthermore, data collection system must be capable of generating reports to be shared with Health Innovation Networks and Adult Critical Care Networks. Funding provided in the pilot could be considered as contribution toward adopting a digital data system, if one is not already in place. However, as this is a non-recurrent amount, future costs would need to be covered by the organisation.

Regardless of the data system used, whether it be a bespoke organisation system, a commercial system, or a manual spreadsheet, the Adult Critical Care Network will endeavour to support the pilot sites with data/ report retrieval and collation on a central network dashboard.

Service User/ Referrer Feedback System

Assessing the value and impact of the pilot as a resource and service is complex and therefore it cannot be solely measured quantitatively. One of the key aims for the pilot is to improve patient and relative experience. Other forms of evaluation should be through obtaining service user feedback. An online survey link could be sent to the referrer's mobile phone via text alongside a standard message following the discharge of the patient from the service. Any feedback should be provided anonymously, however, recipients can be given the option to provide contact details and consent to be contacted in the future for further testimonials.

Example of feedback survey - https://www.surveymonkey.com/r/ZB8GZZF

Promotional Materials

- Patient and Visitor Information Leaflets - Approval and publication should be obtained by the organisation information leaflet group
- Information Posters
- Information Banners
- Information Stands
- Digital Screensavers

Templates available for download and editing via link - https://www.mcctn.org.uk/marthas-rule.html

NB: The service and promotional materials need to be equally available and accessible to a diverse population, ensuring inclusivity throughout the pilot. Consideration needs to be given to providing materials in various spoken languages, easy read versions, and in different formats.

PHASE TWO- SUGGESTED CHECKLIST

- ☐ Obtain dedicated mobile phone.
- ☐ Record voice message.
- ☐ Provide number to relevant key stakeholders (PALS/ switchboard).
- ☐ Set up digital data collection system/ log with minimum data set.
- ☐ Set up service user feedback survey.
- ☐ Design promotional and information materials.
- ☐ Print/ procure promotional and information materials.
- ☐ Finalise design of patient wellbeing check.
- ☐ Print patient wellbeing checks/ charts or develop integration of element into digital system.

PHASE THREE - PROMOTION and EDUCATION

Internal Promotions

Internal promotion and education for all staff members within the organisation is essential to raise awareness of the service, alleviate possible fears or misconceptions, and provide opportunities for questions and answers.
Consider the following platforms for internal promotions -

- Internal emails
- Organisation internal intranet page
- Screensavers
- Learning and sharing events
- Organisation/ teams newsletter or bulletins
- Internal social media/ communication platforms
- Matrons/ sisters forum
- Ward meetings

Staff Education

Educating staff about the service will ensure they remain well-informed and confident promoting the service. It should improve staff engagement and collaboration, addressing any concerns or misconceptions, fostering a positive and proactive approach for the service implementation and embedding. It also provides an opportunity to educate and emphasise the importance of recognising soft signs of deterioration and the listening to patient/ relative concerns.

- Trust inductions
- Grand round (medics)
- E-learning module
- Targeted training (adhoc/ BLS/ILS/AIM/BEACH/ALERT/AWARE)
- Deteriorating patient teaching including identification of soft signs of deterioration
- Ward staff champions/ trainers (act as link educators, delivering bitesize teaching and act as a conduit between the service leads and the ward)

External Promotions

Although Martha's rule being publicised by the press and the public may have awareness of the pilot, it is still essential to promote the service to ensure an accurate understanding of its aim, how and when it can be accessed, the service limitations, and to manage public expectations.

Consider the following platforms for external promotions -

- External organisation website
- Organisation social media
- External stakeholder events
- Local press coverage
- Promotional event (information stands/ Q&A sessions)

NB: External promotions should be completed as the last action to mitigate the risk of referrals prior to the launch date and should consider any agreed standards set out nationally as part of the project by NHS England.

PHASE THREE - SUGGESTED CHECKLIST

☐ Contact organisation communications team and discuss options for internal and external promotions.

☐ Draft promotion content for newsletters/ websites/ screen savers etc. (website content template available for download and editable - https://www.mcctn.org.uk/marthas-rule.html)

☐ Deliver/ publish promotional materials, organise, and complete promotional events.

☐ Contact learning and development team, engage support, and explore options to deliver education.

☐ Draft education content (presentations/ teaching sessions/ bitesize teaching/ online learning).

☐ Commence delivery of education programmes.

☐ Consider delivering patient/ visitor/ staff roadshows.

PHASE FOUR - IMPLEMENTATION

The implementation phase will involve launching the service with the project lead/manager actively supporting the team. This period will be crucial for identifying and addressing any issues that may arise, with ongoing communication and assistance from the organisation leadership team, ICB, regional Health Innovation Networks, and the Adult Critical Care Network team. As the service is embedded, data collection will begin to facilitate future analysis and reflection.

Additionally, the team will have opportunities to participate in the Midlands Community of Practice, which offers a platform for sharing and learning from experience. The Community of Practice will be led by the West and East Health Innovation Networks along with the Adult and Paediatric Critical Care Networks. Continued support will be provided through educational and supportive webinars provided by the Midlands Health Innovation Networks and/or Adult Critical Care Network teams aimed at optimising service delivery.

PHASE FOUR - SUGGESTED CHECKLIST

☐ Launch the service.

☐ Regularly check in with the team, providing opportunities for them to escalate concerns.

☐ Update organisation leadership team, Health Innovation Networks and Adult Critical Care Network team - in particular in view of escalating concerns.

☐ Ensure accurate and up to date data collection.

☐ Establish audit programme.

☐ Ensure service user feedback surveys are being sent out in a timely manner following patient discharge from the service.

☐ Attend Midlands Community of Practice group meetings.

☐ Attend Health Innovation Network/ Adult Critical Care Network team webinars.

PHASE FIVE - MONITORING and EVALUATION

Ongoing monitoring and frequent evaluation of a new service within a pilot is crucial to ensure that the service is meeting its intended goals and is on the trajectory to delivering the desired outcomes. It helps identify any issues or inefficiencies early, allowing for timely escalation, support and solutions. Evaluating will provide valuable insights that will inform decision- making and strategic planning for the future of the service and at a national level.

There is an expectation of continuous monitoring to foster accountability and transparency, ensuring engagement and support from stakeholders. It will support ongoing learning and development, enabling the team and other organisations to refine and enhance the service based on evidence and feedback.

There is an expectation for the teams to be responsible for providing data, reflections, and evaluations to their organisations through their governance processes. Additionally, a system must be established to ensure these core metrics are conveyed to Health Innovation Networks and/or NHS England on the progress on the pilot.

Element Two: Minimum Dataset

Obtaining data is crucial for analysing and evaluating the impact of the service and informing the future of Martha's Rule pilot. It is recommended that organisations use a standard minimum data set, which will facilitate effective comparison and analysis. NHS England will provide a required minimum data set; the list below can be used to complement any required data NHS England request.

- Date and time of referral
- Name of referrer
- Number/ contact details of referrer
- Relationship of referrer to patient
- Name of patient
- Location of patient
- Member of staff taken the call
- Reason for referral/ concern
  - Clinical condition
  - Communication issue
  - Non-clinical (parking/ visiting/ hygiene etc)
  - Other - add to comments
- NEWS at time of referral
- Feedback survey sent + date
- Date and time discharged from service
- Date and time of response/ first review
- Response to referral
  - Asked to contact ward manager/ parent team
  - Clinical review
  - Verbal advice/ reassurance
  - Signpost to another service/ team
  - Other - add to comments
- Overall patient outcome
  - Patient improved as a result of review
  - Current ward care adequate
  - Transfer to higher level of care
  - End of life care
  - Not applicable/ unknown
  - Other - add to comments

Element three: Compliance Audit

Monitoring compliance with the implementation of the Patient Wellness Rounds is crucial to ensure the practice is effectively embedded into routine care. Following the initial implementation, regular audits should be conducted to assess adherence. These audits, carried out routinely by the project team, will evaluate the frequency and completion of rounds as well as the appropriateness of escalation actions taken. The findings from these audits should be reported directly to the ward team and align with the trust's governance processes. This approach not only helps identify areas needed further support and improvement but also serves as an opportunity to recognise and share instances of good practice, thereby fostering a culture of continuous improvement.

Suggested measures of audit -

- Has the Patient Wellness Round been completed at least once a day? (Y/ N/ NA)
- If no, how long since the last Patient Wellness Round been completed?
- If NA, why was it not completed?

- Was the Patient Wellness Round completed with the patient or relative?
- If not the patient, why?
- If the patient did not have capacity at the time of the Patient Wellness Round, was this formerly assessed and documented in the patients notes?

- What was the NEWS 2 score at the time of the Patient Wellness Round?
- What was the Patient Wellness score?
- Was the total Patient Wellness score calculated correctly?
- What was the level of escalation (Green, Amber or Red)?
- Was the correct escalation pathways follow as per trust protocols and matrix?
- Was the Patient Wellness Round fully completed (no gaps)?
- What position was the person completing the Patient Wellness Round?

Deep Dive Audit

Conducting deep dives into specific cases will provide invaluable insights into the patient's clinical condition in relation to their self-reported wellness score. This analysis may help identify whether there is a link between self-reported wellness as a predictor for deterioration. It will also clarify the escalation processes in response to concerns and interventions carried out, highlighting cases where the wellness round prompted timely escalation and intervention, potentially preventing further deterioration or facilitating early access to higher levels of care. As with any clinical audit, the process should identify areas needed further support and improvement but also serves as an opportunity to recognise and share instances of good practice, thereby fostering a culture of continuous improvement.

Criteria for deep dive audit -
Patient Wellness score >6 Escalation Pathway >Amber

Suggested measures of audit -

- Compliance audit as above
- Patient demographics (age/ sex)
- Ward (Medical/ Surgery/ Acute Assessment/ Respiratory/ Liver/ Oncology etc.)
- Outlier bed (Y/N)
- Date of hospital admission
- Reason for hospital admission
- Previous high NEWS >5 (Y/N)
- If yes, what was the previous high score?
- Escalation plan in place (Y/N)
- If yes, details of escalation status (full escalation/ treatment limitations)
- DNACPR status
- Was the appropriate healthcare professional escalated to within 1 hour of the Wellness Round score? (Y/N/NA)

- If no, provide details.
- What grade/ speciality was healthcare profession that was escalated to?
- Was the patient reviewed by the appropriate healthcare professional within 1 hour of the escalation? (Y/N/NA)
- If no, provide details.
- What grade/ speciality was healthcare profession that reviewed the patient?
- What interventions were carried out following the review?

☐ Bloods
☐ ECG
☐ Xray chest/ abdo/ pelvis/ limb
☐ ABG/VBG
☐ Referral to another speciality (detail which)
☐ Patient/ relative update
☐ Other (further detail)
☐ Medication (details which)
☐ Oxygen
☐ Transfer to another ward (details which and why)
☐ CT head/chest/thorax/abdo/pelvis
☐ Review of escalation plan
☐ Review of resuscitation status

- NEWS score following escalation, review and interventions.
- When was the next Patient Wellness round completed (minutes/hours)?
- What was the Patient Wellness Score on the next round?
- Did the patients clinical condition improve following these events? (Y/N/NA)
- If no, what else was done?

PHASE FIVE - SUGGESTED CHECKLIST

- ☐ Minimal quarterly reports through organisation governance processes
- ☐ Quarterly reports and progress updates to Health Innovation Networks
- ☐ One-year pilot review (data and learning reflections)

PHASE SIX - BUSINESS as USUAL

Integrate the new service seamlessly into existing operations while maintaining focus on the pilot's specific objectives. The entails delivering the service consistently and efficiently, continuously monitoring and evaluating to ensure it is meeting the goals and identifying any areas of improvement.
Phase one learning surrounding implementation will be shared with NHS England. Following the completion of the pilot, there should be guidance from NHS England to inform next steps and determine the future of Martha's Rule at both local and national levels.

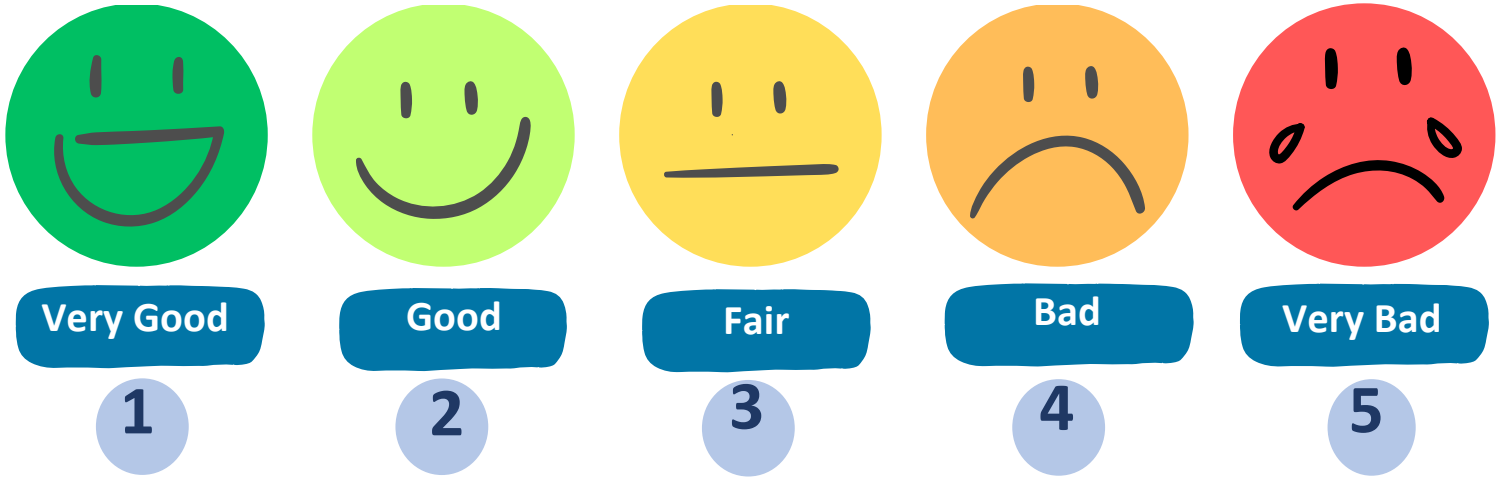
ELEMENT THREE: WELLNESS CHART TEMPLATES

The Patient Wellness Round chart templates provided can be supplied to the wards either as paper charts or integrated digitally, depending on the trust's current documentation formats and digital abilities.

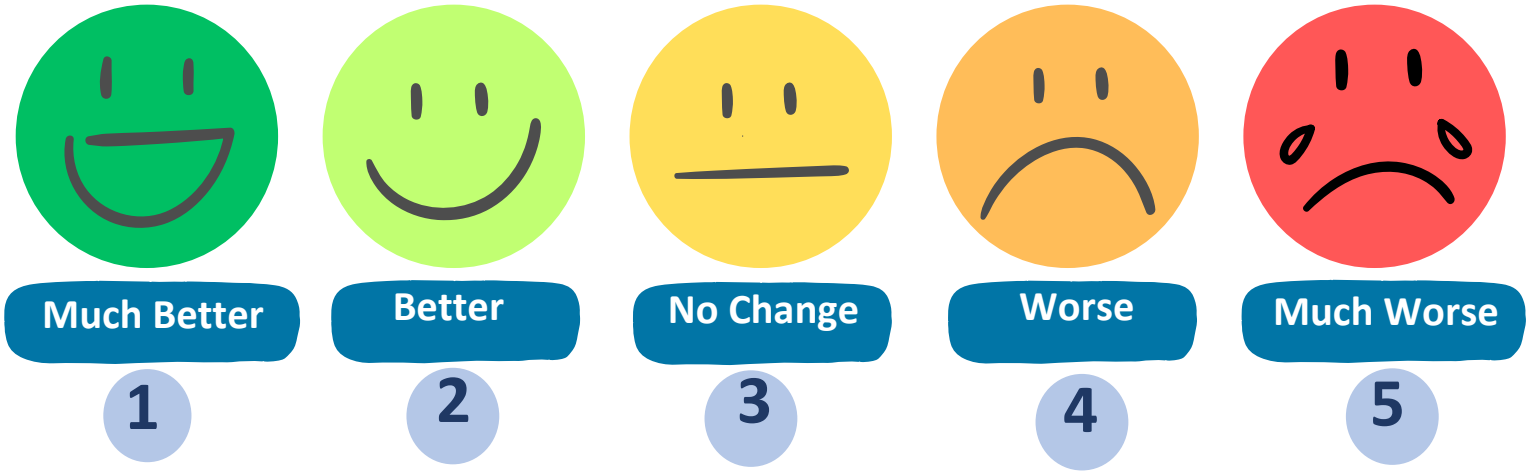
Patient Wellness rounds should be carried out by any of the ward clinical staff members with the patient and/or their relatives at least once per day. If the patient is deemed not to have capacity at that point, a capacity assessment must be completed and documented in the patient's notes. The Wellness Round must then be completed with the patient's relatives. It is recognised that pilot sites may already have a system in place that would be ideal for incorporating this element, therefore the templates are a suggestion for sites that have not confirmed their process for completing this element.

Wellness Round

Question 1: How are you feeling?



Question 2: How are you feeling compared with to the last time you were asked (or compared to yesterday)?



Patient Wellness Score Escalation Matrix				
2	3	4	5	6
3	4	5	6	7
4	5	6	7	8
5	6	7	8	9
6	7	8	9	10

Escalation Pathways Based on PW Score	
2-5	Continue to monitor
6-7	Consider increase observation frequency Inform Nurse in Charge Inform medical team caring for patient
8-10	Consider increase observation frequency Inform Nurse in Charge Inform Medical Team caring for patient Consider escalation to Critical Care Outreach Team

Adapted from original version by Bradford Teaching Hospital NHS Foundation Trust

Wellness Round should be carried out with the patient and/or their relatives at least once per day
Any additional information should be documented in the patients notes

Wellness Round

P - Patient Completed R - Relative Completed U - Unable to complete (document reason in patients

	Example	***Example***							
Date	***10/10/2026***	***11/10/2026***							
Time	***10:00***	***12:00***							
PW round completed with	***P***	***R***							
PW Q1 Score	***5***	***2***							
PW Q2 Score	***4***	***2***							
Total PW Score (Q1 +Q2)	***9***	***4***							
Level of Escalation required	***RED***	***GREEN***							
Informed Nurse in Charge	***Y***	***NA***							
Informed Medical Team	***Y***	***NA***							
Informed CCOT	***Y***	***NA***							
Documented in patient notes	***Y***	***NA***							
PW round completed by (name)	***A Bloggs***	***B.Cloggs***							
Position	***HCA***	***RGN***							
PW round completed by (sign)	***ABloggs***	***BCloggs***							

CONCLUSION

Martha's Rule is a crucial component of the NHS Patient Safety Strategy (2019), which aims to continuously improve patient safety by building on the foundations of safe cultures and safer systems. The strategy intends to support staff and providers in sharing safety insights and empowering patients and staff with the skills, confidence and mechanisms needed to enhance safety. Getting this right, the first time could save lives and alleviate financial burdens on the NHS. The pilot aims to provide valuable insights, foster involvement, and drive improvement by engaging all key stakeholders, including local ICBs, organisational executive teams, services leads, healthcare professionals, and importantly, patients and their relatives. This collaborative approach is essential for creating a safer healthcare system and leading the advancements of safety practices throughout the NHS nationally.

ADDITIONAL RESOURCES/ REFERENCES

Additional Resources

https://www.england.nhs.uk/patient-safety/marthas-rule/

https://www.mcctn.org.uk/marthas-rule.html

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FREQUENCY ASKED QUESTIONS

1. How does this relate to Paediatrics?

   This guide relates to Paediatrics as there is a requirement for pilot sites to explore the implementation of Martha's Rule in this field. Recognising the complexity and the need for further collaboration with Paediatric experts through separate workstreams to support. West Midlands Paediatric Critical Care Network have been accepted into a focussed Paediatric NHS England pilot.

2. How does this relate to Call 4 Concern©?

   The Call 4 Concern© initiative was first introduced in the UK by the Royal Berkshire Hospital as an inpatient safety service, allowing patients and their loved ones 24/7 access to Critical Care Outreach teams. Many other trusts have adopted this name, making it one of the more common and recognisable nationally. Although there is no requirement to use Call 4 Concern©, there are considerable benefits to standardising terminology for patients, relatives, and staff.

3. How does this relate to the PIER Framework?

   The PIER Framework, which help systems to **p**revent, **i**dentify, **e**scalate and **r**espond to physical deterioration, will be implemented as part of an integrated programme to improve the management of deteriorating patients. Alongside Martha's Rule, the PIER Framework is part of a broader Patient Safety Strategy. This initiative aims to enhance NHS support for staff in managing patient deterioration and to encourage greater involvement from patients' families and carers.

4. What role does Provider Site hold in implementation?

   The provider site and its project team/ key stakeholders are responsible for proactively leading the improvement programme, providing leadership oversight, establish planning and methodology, and addressing barriers to the pilot's progression. The pilot site is expected to attend collaborative learning sessions, report progress and share lessons. Additionally, the provider site should ensure adequate representation from clinical departments and patients with lived experience to promote diversity and inclusivity within the local patient population.

5. What role does Health Innovation Networks hold in implementation?

   Each site will be allocated a Patient Safety Collaborative Workstream Lead (Health Innovation Network). This lead will support system-level planning and provide expertise and coaching in quality improvement. They will aid stakeholder engagement, coordinating activities among all relevant system stakeholders to facilitate sharing and learning. Additionally, they will play a key role in reporting issues, concerns, feedback and progress to the National Patient Safety Team.

6. What role does the Adult Critical Care Networks offer?

The Adult Critical Care Networks can provide guidance and support throughout the pilot, ensuring that expertise and resources are accessible. It can also serve as a platform to connect professionals and aid communication, offering opportunities for sharing knowledge and experience alongside educational resources to improve patient safety and care outcomes.

7. What is the governance process for Martha's rule?

The NHSE Managing Deterioration and Martha's Rule Board has overall oversight throughout the duration of the pilot. Provider sites have existing quality governance reporting structures that support monitoring systems and processes, ensuring patient safety and quality of care. Therefore, they should utilise these existing governance processes. The provider site should identify relevant patient safety or quality committees to report to for local oversight. If these committees do not exist, it is encouraged that they are promptly formed.

8. Is the funding recurring?

No, the £40,000 is a one-off payment to support the pilot and is non-recurring.

9. What if there are barriers with external promotions?

Organisations may be reluctant to promote their pilot externally due to concerns about potential negative public perception. However, it is important to recognise that this initiative if a national effort designed to improve patient care by actively listening and responding to patients and their relatives. The initiative is grounded in learning from past events and fosters a culture of openness and transparency. By implementing this initiative, we are adding an additional safety net to help prevent patient deterioration. These measures represent positive developments within the healthcare system, which should be communicated and celebrated publicly.

10. How should we address potential pushback from the ward staff regarding this initiative?

To address potential pushback from ward staff regarding the initiative, it's essential to engage them early in the process and communicate the benefits clearly. Highlight how this initiative is designed to enhance patient safety and outcomes.

It is important to clarify that the patient/ relative activated CCOT service is not intended to take over or undermine care or decisions made by the ward staff. Instead, it aims to support and facilitate smooth communications. Additionally, supporting patients, relatives and ward teams by offering expert advice and promoting collaborative working.

Providing comprehensive education and support will help staff understand the importance of the initiative. Additionally, encouraging feedback and actively addressing concerns will create a sense of collaboration and openness, ultimately leading to a smoother implementation and greater acceptance among ward staff.

11. Will this initiative overwhelm the Critical Care Outreach service?

Data from other trusts that have implemented patient/relative activated services report approximately 2% increase in workload and on reflection report that this is manageable within their current workload.
Moreover, the implementation of element two, which involved routine patient wellness checks at ward level, should support identification and prediction of deterioration using soft sighs and is directly relation to the prevention part of the PIER framework. This proactive approach should, in turn, reduce or prevent the need to element three/ activation of CCOT.
An initiative of this scale has not been conducted in England previously and is expected to provide valuable insights and learnings for the future. Therefore, to develop the initiative, it is crucial for pilot sites to share their reflections and experiences.