Turning Concern into Action: The Practicalities of Martha's Rule

Martha's Rule has now been introduced to all 210 acute NHS hospitals in England and provides an opportunity for patients, families and staff with a formal mechanism to rapidly access an independent expert review (Graham, 2025). Introduced, following the tragic case of Martha Mills who died from sepsis in 2021, after her family had repeatedly tried to raise concerns, which were not acted on by healthcare professionals. In consequence, Martha's Rule was designed with the remit to address the challenges faced by patients and families, but also staff who want to escalate concerns and is being led by the Patient Safety Team at NHS England. In this piece, we discuss some of the key issues relating to the practicalities of implementation of Martha's Rule.

Martha's Rule is one of, but not the only strategy to support the recognition and escalation of the deteriorating patient which has been an ongoing cause for concern. There is significant evidence linked to poor recognition and identification of deterioration to patient harm, and high mortality rates. For example, in 2022, there were 251,595 deterioration related deaths in English NHS hospitals, with evidence suggesting that 3% may have been avoidable (Hogan et al, 2015). This equates to 5 avoidable deaths in every Trust every month which could have been avoided, particularly as over a decade ago, Donaldson et al (2015) thematic review of over 2,000 deaths viewed as occurring because of unsafe care. The identified contributary factors related to variations in the management and monitoring of deterioration in nearly 70% of these cases.

There have been innumerable attempts to improve identification of the deteriorating patient, essential prerequisites for patient safety initiatives (National Institute for Health and Clinical Excellence [NICE], 2007; 2020). However, since the formal introduction of patient safety initiatives nearly three decades ago, the UK healthcare systems have radically advanced with initiatives such as track and trigger systems, critical care outreach, changes in nurse, medical and allied health professional education programmes. The results of these healthcare system changes include evidence that degree educated nurses improve outcomes and reduce mortality (Smith, 2010). In addition, a shift in focus from resuscitation training to the chain of survival has resulted in a stronger response to the deteriorating patient (Resuscitation Council (UK), 2024).

In the light of these successful changes, the failure to listen to concerns of patients and families' remains a challenge (Parliamentary and Health Service Ombudsman, 2023).

There also remains a question of why no such changes arose from the many inquiries that have occurred and we still needed to introduce patient safety initiatives such as Martha's Rule to save patients. There is a second question that needs to be addressed, in an already overstretched healthcare system how you truly embed a safety initiative. Martha's Rule rests predominantly on the Critical Care Outreach services, which have differing models and were not designed to include the additional workload and complexities accompanying this initiative (CC3N, 2020). In consequence, the vast majority of calls are made directly to Critical Care Outreach Teams (CCOT), which consist of specialist nurses and practitioners whose core function is the recognition and rapid response to acute physiological deterioration. It could be considered that the demands from these direct Martha's Rule calls are impacting on service delivery and risk taking them further away from their core purpose.

This is supported by the national data which reveals that across England, 13,481 Martha's Rule calls were received between September 2025 and March 2026, with monthly volumes reaching 1,129 in January 2026. Calls are continuing to rise and have more than quadrupled in the last 18 months (NHS England, 2026a). However, what the national figures do not capture is the proportion of activities arising from calls that fall outside of the CCOT clinical remit, and what the financial and workload implications are for the teams. This is reinforced by regional data from the Midlands, which points out that across the programme to date, approximately two thirds of all Martha's Rule calls do not relate to patient acute deterioration. The dominant driver of calls is related to communication including concerns about general care, uncertainty about treatment plans, and concerns about discharge. This reflects the unmet patient and family need that the ward environment, organisation and healthcare system have failed to address. The Midlands recorded 476 calls in a single quarter (Q4 2025), of which 310 were not reviewed by a clinical team, suggesting the call was likely to be unrelated to acute deterioration. Those calls are not a failing of the Martha's Rule programme, conversely, they signal the extent of demands is such that the healthcare

systems are unable to keep up with them. Also, that today, patients and families readily reach for the only pathway they know will be heard.

A snapshot of what this means in practice, is that in the Midlands, across 41 of the documented calls from five sites in a single month, total CCOT time amounted to 41.6 hours. Only 47 % of that time was spent on calls related to actual acute deterioration. Non-reviewed calls, those triaged by CCOT and signposted to a more appropriate service, took a median time of 20 minutes to manage. Reviews that established that following assessment, no deterioration took a median time of 51 minutes. Scaling up these median times against the average monthly Midlands call trends, leads to an estimated to be over 59 hours of CCOT time per month. This increase in activity and demand on time has been met by existing CCOTs without additional funding or resources.

This trajectory is being further compounded by the scaling up of the programme into other areas such as maternity, neonates and emergency departments. An example arising from a similar approach (using Ryan's Rule) in Queensland is worrying; because over eleven years, annual call volumes almost quadrupled, and data shows no sign of the trend plateauing (Kapur, 2025; Flynn et al., 2022). Queensland has also found that the most consistent lesson from a decade of implementation is the need for enhanced communication between ward teams and patients at the earliest stages (Flynn et al., 2022).

Overall, the question we are asking is not whether Martha's Rule should exist, it absolutely should, rather, the question is whether it is sustainable in its current delivery model. Having specialist deterioration teams absorb an open-ended volume of calls relating to communication and general care, without additional investment, standardised triage methods and mandated ward-level communication is not sustainable. Adoption of the Prevention, Identification, Escalation and Response (PIER) Framework could reduce non-deterioration demand at source (NHS England, 2026b); however, this is too not a model that will sustain. Decision fatigue is always a risk in high-volume, high-stake clinical roles, particularly when they are emotive in nature (Grignoli et al., 2025). The cumulative pressure of non-deterioration calls on teams with a different core purpose in a workforce already stretched, variably

resources, and without a national establishment standard, has to be a cause for concern.

An advantage of Marthas' Rule is that is that patients, families and healthcare professionals can raise their concerns during the context of care, instead of reflecting on what went wrong after the event. Therefore, it is important for healthcare professionals to know that Martha's Rule works two ways, they could either be on the receiving end of a Martha's Rule concern, but also, they could be the one raising it. Recognising this requires a mind shift, it is no longer just the healthcare professional providing care, but there is a reciprocal right for patients and families to challenge care. Also, with many hospitals overstretched Martha's Rule can provide another safety net that approaches deterioration from an alternative perspective. However, for this to be effective there remains a need for an organisational change. For example, Martha's Rule needs to be clear and not be confused with other safety policies such as duty of candour, Jess's Rule, or complaint procedures. The governance around this initiative is challenging because of the differences in responsibilities between bodies such as the Care Quality Commission and hospital governance teams and finally how is data gathered and reported locally.

Then there is the practical aspect to consider, for example, professional hierarchies, resistance from staff who may feel the independent expert review may undermine their clinical judgements. However, there is a concern that not all patient groups will benefit equally from Martha's Rule, for example those with differing health literacy, language barriers, or less confidence in challenging medical authority might be less likely to use it effectively (Power at al., 2025). For current and future healthcare professionals', systems and cultures need to change such that strategies are developed that embed Martha's Rule into practice so that it becomes accepted practice. While mandatory training such as e-learning is crucial for information delivering and sharing, other educational strategies such as simulation need to be developed and making ways to escalate care real and practical, such as the West Midlands Paediatric Network Advanced Communication Training.

In conclusion, embedding Martha's Rule requires a multi-disciplinary team-based education and escalation approach as part of a wider system response to managing deterioration. Also, it is more than just process, it is about having healthcare

professionals with the knowledge and skills to make clinical decisions and recognise their multi factorial role within Martha's Rule working in a healthcare environment where the culture is one that views timely escalation and response as essential to prevention of deterioration and associated harm. Perhaps Martha's Rule should be judged not by how often it is used, but by how rarely it becomes necessary.

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