Call for Concern Implementation

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All Health Boards in Wales have to adopt a patient and family-initiated escalation approach which will enable the patient or their family to call for immediate help and advice if they are worried about instances of deteriorating health. Once matured and fully implemented, the system should work across 24-hour period 7 days a week and be accessible to in-patients and their families and carers on all acute sites. This should include neonates, children, adults, pregnant women and birthing people. This will be known as Call for Concern and is based on Martha's Law but recognises that this work has come from many families and individuals campaign to put patient's voices at the centre of their care.

3 Principles of Martha's Rule

1. Daily Structured Check-In from Patients / Families
   Patients will be asked *at least daily* about how they are feeling, and whether they believe they are getting better or worse. This must be recorded in a structured way and acted upon. NHS England Digital+2NHS England+2
2. 24/7 Rapid Review Access for Staff
   All staff must have round-the-clock (24/7) ability to request a rapid review from a separate care team (specifically the Critical Care Outreach Team or equivalent) if they are concerned that a patient is deteriorating and not being responded to. NHS England+2NHS England+2
3. 24/7 Rapid Review Access for Patients, Families, Carers & Advocates (Escalation Route)
   Patients, their families, carers and advocates must also have access to the *same* rapid review process, available any time, and hospital must advertise/promote the route (posters, leaflets, bedside info etc.). NHS England+2NHS England+2

SBUHB Plan for Call for Concern

Time line for implementation

1. Patient Wellness Score- By end of Sept 2025.
2. Changing Culture of Escalation- Stakeholder engagement September and November 2025. Engagement December 2025 to May 2026
3. National Tiered response- Consultation with Service Groups April 2026 for implementation June 2026. National work of Acute Physical Deterioration Implementation Network may impact on this aspect of the time line.

Call for Concern SBUHB plan in detail

1. **Patient Wellness Score**

Martha Mills' inquest, one of the recommendations from her parents and safety experts was that patients should be asked daily, "How are you feeling today?" and "Are you more worried than yesterday?"

Maternal Early Warning Score, Paediatric Early Warning Score and Newborn Early Warning Track and Trigger 2 all have a patient or carer concern section. SBUHB included a Patient wellness score- On every set of vital signs recorded we ask the question – do you feel better, worse, or the same as when you last had your vital signs recorded? B, W or S is recorded on the chart. There is a strong evidence base that this is a sensitive (but not specific) indicator of deterioration. SBUHB is the first HB in Wales to use this and we are monitoring its use carefully. It should be reported along with NEWS at any escalation of the patient.

2. **Changing the Culture of Escalation**

Through many investigations, incident reviews and inquiries there is a common theme where staff, patients and families did not feel heard when they have expressed concern. It is our intention to change this culture.

- Thank you for telling me this- Toyota is renowned for having one of the best safety cultures in car manufacturing industry. Staff are trained to say thank you when any concern or problem is brought to them. There is strong evidence that staff are reluctant to escalate concerns because of bad experiences escalating patients.
- Civility Saves lives- this concept is well understood that rudeness and disrespect impacts on the outcomes for the patient. As above putting people off escalating concerns and but also reducing the effectiveness of further communication.
- Fresh Eyes – a concept from maternity care. When a midwife is asked to see a patient with "fresh eyes," they review the patient with minimal handover, reducing the risk of confirmation bias. The midwife currently caring for the patient may be influenced or constrained by their existing mental model of the patient's condition, so a fresh perspective helps ensure a more objective assessment.
- Safety Huddles – A useful tool in understanding and communication the deteriorating patient. Although Safety Huddles exist across all areas in SBUHB they vary and can be a burdensome, it is hoped this work will help standardise and condense huddles and increase the focus on safety.
- 4 questions all patients should know the answer to- Whats wrong with me? What do I need done before I go home? How can I help my recovery/ discharge? How long should I expect to be in hospital if all goes well?

3. **National Tiered Response**

This is the final part of the Call for Concern plan in SBUHB. In many areas this is what is considered Call for Concern. Those areas that have the phone line that allows 'a jump call' usual to the outreach team receive very few calls around 5 calls every 2 months and only 1 of those is related to acute physical deterioration. Each hospital site will be consulted on how it will provide this service but it will be supported with some national work providing communication strategy. It will be tiered encouraging local resolution with nurse looking after the patient and then the nurse in charge before contacting call line.

References

The evidence on Martha's Rule (England)

- Rolled out in 143 pilot acute NHS sites starting May 2024; expanding further. NHS England
- Between Sept 2024–July 2025: ~5,583 "Martha's Rule" calls. 41% related to acute deterioration. NHS England
- Outcomes included: **~99** urgent transfers to ICU/HDU; **~55** transfers to other enhanced care; many other changes of treatment. NHS England
- **Condition HELP (USA) – UPMC Children's Hospital (2005)**
    - One of the first family-activated rapid response programmes.
    - Parents/patients could dial "Condition H" (for Help).
    - Evaluations showed *most calls were appropriate*; ~40% resulted in changes to management, ~10% in transfer to higher care.
    - Families valued reassurance, staff initially worried about misuse but call volumes were manageable. **Dean BS et al., *Jt Comm J Qual Patient Saf*, 2008**.

Further reading

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

https://jme.bmj.com/content/early/2024/01/05/jme-2023-109650

https://bjgp.org/content/73/736/504