Martha's Rule (MR) in the Emergency Department; Learning to Date August 2025

Background/Summary

This national programme of work has been commissioned by NHS England, being delivered until April 2026 by the Improvement Academy (IA) in partnership with Health Innovation Yorkshire &Humber.

The aim is to explore how Martha's Rule (MR) can be implemented in Emergency Departments (ED); a learning year to result in recommendations for implementation and spread.

7 volunteer pilot sites will be supported selected from over 20 Trusts that expressed an interest to participate.

Through this selection process 24 conversations took place between the IA and Trust leads from small Rural to Large TH's. Covering 15 Type 1, 3 with UTCs, 2 with MIUs, 1 Paeds ED, 1 Major Trauma Centre.

Aim of the conversations was to explore different escalation models, potential inequalities, MR work to date in ED's, ideas for change and perceived barriers.

This report is a summary of the learning gained.

Insights

- High levels of interest and enthusiasm for the work, seen as the 'Right thing to do'.
- Work usually led by MR leads (often senior nurses) at Trusts although most had engaged with their ED teams
- Escalation pathways for ED varied; around 50% had CCOR (or equivalent, 2 Matron Triage, 1 Clinical manager triage, 2 Acute Response team
- Where CCOR did not previously attend ED, different escalation models were being explored.
- Trusts already testing in ED: 1 Component 1, 6 testing components 2&3
- Components 2 and 3 were seen as less of a challenge, Trusts who had Call for Concern (or similar) in place (prior to MR) were in a stronger position to spread to ED (where not already in place).
- Where Trusts had spread components 2&3 to ED there had been little uptake (small numbers only).
- Different challenges being faced by Trusts who have EPR's vs Trusts who are still paper based. Paper based systems quicker to change but electronic prompts e.g. for PWQ seen as helpful.
- Consideration needed around patients on non-ED pathways e.g. GP, SDECs and if they are part of MR?

Challenges	• ED Crowding was seen as a major challenge, making it hard to follow designated processes and putting patients at risk. • Above liked to extreme levels of staff activity was expressed by all as a risk to the work. • Finding the best way of communicating the message to **all** patients was of concern, recognition of challenges reaching to all our ED population, risk that could lead to even greater health inequalities. e.g. LD MH, deprivation. • Complex escalation pathways was seen as a possible barrier especially where CCOR weren't the first route. • Challenges around responders being host team (once referred) or ED team where patients waiting beds in their correct clinical area. • Trusts undergoing re-structuring and where there are external concerns leading to increased scrutiny not in a place to take on or spread improvement work. • Possible calls relating to non-deterioration concerns and how they can be handled to ensure correct response and patients asking other services for a response e.g. PALS. • Possible burden to MR from mental heath patients linked to mental not physical health deterioration and how they can be responded to.
Initial Change Ideas	**Component 1:** • Thinking about the possible triggers for a PWQ, e.g. when in the ED journey would be beneficial, e.g. 12 hour review. • Understanding how to ask the question the first time and when (as a baseline). • Sharing different tools and considering how they can be adapted for an ED environment including softer signs. **Component 2&3:** • Work to standardise triage of all calls to help ensure both deterioration & non deterioration calls get the most appropriate response • Working to understand calls that come in via a different route, e.g. PALS and how they link with MR processes. • Understanding how to communicate MR to all ED attendees • Consideration for non ED patients in the department e.g. SDEC/UTC/GP and how and if MR applies?

	• Work to map entry to departments, different pathways, processes and key staff involved (including non-clinical and ambulance) and access to MR • Developing robust ED escalation processes especially in Trusts where CCOR don't in reach.