The Rt Hon Steve Barclay MP
Secretary of State for Health and Social Care
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

20 October 2023

Dear Steve,

I am writing to you as agreed to deliver my recommendations for how we can implement Martha's Rule across the NHS in England. I wanted to start by thanking you for the opportunity to do this work and providing us with the space in the Department to conduct the sprint policy sessions. I, and my team, thought the venue provided the perfect collaboration space and set the right tone for all involved about the importance of getting this right.

The sprint sessions themselves were intense but energising. I was struck by the pace at which progress was made. Carrying out policy work like this is important and doing so quickly can generate the momentum needed to make the change required. While I don't think this way of working would be appropriate for all policy development, I think that the way my team approached and carried out the sprint sessions does set a clear template which others can follow to make rapid progress towards a specific goal. There will be value in evaluating the sprint policy development for future use and I would welcome this approach.

I also wanted to pay tribute to Martha's parents Merope and Paul. Throughout the sprint process they provided incredible support and played a vital role in making sure that the recommendations we've developed feel like the right ones to support patients, their families and carers in the future. Their presence at the sprints helped to ground the process in reality and ensured a clear focus on how we help patients.

The process which we undertook was rapid but comprehensive. We held four sprint policy sessions of three hours in length which looked at four separate themes:

- Defining the problem to be solved;
- Learning from the feedback regarding NHS England pilots;
- Understanding what already exists and how Martha's Rule fits within the landscape; and
- Developing the solutions for successful implementation.

These sprint sessions were attended by 39 people across four days, some attending more than one session. Beyond this I have held more than 20 meetings outside of the sprints to hear from patients, parents, patient representatives, regulators, clinicians, professional bodies and trade unions. I've visited Royal Berkshire NHS FT to learn from frontline teams about Call4Concern and spoken to those with expertise across the UK but also in the USA and with representatives from Queensland Health in Australia to hear about their experiences of developing and implementing Ryan's' Rule there. There is overwhelming support from a wide variety of people to include the views of patients and families as key members of the team. The information which was generated within and beyond the sprints will be critical to the successful implementation which must now follow.

The key points of my recommendations are these:

- We must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least on a daily basis. In the first instance this will cover all in-patients in acute and specialist Trusts.

- All staff in those Trusts must have 24/7 access to a rapid review from a critical care outreach team who they can contact should they have concerns about a patient.

- All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition. This is Martha's Rule.

I consider these recommendations to be a cultural intervention themselves in a health system which is under pressure with vacancies and following the incredible efforts of staff through the Covid-19 Pandemic. In order for them to be successfully implemented we will need to consider what enabling factors will support this. A clear message was heard about inclusion and how health inequalities need to be reversed through these steps, taking particular care that communication to groups that lack agency is required. We have heard that the structures in paediatrics are different to adult care and special consideration will need to be made for escalation of concerns about paediatric in-patients for staff and families.

We will need to consider aspects around how we flatten hierarchies, empower patients and staff, incentivise the right leadership behaviours across Trusts, create an environment of psychological safety for staff to raise concerns, drive civility in the workplace and support the entire healthcare system to work together towards successful implementation. It can't be done by just one part of the system, it must be done collaboratively and collegiately across the system. Parts of the healthcare system outside acute and specialist trusts will be able to learn from the implementation of these recommendations how this could support patient voice and detection of deterioration in other settings.

I am immensely proud of the work which all involved in this project have done in particular how different parts of the health system have worked together and suggested ways that they can support the implementation of these recommendations. I believe implementing the recommendations above will improve patient safety across the system and empower all patients, their families, carers and advocates to be equal partners in their healthcare.

With best wishes,

Yours sincerely

Dr Henrietta Hughes OBE FRCGP SFFMLM
Patient Safety Commissioner