Evaluation of the modern matron role in a sample of NHS trusts

Final Report to the Department of Health

October 2004

by

The Royal College of Nursing Institute

and

The University of Sheffield School of Nursing and Midwifery

Susan Read and Mick Ashman
University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Cherill Scott and Jan Savage
RCN Institute
Royal College of Nursing
20 Cavendish Square
London W1G 0RN

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Evaluation of the modern matron role in a sample of NHS trusts

Section 1: Introduction

The Department of Health Policy Research Programme commissioned research to investigate: how NHS trusts were establishing 'modern matron' posts; the experiences of nurses in these posts; and the impact of their activities on patient care. The research team was also asked to identify messages and lessons for trusts about the processes and inputs that enabled matrons to work effectively.

Section 2: The policy context

Health Service Circular 2001/010 (*Implementing the NHS Plan - Modern matrons)* contained guidance for NHS organisations and identified the following three main strands of the matron role:

- Providing leadership to professional and direct care staff within their group of wards in order to "secure and assure the highest standards of clinical care.
- Ensuring the availability of appropriate administrative and support services within their group of wards.
- Providing a "visible, accessible and authoritative presence in ward settings to whom patients and their families can turn for assistance, advice and support".

Subsequent guidance from the DH in 2003 spelt out the '10 key responsibilities' of modern matrons and recommended that the role should be developed in other types of clinical area, such as Accident & Emergency departments.

Section 3: The research process

Project timescale: February 1 2003 – Jan 31 2004.
Research ethics and governance: Ethical approval was obtained from a Multi Centre Research Ethics Committee in February 2003 and research governance permission received from the 10 case study trusts during the spring and summer of 2003.
Phase 1 of project: questionnaires were sent to Directors of Nursing in all the NHS trusts, including Primary Care Trusts (PCTs) in England listed in the Directory of NHS Management (Binley's 2003). A total of 545 questionnaires were sent out, followed up with one reminder to non-respondents.
Phase 2 of project: this consisted of 10 case studies designed to investigate all aspects of the modern matron role in a sample of NHS trusts and, as far as possible, to evaluate its impact.

The case study sites included six acute trusts, two mental health and learning disabilities trusts and two primary care trusts. They were selected from different parts of England, and represented different organisational structures and different types of locality (urban, inner city, or other).

Section 4: Findings from Directors of Nursing National Survey (Phase 1 of project)

The response rate from the national survey was 76% (n=414). The key findings were as follows:

- 73% of responding trusts (including PCTs) had appointed at least one modern matron by June 2003.
- Within these trusts a total of 2419 posts had been created; assuming a similar level of appointment in non-responding trusts, we concluded that the national figure would be in the region of 3200 posts.
- The largest number of matron posts within any single organisation was 52 but the majority (75%) of trusts had made between 1 and 10 appointments.
- There was significant variation in the salaries paid to matrons; whilst the majority (89%) received between £25000 and £35000, a few received less than £25000 and almost 11% received more than £35000.
- Out of 2115 WTE matrons, 987 (47%) were on H grade, and 933 (44%) on I grade, but 3 (0.1%) were on F grade and 192 (9%) on G grade. Twenty of the responding trusts stated that their matrons were on the Senior Manager Pay Scale.
- Many trusts had diverted some resources to support the introduction of matron posts but only 19% of trust had made new money available.
- The title of 'matron', or 'modern matron' was not widely used: only 50% of trusts nationally used a title that contained the word 'matron' anywhere within it.

Section 5: Phase 2 (case studies)

Background information about each of the ten selected trusts is set out in anonymised 'thumbnail sketches'. Questionnaires were sent to all matrons in the ten trusts, (n=176) asking for details of their qualifications, previous career, clinical specialty and areas of responsibility and experience of working in the post. Receipt of the questionnaires was followed by selection of three matrons in each of eight trusts for more detailed study, to give a variety of clinical specialties and settings (time did not allow for full case studies in two trusts). A total of 131 semi structured interviews were conducted with these matrons and with their key contacts in the eight trusts. This allowed exploration of the matron role in greater depth and

from a number of perspectives (including those of more junior staff). A short questionnaire was developed and distributed to patients in different clinical areas, to test how 'visible' and 'accessible' matrons were from their point of view.

Section 6: Survey of matrons in case study trusts

All matrons (N=176) in the 10 case study trusts were sent questionnaires; 121 responded, a response rate of 69%. The replies, which reflected the situation in between June and December 2003, included the following items of information:

- 10% of respondents were under 29; 31% were within the 30 to 39 age range; 31% were within the 40 to 49 range; and 14% were over 50.
- Only 23 (19%) of respondents actually used the title 'matron' or 'modern matron'.
- Most appointments (88%) were substantive posts, with 10% working in an acting capacity.
- The grade profile within the 10 trusts correlated strongly with the national profile with 85% of matrons at H or I grade and 12% working outside the clinical grading structure (for example, local trust grades or senior manager pay).
- On appointment 45% of matrons were given specific targets to achieve, whilst 50% were given the discretion to set their own targets.
- 54% of matrons dealt with inpatient only services,
- 29% were responsible for combined inpatient / outpatient services
- 2% were responsible for outpatient only services.
- 9% covered inpatient, outpatient and community services.
- 77% of matrons covered one geographical site whilst 23% covered more than one.
- Despite the DH's pronouncements about matrons' key responsibilities, only 9% reported spending significant time addressing concerns about catering or cleaning. The most frequently reported activities in the previous two weeks included: attendance at meetings at trust or directorate level (reported by 77% of respondents); provision of staff support and liaison for wards (reported by 49%); and delivery of direct patient care (reported by 44% respondents).

Section 7: Themes from case study findings

Nine major themes were identified:

- Different approaches to implementation
- Selection and recruitment
- Preparation for the role

- Remit of the role
- Different understandings of the role
- Working relationships with other staff
- Matrons' experience of the role in relation to their '10 key responsibilities'
- Power and authority
- Impact of the role

Section 8: Models of implementation

Three models of implementing the matron role were identified:

- The essentially clinical model: this has some similarities to the 'senior sister' role. Involvement in clinical activity may vary from undertaking rostered duties to doing occasional 'hands on' shifts.
- The essentially managerial mode: this has some similarities to the 'nursing officer' role and is more remote from the clinical area.
- The 'mixed mode' model.

There was no evidence to suggest that any one of these models was the most effective, as there were advantages and disadvantages to all three. Trusts might find it helpful to have these models in mind when planning and establishing matron posts.

Section 9: Summary, conclusions and messages

The study's findings highlight the enormous variability in the ways in which the modern matron role is being implemented. Whilst there were difficulties with evaluating the impact of modern matrons, due to the shortage of verifiable information, there was plenty of anecdotal evidence to suggest that individual matrons were having a positive impact on improving standards of nursing care; improving the patient environment; improving skill mix and staff retention; improving staff morale; encouraging staff development; and substantially reducing the number of formal complaints from patients and their families. Other notable achievements (for example, changing the contract for ward cleaning in order to improve cleanliness) had been achieved by matrons acting collectively.

Matrons and their colleagues indicated that there were some potentially difficult issues that could affect the success of a matron role:

- Role conflict and tensions
- Lack of clarity and shared understandings about the role
- Fragile sense of authority

- Blurred interface with other organisational roles
- Competing priorities
- Role overload
- Inequitable grading & responsibilities

The research findings suggest that these and other difficulties can be avoided by careful planning for matron posts and by providing appropriate good organisational support to matrons once they have been appointed.

Messages for trusts: three key areas of matrons' responsibilities

The research team consider that the following processes and inputs are necessary to help modern matrons exert maximum influence over the three key areas of cleanliness, standards of basic care and improving patients' experience:

Cleanliness and the patient environment

- Matrons should be involved in developing and monitoring cleaning specifications.
- Matrons should take into account the views of staff about specific requirements in different clinical areas when setting service specifications for cleaning.
- Whether cleaning services are provided in house, or by external contractors, there should be clear and agreed channels of communication to enable matrons to report concerns about standards in their clinical areas to the responsible service managers.
- Trusts need to define which members of clinical staff can take action on these concerns in the absence of the matron.
- Consideration needs to be given to the suitability of the buildings and furnishings to enable effective cleaning to take place.
- Adequate financial resources need to be made available to provide good cleaning services.
- Trusts should ensure that staff responsible for cleaning should have appropriate training especially related to principles of infection control.
- Staff responsible for cleaning should be seen as and function as essential members of the clinical team and have a designated ward area.
- Trusts should provide regular opportunities for matrons to meet with estates and facilities.
- Trusts should clarify responsibilities for ward environment budgets so that matrons and ward sisters can maximise their benefit.

- Trusts should find resources to employ ward housekeepers where they have not already done so.

Standards of basic care

- Matrons should be allowed to focus on their 10 key responsibilities
- Matrons should work closely with ward staff to implement systematic approaches to quality improvement such as "Essence of Care".
- Trusts should take account of messages from staff transmitted through matrons about staff numbers, skill mix and staff capabilities.
- Trusts should provide resources for staff training, education and development in order to support matrons in improving patient care.
- Matrons should have regular access to their Director of Nursing to ensure that their professional concerns about standards of basic care are noted at the highest level.

Improving patients' experience

- Matrons need to be clearly identifiable to patients through the use of appropriate badges and ward and departmental notice boards.
- Trusts should provide written information for patients on the role and responsibilities of matrons and how to contact them. Any literature should be translated into appropriate languages.
- Trusts should establish clear guidance about the respective roles of matrons and the PALS officers in addressing patient and carer concerns and complaints.

General messages to trusts

Taking a strategic approach to establishing modern matron roles

- Trusts should have a clear understanding of the matron role and an expectation of how it can fit into the nursing strategy within their organisation.
- Trusts providing mental health and learning disabilities services may wish to take into account forthcoming guidance (summer 2004) from the modern matron group at the National Institute for Mental Health.
- Where possible trusts should be prepared to allocate funding for new matron posts rather than overstretching the existing clinical leadership capacity.
- Whilst there may be advantages to allowing clinical directorates discretion in establishing matron posts to meet their own requirements, there is a danger that too much devolution and diversity might raise serious questions about equity of workload.

- Matrons should be given a realistic remit to guard against role overload and unrealistic time frames and help them address their 10 key responsibilities.
- Cross-boundary posts require careful planning, to allow for the complexity of building professional networks across different agencies, as well as for the day-to-day practicalities of maintaining high visibility and accessibility between different sites.
- Job descriptions should be based on the needs of a clinical area and should be guided by the principles set by the Department of Health.
- The clinical / managerial balance can be problematic and trusts need to give careful consideration to those responsibilities given to matrons and those given to general managers.
- Trusts should evaluate the impact of matron posts; evaluation should not be narrowly focussed on achievement of targets, but should also consider the effectiveness of the leadership component of the role taking into account the views of junior staff and patients.

Selection

- Selection of matrons must take into account the importance of good interpersonal skills and good communication skills.
- Techniques employed for selection should focus on the transformational leadership potential of candidates.
- Matrons should be clinically credible; what this means depends on the clinical specialism and this may or may not involve in depth specific technical knowledge.

Preparation for role and CPD

- Trusts should recognise the need for adequate preparation at an appropriate time (i.e. early on).
- All new matrons should be given an induction course on which they meet key staff and familiarise themselves with trust systems and policies. This is especially important for matrons who are new to a trust.

Providing appropriate support

- Matrons should have the opportunity participate in regular reviews of progress with their line managers and to obtain constructive feedback on their performance.
- Matrons need proper clerical and administrative support.
- Trusts should not introduce matron roles in isolation but ensure networking, mentoring / clinical supervision and peer support opportunities are available.

- Ideally, matrons should not have to share offices, particularly when they are likely to be involved in private discussions with patients, carers, or staff.
- Matrons should be provided with IT support including personal computer and printer.

Developing future clinical leaders

- It is important for trusts to be seen to develop and support matron posts in such a way as to make them attractive to future recruits.
- Matrons and their managers should be encouraged to think about succession planning and ways in which staff may be helped to prepare themselves for the role in future.

Suggested areas for future research

- How best to obtain patients' views about their care, and patients' perceptions of matrons.
- An investigation of the interface between matrons and ward housekeepers
- A repeat of the national Director of Nursing survey seeking their perceptions once posts had been established and working for three years.
- Further investigation in trusts where the introduction of the matron role evaluated very positively to explore the long-term impact on the organisation.

Acknowledgements

We would like to thank members of the Modern Matron Project Advisory Panel for their insightful comments and ideas. The members of the Panel were:

Geraldine Cunningham, Programme Director, RCN Clinical Leadership Programme
Pam Hibbs, Convenor RCN Fellows and retired Director of Nursing
Jenny Kay, Director of Nursing, Dartford and Gravesham NHS Trust
David Moore, Deputy Chief Nursing Officer, Department of Health
Gill Musson, Lecturer, University of Sheffield Management School
Sally Redfern, Professor, Florence Nightingale School of Nursing and Midwifery, Kings College, University of London
Jackie Taylor, Modern Matron, Harrogate Health Care NHS Trust
Angela Turner, formerly advisor to Nursing Directorate, Trent Regional Health Authority
John Wilkinson, Research Commissioner, Department of Health Policy Research Programme

We are also grateful to members of our administrative support teams:
at the University of Sheffield School of Nursing and Midwifery,

Amanda Cowan, Research Support Co-ordinator, Pauline Gregory, Research Administrative Assistant, Barbara Harrison, Secretary

at the RCN Institute,

Jessica Lichtenstein, Administrative Assistant, and Claire Yates, Research & Development Administrator,

In addition, we thank early informants on the modern matron role, who helped shape our understanding of relevant issues and influenced our research approach. We cannot name them here because some belong to trusts which later participated in the study, but we express our gratitude nevertheless.

Finally, we are greatly indebted to the trusts that allowed us access, the Directors of Nursing involved in our national survey, and in particular to the modern matrons and their key contacts in our case studies. We hope we have done justice to their work.

SECTION 1: INTRODUCTION

1.1 Terms of Reference

This is the report of a research project funded by the Policy Research Programme at the Department of Health. The project was a collaboration between the RCN Institute, London and the School of Nursing & Midwifery, University of Sheffield. A team of four researchers worked on the project between February 1 2003 - February 28 2004. A project timetable is shown at the end of this chapter. The terms of reference were as follows:

- To undertake a survey of Directors of Nursing in all NHS Trusts in England to obtain information including the number and type of matron posts early in 2003.

- To describe the experience of a purposive sample of 'matron' post holders regarding the initiation of their posts, their characteristics and qualifications, their responsibilities, daily work practices and relationship with key contacts.

- To identify different models of working relating to the achievement of objectives of these posts and, where possible, identify the impact on patient care.

- To identify messages and lessons for trusts about processes and inputs that enable matrons to exert maximum possible influence over cleanliness, standards of basic care and the patient's experience.

1.2 Study aims and objectives

The aims and objectives of the study were developed in response to; the requirements of the original research brief; the issues raised by the review of relevant policy and literature (see section 2); exploratory fieldwork in a number of trusts; and further discussions with the Department of Health, which resulted in an agreement to undertake a preliminary survey of all Directors of Nursing in NHS Trusts in order to collect information about the total number matrons in post, their grades, conditions of appointment, and so on.

1.2.1 Aims

1. To use the experiences of matrons to understand the content of the role and the challenges involved in undertaking it.
2. To identify what sorts of educational in-put and clinical experience are most helpful in preparing matrons for the new role.
3. To identify different models adopted by trusts to implement the modern matron policy initiative, and to consider the advantages and disadvantages of these models.
4. To evaluate these different approaches to implementation against (i) the stated policy goals of individual trusts and (ii) the stated policy goals contained in the DH guidance.
5. To suggest how trusts and clinical networks can enable matrons to realise the full potential of the role.
6. To map the range of matron role implementation across the NHS in England by means of a survey of Directors of Nursing in all NHS Trusts.
7. To ask patients and their families about their experience of the impact of the new matron roles on patient care.

1.2.2 Objectives

1. To outline the number and location of matron posts existing in early 2003, with analysis of approaches to implementation.
2. To describe how matrons are exercising their responsibilities for the quality of support services and the patient environment.
3. To describe how matrons are making themselves accessible to patients and to what extent they are able to work with Patient Advice and Liaison services to respond to the concerns of patients and families.
4. To ask other hospital staff, patients, their families and representatives (for example, from patient forums or local Community Health Councils) for their perspective on whether and how matrons are making positive changes to patients' experiences of care.
5. To obtain background information relating to matrons' educational and clinical experience, and any other special preparation seen as helpful for the role.
6. To obtain information from post-holders and their key contacts about the matron's role with respect to the:
    - organisation's expectations (as set out in formal job description)
    - values and priorities of post-holder
    - nature of their relationships with patients and families.

- nature of working relationships with staff in related roles (clinical and non-clinical)
- line management accountabilities
- major day-to-day responsibilities
- scope of decision-making within the above
- available resources
- informal networks

7. To obtain examples of how organisational factors enable or preclude matrons from achieving their objectives.
8. To explore the extent to which trusts are implementing the modern matron guidance as part of a systematic re-structuring of nursing services.
9. To explore the process and outcomes of clinical leadership from the perspectives of matrons and the nursing staff in the wards for which they are responsible.
10. To describe how matrons are helping to sustain high standards of nursing care.
11. To investigate how trusts are assessing the impact of matrons on patient care and – where possible and appropriate – to utilise any available, routinely-collected data for the project.

1.3 Plan of report

The report has ten sections as well as appendices. Section 2 gives the policy context and discusses relevant literature. Section 3 describes the research approach and processes, for the national survey of Directors of Nursing, and the case studies, including the sampling strategy, data collection methods, and data analysis and interpretation. Section 3 also sets out ethical issues, processes of ethical approval and research governance registration.

Section 4 gives findings from the national survey of directors of nursing. Section 5 gives background information for the case study trusts including charts showing quantitative data about the trusts and information on the number of participants. Section 6 shows findings from the matron survey in 10 trusts.

Section 7 provides findings from the case study trusts arranged by themes, which are:

- Modes of implementation
- Selection and recruitment
- Preparation for the role
- Remit of the role
- Understanding of the role

- Working relationships
- Experience of the role
- Power and authority
- Impact of the role

Section 8 is a discussion of the findings, with especial attention given to models of implementation and their advantages and disadvantages. Section 9 is a summary, conclusions and messages emerging from the project. Section 10 contains the references.

The appendices contain information sheets, consent forms, schedules and research instruments.

1.4 Terms and conventions used

We have used the term “matron” or occasionally “modern matron” routinely for all incumbents of the role, despite the fact that most of them have other titles. We have done this partly for simplicity, and partly to try to help maintain anonymity for participants.

The term “ward sister” is used generally to refer to ward managers and charge nurses as well.

We proceed to describe the policy context of the research and to review the literature surrounding the matron role in today’s NHS.

Table 1: Timetable for 'modern matron' project, February 1 2003 – March 16 2004

Phase/ Activity	Feb 2003	March 2003	April 2003	May 2003	June 2003	July 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	March 2004
Preparation & literature review														
LREC and R&D procedures all trusts (MREC approved)	**Concurrent applications**				**All applications cleared**									
National survey			**Mailing to all Directors of Nursing**	**Mailing to non responders**	**Analysed**									
Data collection, all trusts				**First surveys of matrons by trust**		**First inter-views**								
Concurrent data analysis														
Advisory group						**July 31**				**Nov 24**			**Sent early draft for comment**	
Writing Report														

SECTION 2: POLICY CONTEXT AND RELEVANT LITERATURE

2.1 The NHS Plan, 2000

The *NHS Plan* (Secretary of State, 2000) set out the government's strategy for modernising all aspects of the National Health Service, improving the quality of care, and making the service more responsive to the needs of patients and their families. The public consultation that preceded the *NHS Plan* had found that patients and their relatives were often concerned that responsibility for aspects of patient care was diffused, and that nurses had insufficient authority to remedy shortcomings across services which were fundamental to patient care. There was a perceived need for a strong clinical leader with clear authority at ward and unit level. In response to this finding, the *NHS Plan* proposed that every hospital should appoint 'modern matrons' - senior sisters and charge nurses who would be easily identifiable to patients and accountable for a group of wards.

The *NHS Plan* outlined several other initiatives which, taken in conjunction with 'modern matrons', were designed to help frontline staff to improve the quality of the patient experience and to boost public confidence in NHS capacity to listen and respond quickly to the concerns of patients. These initiatives included the NHS Clean Hospitals Programme; the plan to introduce ward housekeepers to provide direct support at ward level (by December 2004); the establishment of Patient Forums and Patient Advocacy & Liaison Services (PALS); setting new standards for hospital food and patient nutrition; a new campaign to prevent and control hospital-acquired infection; and the provision of a £5,000 budget for individual ward managers to spend on improvements to the ward environment.

2.2 Strengthening the nursing contribution to patient care

The ward budget initiative was in line with the strategic goal of enabling nurses to expand the scope and range of their clinical and leadership activities in the NHS. This strategy had recently been set out in *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (DH 1999). The *NHS Plan* built on this, and indicated that employers would be required to empower appropriately qualified nurses to undertake the Chief Nursing Officer's '10 key roles for nursing'; these included the right to make and receive referrals; admit and discharge patients; order investigations and diagnostic tests; and run clinics and prescribe drugs. The Nursing Division at the Department of Health issued guidance to the profession on a systematic approach to quality improvement: *Essence of Care: patient-focused benchmarking for health care practitioners.* This is a toolkit

covering eight ‘fundamental aspects of care’, namely: principles of self care; food and nutrition; personal and oral hygiene; continence and bladder and bowel care; pressure ulcers; record keeping; safety of clients with mental health needs in acute mental health and general hospital settings; and privacy and dignity.

The development of clinical leadership in all professions was a central part of the NHS modernisation agenda, with its focus on the needs of patients and the delivery of patient-centred care. The NHS Leadership Centre was established in 2001 as an integral part of the NHS Modernisation Agency, to promote leadership development across the health service; its aims were to set the standards for outstanding leadership qualities in the NHS and to describe the key characteristics, attitudes and behaviours to which leaders should aspire. Employers were encouraged to send ward sisters and charge nurses on leadership courses, the two most popular of which were the 3-day Leading Empowered Organisations (LEO) programme and the RCN Clinical Leadership course (Cunningham & Kitson 2000a and 2000b). The RCN course was based on the theory of ‘transformational leadership’ which we explore in more depth in our literature review.

2.3 HSC 2001/010: principles, not prescription

Health Service Circular 2001/010 (*Implementing the NHS Plan - Modern Matrons)* contained guidance to NHS organisations on the twin priorities of (i) taking action ‘to ensure that all ward sisters and charge nurses have the authority and support they need to get the basics of care right’, and (ii) establishing matron posts (senior sisters or charge nurses), each accountable for group of wards and backed up by appropriate administrative support.

This section summarises the main points of the circular, which was very important in shaping the research project reported here. It identified three main strands of the matron role:

- Providing leadership to professional and direct care staff within the group of wards for which they re accountable in order to “secure and assure the highest standards of clinical care”
- Ensuring the availability of appropriate administrative and support services within the wards for which they are accountable.
- Providing a “visible, accessible and authoritative presence in ward settings to whom patients and their families can turn for assistance, advice and support”.

All trusts with in-patient beds were required to develop plans to establish matron posts by April 2002. When the guidance was officially launched by the Secretary of State for Health, he promised that there would be 500 matrons in the NHS by April 2002.

Whilst it deliberately avoided making prescriptions about structures, job descriptions or competencies, the circular was clear about the importance of agreeing the line management accountabilities that would secure the level of organisational authority needed by new matrons. It recommended that trusts take the opportunity to undertake a review of their entire nursing structures before appointing matrons. In smaller organisations, it might be appropriate for matrons to be directly accountable to the Chief Nurse, so re-establishing a continuous line of accountability for professional and care standards. In larger organisations, intra-Directorate accountability might be more appropriate. In either case, it was important that Trust Boards should monitor arrangements for ensuring that the fundamentals of care were right.

Matron posts were not to be seen as posing a threat to middle and non-clinical managers, and must not undermine the authority or responsibilities of ward sisters and charge nurses. It was essential that matrons had 'high visibility, so that patients knew whom to approach; to this end, trusts might want to consider providing special uniforms for matrons.

Trusts were advised to make some matron appointments at clinical grade 'H', but most at grade 'I'. They were also invited to interpret the guidance "flexibly", to ensure that implementation took account of the differing needs of, for example, midwifery and mental health services.

2.4 Developing the '10 key responsibilities' of matrons.

Since the publication of HSC 2001/010 – and since the start of our research project - the Department has issued further guidance to trusts on how to strengthen clinical leadership at ward level and to improve the patient experience of care. Early research by the Department into the activities of matrons (summarised below) found an unexpectedly rapid increase in their numbers, as well as examples of their success in a variety of different spheres.

In April 2002, the Department of Health published *Modern matrons in the NHS: a progress report* (DH 2002a). This report stated that, after one year, there were already 1,900 nurses in matron posts – nearly four times as many as originally envisaged. It reported some examples of good practice, and identified 'ten significant activities' that matrons were involved in: for

example, monitoring cleanliness; preventing hospital acquired infection; empowering nurses; resolving problems for patients and their relatives. It announced that, in future, matrons would be expected to provide annual reports about local progress in implementing the *Chief Nursing Officer's '10 key roles for nurses'* (DH 2002c). The report described how some matrons were already successfully using the *Essence of Care* toolkit to raise standards of nursing, and stated that two new patient-focused standards - on communication - would be added to the toolkit. All Accident & Emergency departments would be required to appoint an identifiable matron, to be responsible for the patient experience.

The Chief Nursing Officer followed up this report with further guidance on devolving more responsibility to ward sisters and charge nurses (*Ward Staffing Budgets*, PL/CNO/2002/3, DH 2002b). Trusts were asked to ensure that sisters and charge nurses were properly prepared to assume responsibility for staffing budgets; were given the authority to influence decisions about the staffing profile on their ward; and were given access to specialist expertise and support where full staffing reviews were required. Where individual wards were too small to provide scope for meaningful change for staffing establishments, it might be more appropriate to conduct reviews across a unit or within a group of wards covered by a matron.

Housekeeping: a first guide to new, modern and dependable ward housekeeping services in the NHS (NHS Estates 2002) included suggestions as to different models of working relationships between facilities management, matrons, ward sisters, housekeepers and domestic and catering staff.

Most recently, in a foreword to *Modern Matrons – Improving the Patient Experience* (DH, April 2003), the CNO announced plans to extend the role of matrons in A&E departments by giving them budgets of £10,000 to help bring about improvements in patients' experience of NHS emergency care. She commented that it was becoming clear that the range of functions that matrons perform, and the ways they could improve the patient experience, was 'even greater than originally foreseen'. The report set out more examples of good practice, and spelt out what were now defined as the '10 key responsibilities' of modern matrons:

- Leading by example
- Making sure patients get quality care
- Ensuring staffing is appropriate to patient needs
- Empowering nurses to take on a wider range of clinical tasks
- Improving hospital cleanliness

- Ensuring patients' nutritional needs are met
- Improving wards for patients
- Making sure patients are treated with respect
- Preventing hospital-acquired infection
- Resolving problems for patients and their relatives by building closer relationships.

To summarise, the creation of the matron role provides trusts with an important opportunity, namely to strengthen nursing leadership in the interests of responding swiftly to the problems of patients and their families; improving the ward environment; developing and improving nursing practice; improving staff morale; and ensuring the quality of fundamental aspects of care. However, the role is complex and (as the guidance documents recognise) the effectiveness of matrons will depend considerably on the extent of their authority, the resources they can command, and the nature of the working relationships they establish with ward nursing staff, other clinical practitioners and service managers across the organisation.

2. 5 Overview of relevant literature

The constraints of time meant that this brief review of the literature focused on in-patient nursing services in the acute hospital sector. It is therefore limited in scope, and does not take account of writings on nursing management and leadership in the mental health and community nursing services.

2.5.1 Changing perceptions of the ward sister role

The education, role and responsibilities of the ward sister have been a major focus of comment, prescription and nursing research over the years (for example: Pembrey 1980; Redfern 1981; Stapleton 1983; Fretwell 1982; Brown 1989). It was generally acknowledged that the ward sister role was complex and demanding, with responsibilities for standards of care, teaching students and junior nurses, dealing with personnel issues of staff and the concerns of patients and their families, liaising with medical staff (and most other hospital departments), overseeing domestic staff , and undertaking administrative duties. Despite evidence that ward sisters were not always receiving the best preparation and support for their role, and were struggling to meet all their responsibilities, Pembrey argued that the authority of the ward sister should be augmented: "because she is the only nurse in the nursing structure who actually and symbolically represents continuity of care to the patient …and who has direct managerial responsibilities for both patients and nurses." (Pembrey 1980: 85). It was to prove difficult to achieve consensus on exactly how to achieve this increase in authority.

One perceived threat to the traditional authority of ward sisters, identified by Pembrey amongst others, was the increase in Nursing Officer (NO) posts in the NHS. These new posts had first been suggested in the Salmon Report on senior nursing structures (Min of Health 1966), an early attempt to modernise and improve the profession's career structure in an increasingly complex health service. Salmon had advised that these new 'middle management' nursing roles should have a strong clinical focus and provide practical support for ward sisters; however, this did not happen in the majority of hospitals, where NOs tended to lose their clinical focus and instead become another level in increasingly bureaucratic nursing management structures.

As an alternative to NOs, and in response to the demand for an improved clinical career ladder in nursing, the Royal College of Nursing suggested that there should be two tiers of ward sister posts: 'sister 2 ' and 'sister 1' posts (RCN 1981). A 'sister 1' would be the leader of the nursing team, appointed on the basis of suitable post-basic qualifications and managerial experience; in some cases, she might extend her control over a group of wards. This two-tier model of ward sister posts was widely adopted, with local variations; for example, Binnie (1987) described how her hospital in Oxford replaced Nursing Officers with full-time 'senior ward sisters', who were given authority to manage the change to 'primary nursing' in their areas. The Oxford approach, grounded in a nursing philosophy of individualised patient care and strong clinical leadership at ward level, prefigured some aspects of the 'modern matron' initiative.

A recurring theme in the literature on the ward sister role was the difficulty of balancing clinical, administrative and staff management responsibilities whilst at the same time providing strong leadership to the ward team. Pembrey (1980) and Binnie (1987) challenged traditional approaches by suggesting that the ward sister should become a manager of care, stepping back from 'hands-on' involvement in patient care and delegating responsibility for this to the qualified nursing team, whilst assuming a monitoring and co-ordinating role to ensure high standards were maintained. The difficulty with this model was that, whilst it cleared the way for qualified nurses to concentrate on clinical rather than management activities, it removed the ward sister from the immediate clinical arena, where she had always been regarded as an important role model for nursing staff and students (Brown 1989).

The introduction of clinical grading in 1988 represented another formalisation of nursing roles (Nursing and Midwifery Staffs' Negotiating Council 1988). The exercise was intended to provide a more defined career structure for clinical nurses, yet the precise descriptors that were used to define nursing and midwifery grades and the staff response to them tended to

create a culture of “rigid thinking” with respect to the roles and responsibilities. Furthermore, whilst the grading definitions for G and H grades had clinical emphasis, in reality the post-holders in the ward setting found themselves preoccupied with administrative and managerial duties.

During the 1990s, the introduction of commercial-style competition between NHS hospitals intensified efforts to introduce more rigorous managerial approaches at all levels in the NHS. The Audit Commission issued guidance on how new management skills and information technologies could be applied to nursing services, particularly at ward level. In line with current management philosophies of decentralised decision-making, the Commission recommended that ward sisters should be given more authority over staffing and budgetary decisions (Audit Commission 1991&1992). The professional literature reflected the growing confidence of some ward sisters in relation to the new opportunities of the role (Sills 1992). Glasper (1993) emphasised the clinical leadership potential of the role, where ward sisters could empower nurses to change systems of care in the interests of individualised patient care. Willmott (1998) explored the experiences of G grade charge nurses whose role was developed into that of facilitator and co-ordinator of care (‘ward manager’), empowering primary nurses to manage their own case loads, rather than being involved in direct patient care.

Despite these positive examples of how ward sisters and charge nurses could be given more power to achieve change, there was growing evidence of continuing difficulties with the role. Nursing workloads became more intensive, whilst the nursing workforce became less stable. The Audit Commission found that many NHS trusts had failed to devolve decision-making and budgetary control to ward leaders (Audit Commission 2001). Isobel Allen (2001) described the growing complexity of the ward sister/charge nurse role and identified multiple sources of stress, including:

- feelings of loss of control over their role and responsibilities
- multiple responsibilities and demands on their time
- unclear lines of management and accountability, compounded by loss of traditional professional lines
- poor organisational support, particularly in relation to clerical and administrative assistance
- the pressure of meeting unrealistic management imperatives
- matters of ‘bad housekeeping’ which were beyond the power of ward sisters to remedy

- lack of time to address staffing problems caused by shortages of permanent staff
- poor teamwork with medical and other staff
- lack of time to deal with patients and relatives.

This last finding is particularly significant. Allen found that, whilst medical consultants experienced many of the same frustrations as ward sisters, they gained much job satisfaction from dealing with patients. Ward sisters gained much less satisfaction from contact with patients and relatives, whom they experienced as the source of problems or crises. The modern matron initiative may be understood as an opportunity to address at least some these difficulties.

2.5.2 Clinical leadership

A recent definition of clinical leadership in nursing is: 'nurses directly involved in providing clinical care who continuously improve care and influence others' (Cook 2001). Cook's definition does not equate leadership with position in the nursing hierarchy, but suggests a pro-active approach which can be demonstrated by nurses working at many different levels (see also Kitson 2000).

Cook identifies five key attributes of clinical nurse leadership:

- Creativity: required to generate new ways of working.
- Highlighting*:* the ability to see new possibilities and identify new ways of doing things
- Influencing*:* the ability to help others see and understand situations from various perspectives
- Respecting*:* having regard for the feelings of others, and responding to individual and organisational needs)
- Supporting*:* the ability to support others through change process.

2.5.2.1 Models of transformational leadership

We have already discussed recent policy initiatives aimed at strengthening clinical leadership in the NHS, and the development of courses for ward leaders (see S*ection 2.2).* The inspiration for many of these courses was drawn from the theory of 'transformational leadership' (Burns 1978; Bass 1997). Essentially, this is about engendering higher levels of motivation and commitment among followers, with an emphasis on generating a vision for the organisation or team. According to Bass & Avolio (1994) the transformational leadership approach has four basic components:

- Idealised influence: the leader has charisma and is respected by and admired by the followers.
- Inspirational motivation: the leader's behaviour provides meaning and challenge to the work of the followers.
- Intellectual stimulation: the leader is able to encourage new and novel approaches to the performance of work, and creative problem solving from followers.
- Individualised consideration: the leader listens and gives special consideration to the developmental needs of followers.

Kouzes & Posner (1988; 1995) developed the 'five practices of exemplary leadership' model of transformational leadership (which provided the basis for the RCN's ward leadership programme). Believing that it was important to be able to assess an individual's leadership capacity, they developed the Leadership Practices Inventory (LPI), which provides a 360-degree assessment of leadership behaviour (Posner & Kouzes 1988).

2.5.2.2 Attributes of transformational leaders

Kitson (2000) suggests that transformational leadership requires 'emotional intelligence' as well as cool-headed rationality. Emphasis is placed on personal skills of being able to motivate and inspire others within the organisation to embrace a new vision, or new ways of working. This requires the ability to think analytically; presentational skills which demonstrate a self-confident, empathetic approach; and motivational skills which show consistency between values, goals and their achievement. Alimo-Metcalf & Alban-Metcalfe (2000) employed repertory grid technique to elicit the views of followers on their ideal leader and demonstrated that the attributes they considered to be most important correlated strongly with those of transformational leadership. They argued that leadership development in the NHS should recognise this by actively promoting a type of leadership that meets the needs and expectations of the workforce.

2.5.2.3 Outcomes of effective clinical leadership

The 'transformational' style of leadership is generally contrasted with 'transactional leadership', which tends to be characterised by seeing work in terms of a series of short-term targets and involves achieving change in an authoritarian way, rather than persuading staff and influencing them by example. It is a departure from the hierarchical 'top-down' management styles often associated with nursing, and as such has implications for the capacity of clinical leaders to show sensitivity and skill in dealing with staff, as well as with

patients. There is emerging evidence of the benefits of a transformational style of nurse leadership. Using action research, Manley (1997) demonstrated how one clinical leader's transformational approach to change management in a coronary care unit raised standards of nursing practice, and had a positive impact on patient and organisational outcomes. Similarly, the work of Binnie & Titchen (1998) suggested that the quality of leadership was central to the effectiveness of ward nursing. Cunningham & Kitson (2000a and 2000b) found that participation in leadership programmes led to improvements in ward sisters' self-management, their management of teams and their relationships with the wider organisation. They also found indications of good effects on nurses' and patients' outcomes.

2.5.2.4 Importance of the organisational environment

Research in the USA identified the importance of having an organisational environment in which professional nursing was allowed to flourish, such as in the so-called 'Magnet' hospitals, which reaped the benefits - in terms of staff recruitment and retention, and improved patient outcomes - of giving nurses greater autonomy and control over decision-making (McClure *et al* 1983; Kramer 1990; Scott *et al* 1999). In the UK, Bowles & Bowles (2000) found that Nursing Development Units provided a much more fruitful environment for nurse leadership than did conventional clinical settings. Emerging findings from focus group research done under the aegis of the RCN Clinical Leadership Programme suggests that the organisational factors that are influential in the development of leadership capability are: supervision and support, teamworking, commitment from managers and the organisation to staff development and leadership training, shadowing/mentoring systems and being given the opportunities to lead and practice newly-acquired skills (Single 2004).

2.5.3 Guidance on establishing new nursing roles

During the late 1980s and the 1990s, significant changes took place in the scope of nursing practice; these years saw the emergence of new, specialised nursing roles, sometimes referred to as "advanced" nursing roles (Scott 1998). Many of these roles, such as clinical nurse specialists and nurse practitioners, sat uneasily with conventional nursing management structures**.** The Department of Health Policy Research Programme commissioned a major study, 'Exploring New Roles in Practice' (ENRiP), to map these "innovative" nursing roles (Read *et al,* 1999 and 2001). A guidance document for managers based on the ENRiP study (Levenson and Vaughan 1999) contains practical and strategic recommendations, some of which are concerned with the need for organisations to establish clear lines of responsibility and accountability. It also highlights the need for adequate resources and for appropriate

systems of education and professional development, and points up the importance of undertaking local evaluations of the impact and effectiveness of new roles.

2.5.4 Professional reaction to modern matrons

The reactions of leading nursing organisations to the modern matron initiative were cautious, but generally favourable to its aims. Their concerns focused mainly on the implications for professional management structures and clinical career pathways. The Royal College of Midwives issued a position statement, primarily in response to the trend for some small trusts to replace the post of head of midwifery services (HOMS) with that of modern matron (RCM 2002). The RCM's firm view was that the HOMS was traditionally a senior management post with trust-wide authority for maternity services, whereas matron posts should be treated as middle management appointments at clinical or wards level. The RCM recommended that trusts should keep HOMS posts, but could take the opportunity to extend career opportunities for midwives by creating new or up-graded matron posts at H and I grades. The responsibilities of matrons in maternity services should mirror those in general nursing by ensuring high quality, 'woman-centred' care in all settings, providing professional leadership, taking responsibility for the environment, and defusing complaints.

The Royal College of Nursing had objections to the title of matron, which it considered to be 'gender specific and outmoded in an initiative which purported to be part of a modernisation agenda.' (RCN 2002). The College thought that trusts should review their entire nursing structures before introducing matron posts. It recommended two broad approaches to implementation, taking account of different organisational structures: (i) strengthening and supporting the role of G grade ward sisters so that they had sufficient authority to act and solve problems; and (ii) strengthening the 'senior nurse' role - usually an H grade role, in trusts which had retained this role - so that nurses in these posts could work collaboratively with ward sisters. However, it was important to avoid the danger of creating another layer of hierarchy which a ward leader would have to negotiate before achieving change. Matrons appointed at a more senior level could be part of a 'tripartite' structure of nurse, doctor and manager to provide leadership at directorate level.

Graham & Partlow (2002) conducted an evaluation of personal and professional development amongst directorate senior nurses in one NHS trust. Focusing on the structural and managerial implications of the introduction of matrons, they argued that a two-pronged approach was needed. The role should be introduced with a strategic element and an operational element: the strategic element should be contained in the trust's new 'directorate

senior nurse' role, whilst an assistant matron role should be developed to deal with day-to-day operational issues. The authors suggested that this assistant role could be a rotational secondment for senior nurses to gain valuable exposure to strategic and operational planning and management; this could also help with succession planning for senior roles in the organisation.

After some initial concerns that the new role would be onerous, too strongly predetermined and plagued by a contentious title, the response of nurses has been largely favourable (Lipley 2001a & 2001b). The new role has been interpreted as implicit recognition of the value of nursing, and an acknowledgement that the reduction of a senior nursing presence following reforms such as the introduction of general management (Griffiths 1983), was a retrograde step (Hewison 2001). Some have seen the matron role as a way of reversing the trend within directorates in which senior nurses became focused on operational business rather than nursing priorities, and where lines of accountability became confused (Buchanan and Gibbs 2001). Children's nurses welcomed the matron initiative as an opportunity to raise the profile of children's needs, and to establish strong nursing leadership of this specialism within trusts (Oughtibridge 2003). At the same time, it has been suggested that the matrons may have difficulties in fulfilling their objectives, given the range of other priorities that trusts are concerned with, such as technical excellence and compliance with national performance targets (Hewison 2001).

There is a growing literature describing different approaches to establishing 'first wave' matron posts in trusts. Kemp & Morris (2003) describe the appointment of matrons at directorate level, with both operational and strategic responsibilities; Healy (2002) describes how one trust appointed matrons with a clinical role for each ward or clinical area; Gallagher (2003) reports on how the matron of a community hospital helped to introduce patient-focused, integrated care. The demonstrable benefits of matron appointments are reported to include: an improvement in staffing and staff morale; improved patient satisfaction; and the establishment of a short stay ward resulting in reductions in length of stay and cancellations on surgical wards (Kemp & Morris 2003).

SECTION 3: THE RESEARCH PROCESS

Overview

The research had two, inter-related phases. The first was a survey of all Directors of Nursing (DoNs) across England to identify how the matron role was being implemented across trusts. The second phase was a series of case studies, including a cross-case survey of matrons, to discover how the matron role was being implemented within a range of different contexts.

3.1 The National Survey of Trust Directors of Nursing

The Directors of Nursing (DoN) national survey (referred to throughout the report as "the national survey") aimed to provide the DH with information about progress with the implementation of matron posts in different trust types (e.g. acute, mental health, primary care trust), with varying organisational structures (such as single site and multi-site trusts). It also aimed to develop a picture of the different ways in which the modern matron initiative was being implemented, such as through the creation of new posts, significant reorganisation of existing roles, or the "re-badging" of existing posts.

The survey sought information on the characteristics of the organisation, that is the type of trust and its main health care delivery focus. Questions relating to the number, job titles, salary and grade of matron postholders were asked, together with others relating to the postholder's span of managerial responsibility. We also enquired about the organisation's provision of resources in creating posts and their approach to the introduction of matron posts. Although these were newly established posts it was considered appropriate to seek Directors of Nursing views on the impact of the role on the nursing service and the wider organisation. The survey instrument was compiled based on our literature review, and on discussions with senior managers in the NHS, and with advice from our contacts in the DH. It was piloted informally with ten senior nurses in posts immediately accountable to Directors of Nursing, as we felt they would be well aware of the issues.

Following MREC approval, the survey was conducted by post, working from a database supplied to us by the publishers of the Directory of NHS Management (Binley's 2003). Questionnaires were sent by post to DoNs in all trusts and PCTs in England (as we thought) in April 2003. When the first closing date was passed, we found some trusts had received duplicate copies, and when we checked with a few directors personally known to us who had not responded, found that some had been omitted. It appeared that the database was not

entirely accurate because some trust directors of nursing do not have that title, particularly in PCTs, and so had not been included. So in May the database was checked against the complete list of NHS trusts on the NHS website, and further questionnaires were sent. We were then confident that all applicable directors had received our mailing (n=545). One reminder was sent to all non-respondents by June 2003, and the final response rate was 76% (414 replies). (see Appendix for copies of the information sheet, covering letter and survey questionnaire for Directors of Nursing).

Replies were entered into a database. Quantitative data were analysed using SPSS for windows software and are reported in Section 4. Qualitative data were entered into "Word" and have informed our discussions but further content analysis of this large resource is needed to really benefit fully from the data. Time has not allowed this so far, but it is on the researchers' agenda as papers are prepared for professional and academic journals.

3.2 Case Studies

3.2.1 The case study approach

A case study approach has been defined as:

> … an empirical enquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources are used
> (Yin 1994 p.13).

While there are different kinds of case studies, informed by different epistemological stances and of varying complexity (Mitchell 2000), in the social science literature, the main features of case studies generally include:

- complex, holistic descriptions involving numerous, not highly isolated variables;
- data often gathered by observation; and
- an informal writing style, with verbatim quotations and illustration (Stake 2000 p24).

A holistic picture, or 'completeness' of data is developed through the use of multiple data collection methods and, while the development of themes and hypotheses may be important goals, the prime aim is to develop an understanding of the case (Stake 2000).

Critiques of case study research include the ambiguity inherent in defining a case (Gomm et al 2000), and the absence of any basis for generalisation of the findings (Stake 2000). Stake (1994) for example, argues that cases exist independently, or prior to, the process of

investigation, while Gomm et al (2000, p102) argue that, inevitably, the term 'case' refers to "a case of something. In other words, we necessarily identify cases in terms of general categories", and that their distinctiveness as cases is linked to a notion on the part of researchers about what is typical of some group or population.

In the modern matron study, we sought cases of trusts primarily characterised by different kinds of service provision (acute, primary care etc), and serving different populations (rural, inner city etc) to explore how the policy initiative had been implemented in these different contexts. Our study design, particularly our detailed focus on a sample of matrons within each trust led us to realise that the 'case' could also be understood as the matron. Our purposive sampling of matrons, however, raises issues about the generalisability of our findings.

Qualitative case study research generally focuses on describing a specific group in fine detail, rather than discovering general laws of human behaviour: generalisability has therefore not been a priority (Ward Schofield 2000). There have, however, been attempts to redefine the concept to make it more meaningful within qualitative research, and some consensus has emerged on a 'naturalistic generalisability' (sometimes referred to as transferability, fittingness or applicability) (Patton 1980; Lincoln and Guba 1985). Such transferability has been defined as;

> "the 'fit' between the situation studied and others to which one might be interested in applying the concepts and conclusions of that study".
> (Ward Schofield 2000 p92-3).

Significantly, this approach to generalisability makes detailed or 'thick' description crucial, as without this, there is insufficient information to allow the reader to determine which findings apply to their own situation, and which do not (Patton 1980).

Our study was designed to produce sufficiently detailed descriptions of cases concerning the implementation of the matron role in a number of settings to suggest transferabilty.

3.2.2 Organising framework for the case studies

One feature of case studies is the development of a conceptual framework early in the study to guide data collection and analysis (McDonnell et al 2000). This shared conceptual framework and agreement on methods of data collection is central to ensuring consistency of approach between researchers, and comparability during analysis (McDonnell et al 2000). With careful attention to consistency, multiple case studies enable researchers to compare and

refine the analysis and interpretation of data from different settings, and to move towards a level of abstraction which – whilst stopping short of theory-development – makes it possible to draw general conclusions and make policy recommendations. This approach is considered to be useful for the purposes of policy analysis, in particular to answering the "what works?" questions implicit in the evaluation of policy interventions (Harrison 2001).

As indicated above, our multiple case study approach, which aimed to generate robust and policy-relevant information and recommendations within a short time, required the prior development of a framework to help structure (or organise) the processes of data collection, reduction and analysis. This was particularly important where there were two research teams working in different sites. Miles and Huberman (1994) define such a framework as "the current version of the researcher's map of the territory being investigated" (p 20). They add that it is likely that the map will be modified, as the researcher's understanding of the territory deepens.

The framework for our study had its roots in policy guidance about the modern matron. It was further informed by the extensive exploratory fieldwork already undertaken by both research teams, prior to setting up the study. Together, these sources led us to anticipate two particularly important issues that we believed matrons would be faced with. First, the requirement that NHS trusts should ensure that matrons had sufficient authority within the organisation to achieve their goals. Second, that – in their professional nursing capacity - matrons would be expected to exercise leadership to raise standards of patient care.

3.2.2.1 Authority

We drew on the work of Kogan et al (1971) to help frame our approach to exploring matrons' authority. These authors suggest that the relationship between the concepts of power, authority and role in formal organisations, and what it is that regulates the way people in different roles interact, are of key importance. They argue that working relationships within hospitals depend for their effectiveness on two criteria, both of which are relevant to the matron role. First, that there are clearly defined roles in which there is authority and, second, that the people in those roles have adequate power to make their authority work. Power may be based on knowledge (sometimes described as 'sapiential authority'), expertise and personality. Kogan et al suggest that the location of authority within a hospital can be understood partly through ascertaining the nature of agreements reached between people in different roles (such as who might give or receive instructions or services). Our study, therefore, in addition to collecting information on matrons' main responsibilities, aimed to explore the scope of their decision-making and the nature of their key working relationships.

3.2.2.2 Leadership

According to Dawson (1996), authority and leadership are both central to an understanding of organisational life, and are both strongly associated with other organisational processes of power, communication and decision making. She suggests that leadership exists when someone (the leader) exercises influence over others (the followers) within their group or organisation, for example with respect to the values that are espoused or the manner in everyday tasks are accomplished. Our study therefore aimed to consider the leadership behaviour of matrons through identifying the values they espouse, their priorities concerning the delivery of basic nursing care, the extent to which these are shared across their role set and how they seek to exert influence over members of the ward teams.

3.2.3 Sampling strategy for the case studies

Our purposive sampling strategy was not designed to produce highly typical cases, either of trusts or matrons. First, we had no way of knowing what might represent a typical case and second, we were aware that, in some instances, "it is better to learn a lot from an atypical case than from a magnificently typical case" (Stake 1994, p 243). Cases of trusts were selected to ensure a) geographical distribution and b) a range of different kinds of trusts. In addition, we attempted to select a range of trusts for case study that showed different ways of implementing the modern matron initiative, drawing on data from the Directors of Nursing survey as far as possible. However, as the project needed to be completed within one year, the selection of trusts had to be decided before completion of the survey and was therefore partly guided by advice from a former regional nurse adviser about early implementers of the modern matron initiative. The potential limitations of this approach were, it turned out, minimised by the fact that we found the modern matron initiative was generally implemented in a number of ways **within** trusts in a way that the Directors of Nursing survey did not necessarily indicate.

3.2.3.1 NHS Trusts

Ten case-study sites drawn from all four NHS Regions in England were purposively sampled. In order to include the widest possible variation, selection was on the basis of:

- different trust types (e.g. acute, (teaching and district general hospitals), mental health, and primary care trusts),
- different modes of implementation, such as the creation of new posts, significant reorganisation of existing roles or "re-badging" existing posts, and
- different organisational structures (e.g. single site and multi-site trusts) and
- different contexts (inner-city, urban, suburban/rural).

Within these categories, selection was shaped by pragmatic considerations, such as trust agreement about access.

As the study proceeded, because of time pressures, it was agreed with the Department of Health that the full-range of data collection would be carried out in eight trusts, with matron surveys only carried out in two further trusts (trusts E and F). Background details of all 10 trusts, together with information on how they each implemented the matron role, are provided in Section 5.

3.2.3.2 Within trusts

- We carried out a survey of all matrons in each trust to obtain base-line data. Respondents were asked to indicate if they would be willing to be interviewed in more depth.
- In those trusts that had more than three matrons in post, we selected a purposive sample of three for in depth interview from those respondents who had agreed to be involved. Selection reflected different clinical settings, different clinical specialties and, where possible, differing lengths of time in post. On sites where there were three or fewer matrons in post, we sought to interview them all.
- Each matron selected was asked to identify his or her role-set (that is, key colleagues that they worked with) within the trust. We then interviewed these colleagues along with any other managers, staff, and patient representatives who it appeared could provide us with the sort of data indicated in our detailed objectives. These informants included senior staff in clinical directorates; staff and managers in non-clinical services such as cleaning, catering, and estates management; staff from the Patient Advice and Liaison service and – most important - ward sisters, charge nurses and other nursing staff accountable to matrons.
- Where feasible or appropriate, we also asked patients, their families or carers in the clinical areas of each matron selected for detailed study about their contact with matrons through the use of a simple questionnaire. This was translated into the main languages spoken locally (in all, Urdu, Hindi, Turkish, Somali, Bengali, French and Arabic) to ensure the widest participation possible.

3.2.4 Data collection

3.2.4.1 Strategic approach

In order to permit cross-case comparisons, the two teams collaborated closely on the development of structured or semi-structured interview schedules and on templates for establishing, recording and displaying data. The matron survey instrument was compiled

based on our literature review, and on discussions with matrons in trusts who were not part of our study, who also took part in an informal pilot study. Data were collected from multiple sources:

i) Modern matrons

a) Modern matron survey

Base-line data was collected from matrons across each trust (see Appendix for modern matron covering letter, questionnaire and information sheet). In most trusts, a list of matrons was obtained from a member of the Nursing Directorate. Questionnaires with return addressed, stamped envelopes were then distributed either by external or internal post, at informal meetings or formal meetings attended by matrons. In one trust we were not given names but the deputy DoN undertook to distribute questionnaires on our behalf. Up to three reminders were sent at six to eight weekly intervals and in some trusts, where response was slow, additional reminders were sent out by email. Replies were entered into a database. Quantitative data were analysed using SPSS for windows software and are reported in Section 6. Qualitative data were entered into "Word" and have been used extensively in our reporting of themes in Section 7.

b) Interviews and observation

In-depth, semi-structured interviews were conducted with 21 selected matrons to explore their perceptions and experience of the role (see Appendix for copies of interview prompts, covering letters, consent forms and information sheets). Matrons were self-selected to the extent that we asked for volunteers from those completing the questionnaire. Where we had sufficient volunteers to choose among, we selected our sample with a view to achieving variation in clinical specialty, span of responsibility, age, gender and ethnicity. These tape-recorded interviews, which lasted from between 40 to 90 minutes, generally took place in the matron's office.

We had initially planned to use a vignette to explore more about matrons' sphere of decision-making. However, this form of data collection was abandoned early on in the study as, in practice, it did not generate useful data but tended to disrupt discussions with participants.

ii) Other staff

Semi-structured interviews were undertaken with a range of trust personnel who were included in the study because their names had been put forward by matrons in our interview sample (see Appendix for staff interview schedule, covering letter, consent form and information sheet). In addition, a number of unstructured interviews took place with

members of staff, such as those involved in PALS, who could inform us about additional aspects of the matron role and its implementation. These semi-structured and unstructured interviews took place in a variety of locations, including borrowed offices and corridors and lasted between 15 to 90 minutes. The majority of interviews were tape-recorded and transcribed as soon as possible after the interview. Where permission to record was not given, extensive notes were taken.

In one directorate in Trust D, the matron worked closely with a team of 11 very experienced nurses, including a nurse consultant, a clinical nurse specialist, more than one nurse practitioner, practice development nurses and ward sisters/managers. The matron was not able to identify a small group of these as more significant than any others so the researcher agreed with the matron to devise a questionnaire based on the interview schedule for key contacts of matrons that could be administered to the whole group. The researcher e mailed to the group a letter inviting them to fill in the questionnaires at a team meeting some days later, at which the matron was not present. They all signified their willingness to participate, so the researcher attended their meeting, explained the background and research method, and waited while they filled in the questionnaires. In this way some very interesting data were collected. Case study method has to have a degree of flexibility to accommodate the needs and time pressures of participants.

iii) Data collection from patients, their families and patient representatives

We aimed to distribute short questionnaires to patients, their families or carers to gain an impression of their perceptions and experience of the matron role. However, as we describe below, MREC approval was given on the basis that researchers did not approach patients directly, without the guidance of staff. Pressure of work within clinical areas meant that distribution and response rates were low. In addition, in some areas, staff involvement possibly introduced bias in that only patients who were known to have had dealings with the matron were approached. In some areas, the nature of patients' illness and the distress of relatives meant that very few questionnaires were handed out. In one area, staff decided that the survey would be futile - patients would not know who the matron was - and so they felt unable to help with the distribution of questionnaires.

iv) Documentary evidence

Trusts were asked for copies of:

- job descriptions, as appropriate
- their strategic plans for nursing

- minutes of meetings where introduction of matrons are discussed and/or agreed
- their Patient and Public Involvement Strategy (where available)
- literature given to patients and families about the wards and about standards of care

In addition, where possible, we collected routinely-collected clinical audit material, records of complaints, cleanliness and nutritional matters, and surveys of patient and staff satisfaction. We also sought to establish whether or how trusts were evaluating the matron role and existing quality data about patient experience and patient care.

3.2.5 Data analysis and interpretation

An adapted version of 'framework' analysis was adopted to interrogate and organise the data. Framework analysis, as described by Ritchie and Spencer (1994), has been widely used in applied policy research addressing contextual, diagnostic, evaluative and/or strategic questions. It is considered useful where it is necessary to produce results in a relatively short time, to work in teams, and to ensure the research process is accessible to commissioners and other stakeholders.

The key features of the framework analysis approach are that it is

- grounded - that is, strongly rooted and driven by the accounts and observations of study participants
- dynamic - that is, open to change throughout the analytic process
- systematic - that is, allows methodical treatment of all similar units of analysis
- facilitates easy retrieval of original material
- accessible to others and thus allows interpretations to be assessed by others besides the main analyst.

Framework analysis is a process involving a number of interconnected stages:

1. familiarisation - becoming familiar with the range and diversity of the data
2. identification of a thematic framework
3. indexing - applying the thematic framework systematically to all the data
4. charting - reorganising the data according to appropriate thematic references
5. mapping and interpretation - identifying a structure that illustrates the dynamics of the phenomena under investigation.

We followed the overall process of framework analysis, but adapted the different stages to the requirements of our study. In stage one, members of the research team familiarised

themselves with the data from their own parts of the study, and shared their initial impressions to provide a collective overview of the material and the key themes or thematic framework that it suggested (stage two). This framework was then applied to data from across the case studies, or the individual data sets (stage three). The themes and sub-themes identified through this process were then charted on a case by case basis, as demonstrated in Table 2 (Stage 4).

Table 2 provides an example of data display or charting. It shows fragments of data from one trust that help to constitute a general theme, namely 'matrons' clinical involvement', and how a number of sub-themes can be organised under this rubric (such as the tension between matrons' clinical and managerial duties). The figure also shows how the data is presented on a case-by-case basis (here just from Trust G), and from different perspectives (one column organising data derived from matrons and the other, from their key contacts) in a way that enables the researcher to keep track of the data source (the particular research participant).

The themes identified through this process are presented in Section Seven of the report, together with supportive data from across the case studies (such as data from the matron survey). In stage five of our framework analysis we drew on these themes and sub-themes to construct a number of models of role implementation. These are presented and discussed in Section Eight.

Table 2: Analysis – example of charting

Theme: Matrons' clinical involvement		**Matron perspective**	**Other perspectives**
Sub-theme	Essentially clinical role	**Trust G: Matron 1** Anticipated a largely clinical role, encouraged by Trust stipulation that she was included in clinical rosta (50%) and worked as nurse practitioner. Funded by money for NP post. **Trust G: Matron 3** • while covering wards, provides basic care (often for more unwell patients) on ad hoc basis. • In ICU has covered breaks etc, but thinking of putting aside time for clinical involvements	
	Operational /strategic role	**Trust G: Matron 2** Helps out when staff are in difficulty, but mainly operational. Generally sees role as more strategic than other M roles. **Trust G: Matron 3** Strategic element of role hugely important	**Re: Trust G's Matron 3** • Essentially managerial role **(Senior Sister)**
	Tension between clinical & managerial duties	**Trust G: Matron 2** Size and nature of area covered (community) meant clinical involvement was limited: managerial emphasis identified prior to appointment and therefore not a problem.	**Re: Trust G's Matron 1** • Cannot be clinically involved and run a large budget **(Consultant)** • Good clinical nurses dragged into management with mm role (Quotte p8) (**Consultant)** **Re Trust G's Matron 3** • Concern that MM will be pulled from special position (between clinical and managerial worlds) into assistant general manager role **(Medical Engineers)** • Managerial aspect led to too much time in meetings at expense of time with patients (x-ref) **(Senior Sister)**

3.3 Ethical issues and research governance

3.3.1 Ethical concerns

In the conduct of research involving human participants, four key issues must be addressed when considering if a proposed research project is ethical. These are:

- *Voluntary participation*, which requires that people are not coerced into participating in research;
- *Informed consent*, which means that all participants, whether staff or patients, have appropriate information and adequate time to decide whether to take part;
- *Identification of any risk of harm* (physical or psychological) as a result of participation;
- *Confidentiality*, which means that participants will remain anonymous throughout and after the study.

3.3.2 Processes of ethical approval and research governance registration

The research team had to negotiate two processes:

- *Ethical review*: all projects involving patients and/or NHS staff require ethical approval from a Local Research Ethics Committee (LREC) or if the research takes place across more than one Strategic Health Authority (StHA), by a Multi-Centre Research Ethics Committee (MREC). As our case studies were expected to span a number of StHAs, we had to apply for MREC approval.
- *Research governance registration*: when seeking access to NHS patients, staff or premises, for research purposes, the appropriate research governance mechanisms must be sought and complied with in each trust before the project commences, and local management must agree to grant access. At the time of application these mechanisms varied considerably between trusts, in the amount of information required and the length of time taken.

3.3.2.1 MREC application

Application was made to MREC in mid-November 2002. An accompanying letter to MREC asked for guidance on whether we had to apply for locality issue permission to all individual LRECs, or whether the provisions for "no local researcher", really designed for epidemiological research, could apply, in which case once MREC permission was obtained we would only need to inform LRECs, rather than making application for permission. The project grant holder attended the MREC meeting in December, and a few days before Christmas 2002 the team received a letter asking for further clarification on a number of issues, on which the Chair would need to be satisfied before giving permission to proceed.

MREC required clarification concerning our patient approach, including if and how we were planning to involve non-competent adults, and how we were going to involve patients who did not speak English. They also had reservations about our sampling strategy.

i). Patient approach

Originally, in order to keep within the timeframe and budget of the study, when we submitted the proposal the research design only included patients at the level of consultation with the recently constituted Patient Advice and Liaison Service (PALS) and Patient Forums. However the DH panel of referees asked us specifically to question patients directly because the modern matron initiative was introduced as a result of strong pressure from patients in the consultations for the NHS Plan, to "bring back matron". MREC, however, interpreted our plans to interview patients, approaching them through the good offices of ward sisters, as potentially coercive. In answer to MREC's concerns we therefore proposed to gain patients' perspectives on the modern matron initiative by arranging distribution of simple questionnaires to patients or, where more appropriate, their families or carers, instead of conducting interviews. This approach had the advantage of providing better opportunities for accessing the views of those patients who do not speak English by having questionnaires and information sheets translated into the major ethnic languages (see issue 3 below). We agreed that, in order to ensure the appropriateness of our approach to individual patients, distribution of questionnaires would be guided by advice from NHS staff, such as members of the PALS team and the nursing staff.

ii) Involving non-competent adults

In answer to MREC's concerns about inclusion and consent in relation to such adults, the team promised to ensure that we would seek advice from clinical staff about which patients were sufficiently competent to give consent to be involved in the study and, where appropriate, which relatives it might be appropriate to approach on a patient's behalf. This advice would be sought before the distribution of patient questionnaires in any clinical area. The team believed that these precautions would help to gain data on the experience of non-competent patients and their families in a non-coercive manner**.**

iii) Involving patients whose first language is not English

We promised that as soon as we had confirmation of access to our selected case study trusts, we would inquire which languages were in common use in their catchment areas and arrange translation of questionnaires and information sheets. The 'tick box' design of the questionnaire allowed the meaning of responses to be clear without the need for reverse translation.

iv) Sampling procedure

MREC expressed concerns about our sampling procedure. Our response explained that a multiple case study approach, which aims to generate robust and policy-relevant information and recommendations within a short time, requires a purposive sampling strategy. Indeed, the appropriateness of this approach had been endorsed by the DH expert panel of referees. The developmental nature of a case study approach meant that it was not feasible to specify in advance exactly which parts of any trust, and consequently which groups of staff or patients would be invited to be involved. We outlined for MREC again our clear strategy for sampling trusts and, within trusts, for sampling members of staff and patients.

We sent all instruments (see Appendices) including the patient questionnaire and revised patient information sheet reflecting the new questionnaire (rather than interview) approach, together with our detailed responses to all MREC's points, in late January, together with a renewed request for guidance about the locality permission issue**.**

MREC permission was granted (registration no MREC/2/3/103) on 7 February 2003, but with no mention of locality issues. We therefore re-sought clarification. In the meantime, the team began applications to the various LRECs for our case study sites, in case the ruling insisted that we obtain full locality permissions. In the event, we found there was considerable confusion at local level, with some LRECs wishing to fully review the proposal despite MREC clearance. A very large amount of paperwork was generated in this process. Eventually all these matters were settled but the timetable slipped as a result of both the ethics and governance procedures.

3.3.2.2 Research governance in the case study trusts

As soon as MREC permission was granted, we began to enquire about research governance registration in each trust; procedures varied enormously and in some cases needed many pages of application forms to be filled in. Some trusts even wished to re-assess our research design. Letters seeking management permission were sent to Chief Executives of trusts; in most cases the Directors of Nursing had already given consent to access to their matrons. Some trusts required us to obtain honorary contracts, fill in health questionnaires and provide references before granting contracts; when the contracts came, some had to be re-negotiated because of the impossibility of our yielding intellectual property rights to the trust.

We proceed next to our findings, beginning with the National Survey.

SECTION4: FINDINGS FROM THE NATIONAL SURVEY OF TRUST DIRECTORS OF NURSING

Overview

Section Four gives some contextual information on the matron initiative in England in 2003, followed in Section Five by information on the ten trusts who agreed to take part in case studies, and on the numbers of participants, then in Section Six by descriptive information on the matrons who responded to our survey in the ten trusts.

4.1 Introduction to the national survey

The Directors of Nursing (DoN) national survey (referred to throughout the report as "the national survey") aimed to provide the DH with information about progress with the implementation of matron posts in different trust types (e.g. acute, mental health, primary care trust), with varying organisational structures (such as single site and multi-site trusts). It also aimed to develop a picture of the different ways in which the modern matron initiative was being implemented, such as through the creation of new posts, significant reorganisation of existing roles, or the "re-badging" of existing posts.

The survey sought information on the characteristics of the organisation, that is, the type of trust and its main health care delivery focus. Questions relating to the number, job titles, salary and grade of matron postholders were asked, together with others relating to the postholders' spans of managerial responsibility. We also enquired about organisational provision of resources in creating posts and approaches to the introduction of matron posts. Although these were newly established posts it was considered appropriate to seek Directors of Nursing views on the perceived impact of the role on the nursing service and the wider organisation.

4.2. Response rate and profile of responding trusts

Following MREC approval, the survey was conducted by post, working from a database supplied to us by the publishers of the Directory of NHS Management (Binley's 2003). Questionnaires were sent by post to DoNs in all trusts and PCTs in England (n=545) in April 2003. One reminder was sent to all non-respondents and by June, after ironing out some difficulties explained in Section 3, the final response rate was 76% (414 replies) (see Appendix for copies of the information sheet, covering letter and survey questionnaire for Directors of Nursing). Table Three indicates that the response rate was consistent across the regions at 77%, with the exception of Southern Region, where the rate was 72%.

Table 3: Questionnaires returned and response rate by region

Region	Returned Questionnaires	Responses within Region as % of responses in England	Actual Number of trusts in each Region	Regional Response Rate (%)
London	56	13.5	73	77
Midland	127	30.7	164	77
North	127	30.7	164	77
South	103	24.9	144	72
Unknown	1	0.2		
Total	414	100	545	76

Trusts were asked the main focus of their activity. Most trusts indicated that their activity fell within the main categories of Acute, Primary Care or Mental Health. A smaller number were specialist trusts (eg women's or children's services only), and in some trusts there was "mixed activity".

Table 4: Profile of rust activity in returned questionnaires

Type of trust	Number of trusts	Number of trusts as % of total responders
Acute	131	31.6
Primary Care (PCT) (including Teaching PCT)	203	49.0
Mental Health and Learning Disability	41	9.9
Specialist Trust	18	4.3
Mixed Trust (PCT with MH or LD or both)	21	5.1
Total	414	100

There was some variation in the response rate of different types of trust.

Table 5: Response rate for different types of trust (in England)

Type of Trust	Number of trusts responding	Actual number of trusts of each type.	Response rate (%) for type of trust
Acute	131	158	83%
Primary Care (PCT) (includes Teaching PCT & Mixed trusts PCT with MH or LD or both)	224	302	74%
Mental Health and Learning Disability	41	65	63%
Specialist trust	18	20	90%
Total	414	545	76%

Replies were entered into a database and analysed using SPSS.

4.3 Number of matron posts in England in spring 2003

Our survey revealed that 73% of responding trusts within England (including PCTs) had appointed at least one Matron by June 2003. Within the responding trusts a total of 2419 posts had been created, and assuming a similar level of appointment in non-responding trusts, we concluded that the national figure would be in the region of 3200 posts. The largest number of posts within any single organisation was 52. Twenty-four trusts reported that they had appointed more than 20 matrons, the majority (75%) of trusts had made between 1 and 10 appointments.

Figure 1: Proportion of Trusts that had appointed at least one Modern Matron by June 2003

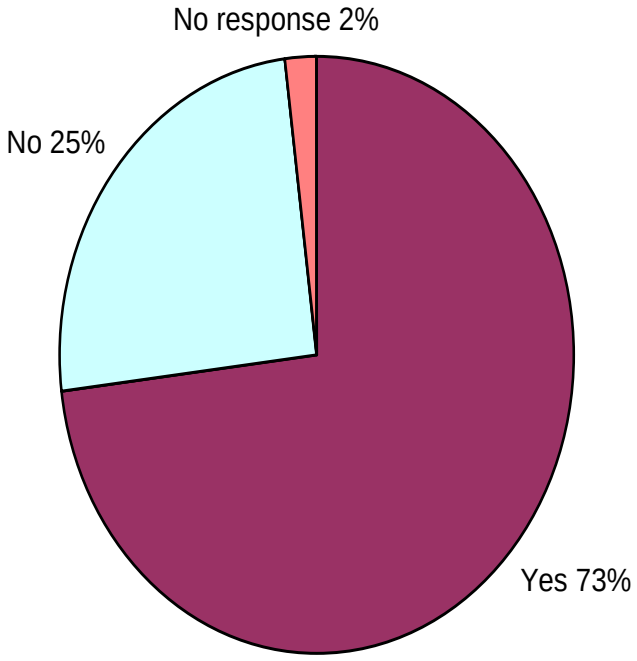
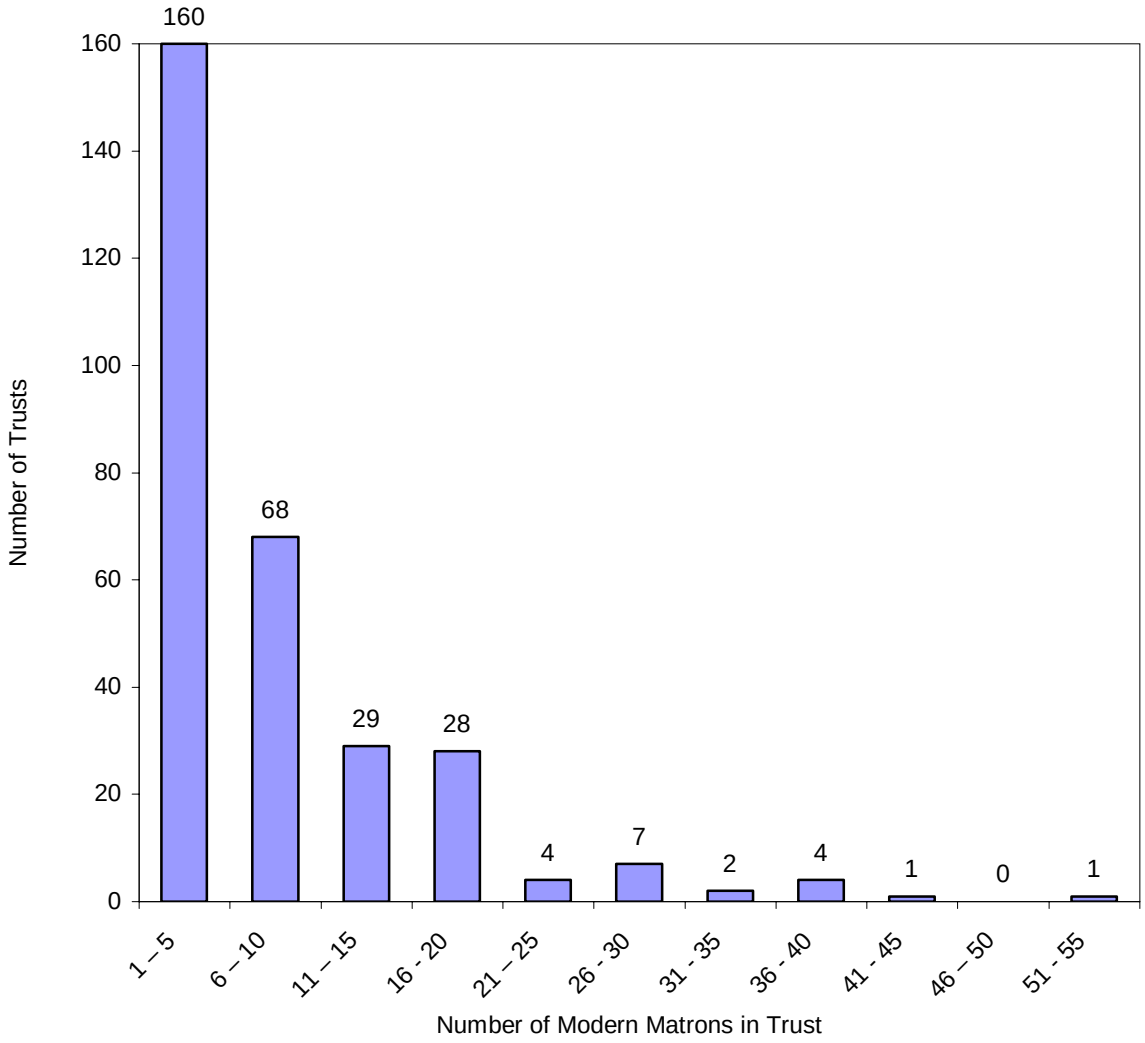


Figure 2: Numbers of Modern matron posts in responding trusts



4.4 Job Titles for Matrons

A plethora of different titles have been created, 113 in all. Of the 414 responding trusts, 77 (19%) used "modern matron" on its own, and 69 (17%) the title "matron" on its own. A further 11 trusts (3%) used one of these titles followed by another e.g. "matron/clinical leader" or "modern matron/senior nurse", whilst another group of trusts (n = 48, 12%) used another title followed by "matron" or "modern matron" e.g. "senior operational manager / modern matron". Therefore 205 responding trusts (50%) used a title (albeit a long one) that contained the word "matron" somewhere within it.

Amongst other titles, "senior nurse", with 43 mentions (10%) was the most common. Apart from that, there was a range of titles more usually associated with senior management such as "deputy director community services", "deputy head of midwifery", "assistant general manager/senior nurse/modern matron", "associate nursing director" and "divisional nurse".

Many titles contained the word “manager”, including “locality manager (matron)”, “clinical nurse manager”, and “service manager”. Others contained the word “head” such as “head nurse”, or the word “lead” or “leader” such as “lead nurse” or “clinical leader mental health”. Further titles began with the word “senior”, including “senior nurse advisor”, “senior nurse clinical practice development” and “senior charge nurse, sister or midwife”.

4.5 Size of clinical areas covered

In the survey, questions were asked about both the smallest and largest numbers of wards or clinical areas for which “matron” post holders had been given managerial responsibility. We had hoped that this would give us some insight into the dimensions of the managerial role. However the response to these questions was patchy, with 36% of responding trusts failing to answer the first of these questions, and 39% the second.

Regarding the smallest area of responsibility, 54% of responding trusts had matrons with three or fewer wards or clinical areas, 9% between 4 and 8 wards and just 1% with levels scattered between 15 and 32 wards, with one trust with greater than 70 areas. Regarding the largest areas of responsibility, 14% of respondents had matrons with 3 or fewer wards, 34% between 4 and 8 wards, 12% between 9 and 17 wards or areas, and less than 1% with more than 31 clinical areas. The difficulty here is that the term “managerial responsibility” was not defined in the questionnaire (it could therefore have been interpreted differently by our respondents), and furthermore the actual size of clinical areas would not have been consistent (for example the very large number of clinical areas overseen by some matrons were probably community premises or GP practices, where there would have been fewer nursing staff compared to a large inpatient ward or unit).

Figure 3: Smallest number of clinical areas managed by matrons

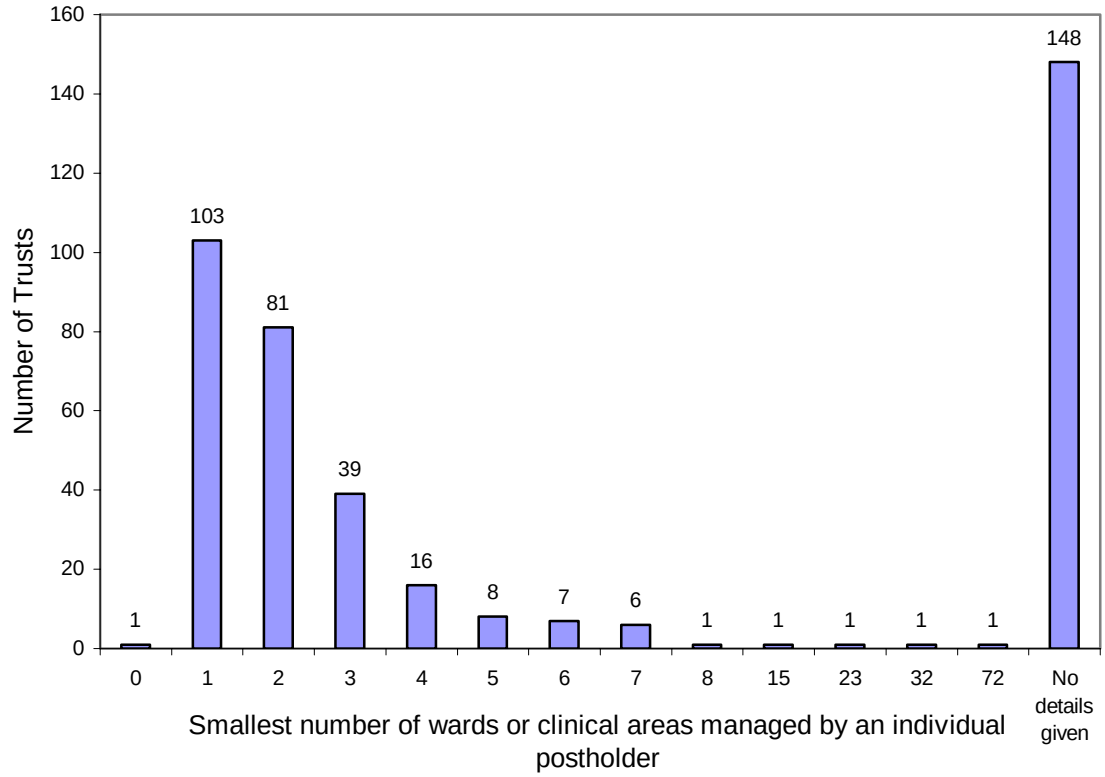
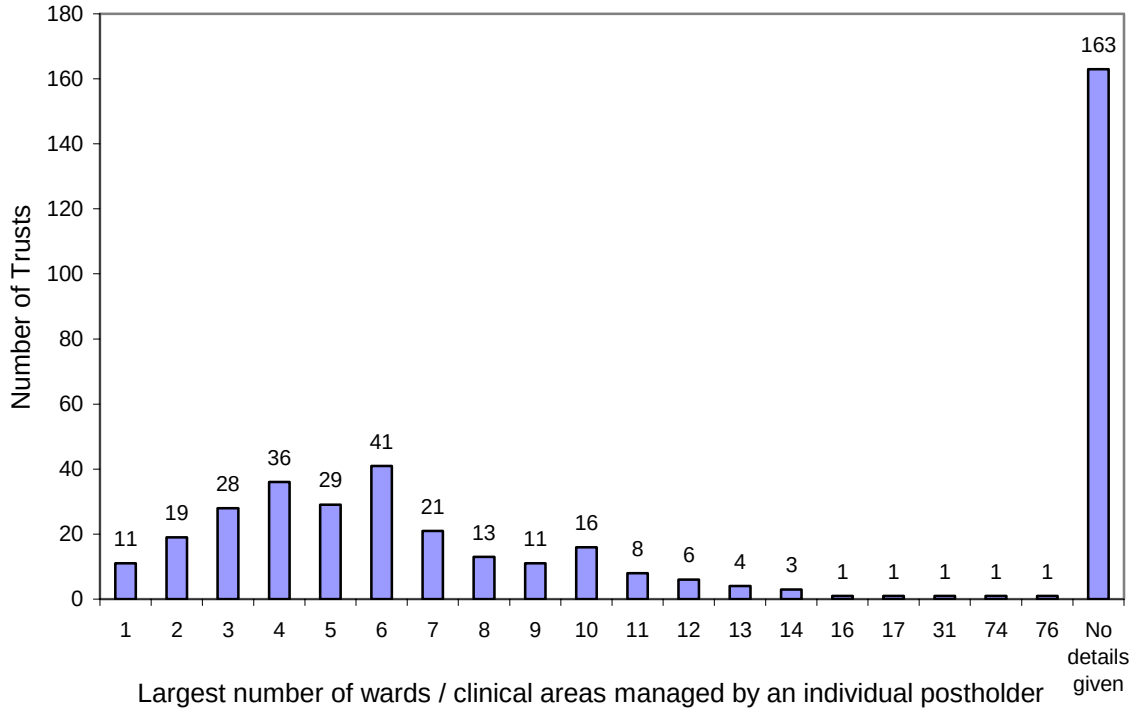


Figure 4: Largest number of clinical areas managed by matrons



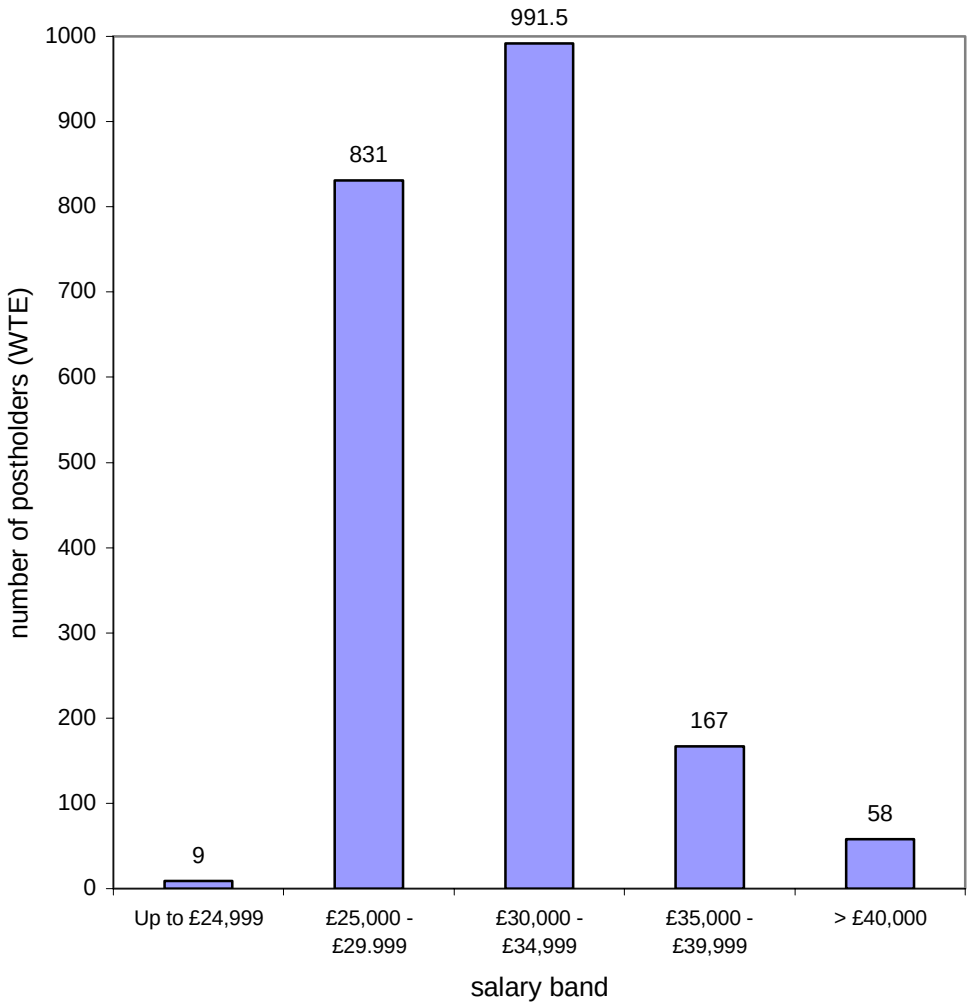
4.6. Types of clinical area covered by matrons.

With regard to the types of wards/clinical area for which matrons were responsible, over half (54%) of respondents dealt with inpatient services only, whilst 29% were responsible for combined inpatient/outpatient services, and 2% for outpatient services only. There were some post-holders (9%) who covered inpatient, outpatient and community services. The majority of matrons (77%) covered one geographical site, whilst 23% covered more than one.

4.7 Salaries and clinical grading

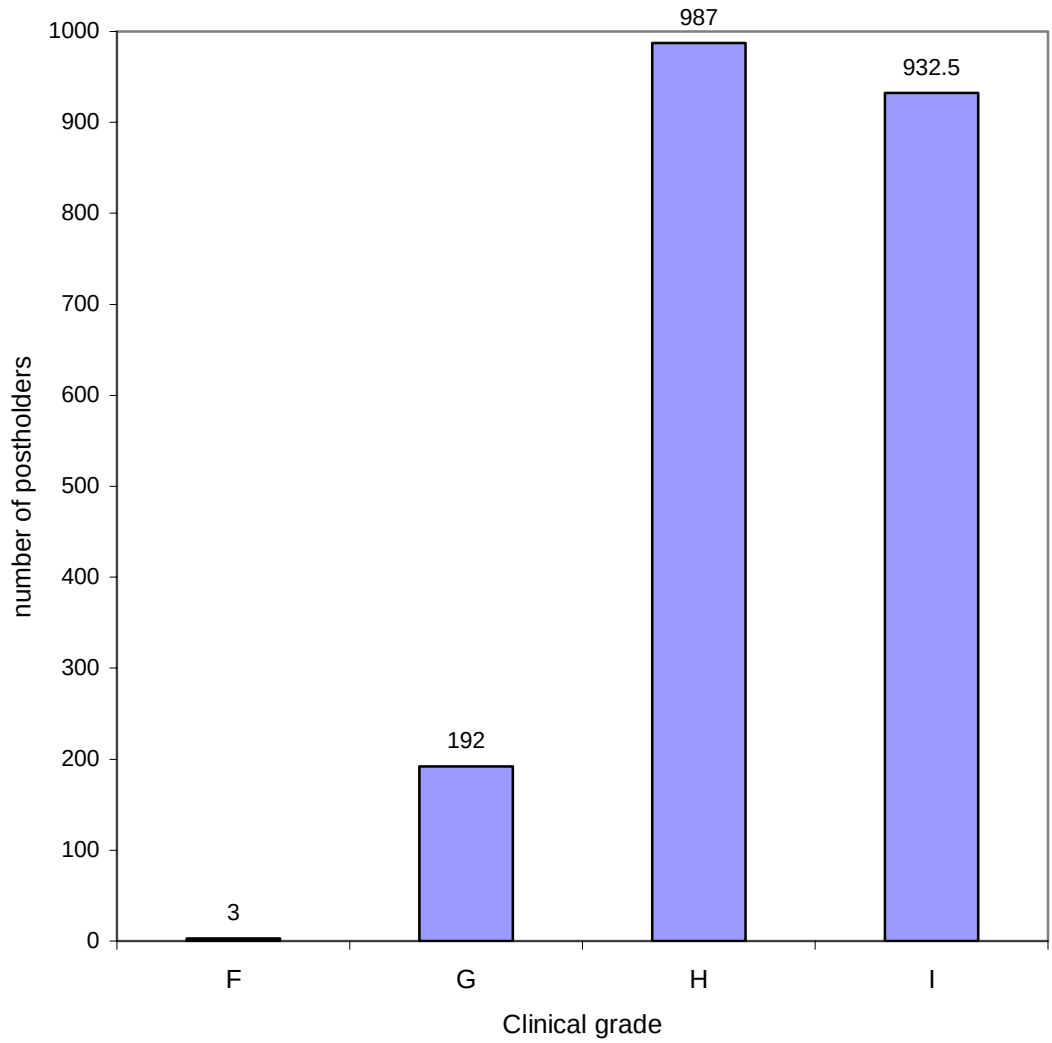
The questionnaire revealed that there was significant variation in the salaries paid to post-holders, although the majority (89%) received between £25,000 and £34,999.

Figure 5: Salary range of postholders



With respect to clinical grade there was a similar spread the majority of posts (91%) were at H or I grade.

Figure 6: Clinical grade of postholders

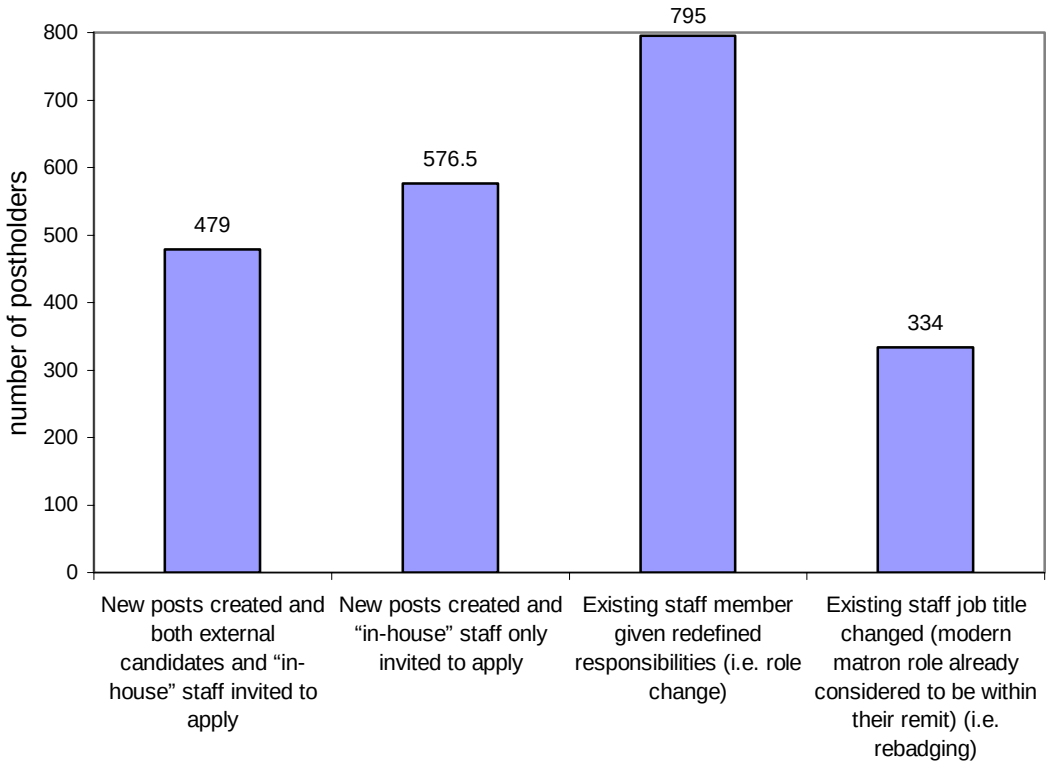


A small number (20) of the responding trusts stated that their matrons had been appointed on the Senior Manager Pay Scale.

4.8 Establishment of matron posts

The national survey revealed that most of the matron posts were introduced in one of four different ways; the commonest approach was to give the appointed post-holder redefined responsibilities (see Figure 7). Other mechanisms were identified by 20 of the responding trusts, these included organisational restructuring or a combination of the four main approaches.

Figure 7: Number of matron posts (WTE) created by the four main approaches



Our questionnaire also explored investment of extra resources in the creation of matron posts. A range of approaches was employed by responding trusts; those most frequently identified were uniforms (41%), formal training (34%), mentorship arrangements (30%), action learning programmes (27%) administrative support (30%), and office facilities (30%). Other initiatives had been identified in around 20 trusts (for example. support to attend conferences). Most of these facilities were funded from within existing budgets, only 79 trusts (19%) had made "new money" available to provide these resources.

The introduction of matron posts was through gradual staged implementation in 129 (31%) of trusts. Fewer trusts, 94 in total (23%) had chosen to introduce the matron on the same day (the "big bang" approach). However a significant number, 191 respondents (46%) did not specify whether either of these methods were chosen by their organisation. Of the trusts responding to the survey, 158 (38%) described the creation of the matron post as part of a service restructuring.

With regard to the ease of appointment, only 36 trusts (9%) stated that there had been difficulties in filling the posts; 228 (55%) of trusts said that they had not experienced any difficulty, whilst 150 or (36%) did not respond to the question. Following the creation of these posts formal evaluation of the role was planned in 79 trusts (19%).

The questionnaire gave respondents an opportunity to identify whether a generic job description or core competencies had been used to define the post. The majority of trusts (55%) had developed a core or generic job description whilst 27% had created core competencies for matron postholders.

4.9 Perceived outcomes of the introduction of matrons (qualitative data)

We were keen to obtain the views of Directors of Nursing on what impact they believed the introduction of matrons had had on service delivery and the trust itself. Our questionnaire therefore gave respondents the opportunity to identify what they thought the positive and negative outcomes of the initiative were.

Some respondents stated that it was "too early" to identify such outcomes, and others presumably did not provide a response for this reason. However positive comments were made by 272 Directors of Nursing (66%), and in some cases individuals identified a number of positive outcomes.

A content analysis of this qualitative data was undertaken. The positive outcome most frequently identified (31%) was that of leadership; (this included such explicit statements as "strengthening of nurse leadership" but also comments relating to the support of staff in the clinical setting). The second most frequently identified positive outcome concerned the environment. This was identified by 20% of respondents and included comments that specifically identified "improved cleanliness" together with those that highlighted a more general improvement in the clinical environment.

Other positive outcomes arising from the introduction of matrons included; a reduction in / improved handling of complaints (18%); improvement in patient /user involvement (11%) and greater visibility (of senior clinicians) at ward level (10%).

Fewer Directors of Nursing (35% of respondents) identified negative outcomes, and of those that did their comments were often "concerns" rather than explicitly negative comments. Many qualified their remarks by pointing out that implementation was still very recent and it was too early to be certain that their negative perceptions would persist.

The "concern" or "negative outcome" most frequently reported (49%) was the lack of clarity regarding the matron role particularly around the issue of conflict between clinical and managerial roles. The second most frequently reported (25%) concern was also a managerial

issue; the matron post was seen as compromising the role and / or responsibilities (also in some cases the development) of other managerial posts (e.g. H grades).

Other concerns or negative outcomes identified by the respondents were; problems over funding the posts (15%); difficulties with the title “matron”, which was seen as “old fashioned” (14%); issues around inter professional rivalry (7%) and, in the case of community trusts the view that the matron post would be difficult to introduce into the community setting (5%).

SECTION 5: AN OVERVIEW OF TRUSTS INVOLVED IN CASE STUDIES, AND OF PARTICIPANTS AND DATA

Overview

The following section contains profiles of the ten trusts used as case studies in the study, providing background information about each trust, an indication of its current performance and details of the way in which the matron was implemented in each organisation. (As mentioned in section 3, we surveyed all matrons in trusts E and F but did not carry out further fieldwork within these.).

Additional information such as NHS performance ratings, the population served, and mortality rates is provided in Table Six following the profiles. This data has been drawn from trust annual reports, and websites such as CHI (www.chi.nhs.uk), the DH (www.doh.gov.uk), NHS Estates (www.patientexperience.nhsestates.gov.uk) and Dr Foster (www.drfoster.co.uk). It should be noted that data in this table have been rounded up or down in order to maintain the anonymity of the trust. However, information provided is sufficiently close to the original to give a realistic picture and demonstrate some of the differences between trusts.

We have not always been able to find information in the same format for all trusts. To provide a sense of the clinical workforce for example, we have used figures on the number of nurses per 100 beds, percentage of staff who are nurses, and/or the percentage of staff involved in direct patient care, as available.

Following Table Six displaying information about the ten trusts, are two more tables; the first, Table Seven, shows the numbers of participants in all the case studies and the types of data obtained, and Table Eight gives profiles of matrons and their key contacts in the eight trusts where detailed case studies were carried out.

5.1 Trust A: A District General Hospital

5.1.1 Background

This medium sized district general hospital moved from a central position to newly built premises just outside the town in 1984. Together with a small satellite maternity unit in the more rural part of the catchment area, and more recently managing children's services (including school health) in the community, it became an NHS Trust in 1993. The trust serves a population of approximately 400,000 in one large and several small towns and numerous villages. The employment in the area used to be concentrated in mining and heavy industry as well as agriculture but the traditional industries have declined in the past 20 years, being replaced by more technological and service concerns. The population is predominantly white and many of the nursing staff come from the local population and have trained and worked in the hospital for their entire careers.

5.1.2 NHS Performance

The trust achieved a 3 star rating in the 2002/3 NHS "league tables". It is now three years since the Commission for Health Improvement visited the trust; the report was mainly favourable although commenting on a higher than average mortality rate. This has recently dropped considerably but was still shown as 105 over the last three years taken together The PEAT score for environment was "good" and for food "acceptable".

5.1.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

The trust established its Patient Advice and Liaison Service (PALS) in October 2002, published its Patient and Public Involvement Strategy in July 2003, and has attained level 3 of the Clinical Negligence Scheme for Trusts (CNST).

5.1.4 Complaints

The trust actually encourages patients to express their dissatisfactions in an attempt to increase standards of care; in the year 2002 - 03 the trust received 377 formal complaints (not all nursing related), 97 % of which received a full response within 28 days. Where complaints were related to perceived shortcomings in nursing care, sometimes a meeting between Heads of Nursing and patients and/or relatives was held so that positive action could be taken.

5.1.5 The picture before implementing the modern matron initiative

The Director of Nursing, interviewed in May 2003, explained that early in 2002, there was a Senior Nursing Officer (SNO) in each of the then four directorates, which he viewed as being equivalent to matrons, although not using the title. However, over the next year, as more direction was given by the Department of Health about the content of the matron role, it became obvious that these senior nurses could not on their own fulfil all the matron responsibilities. Also during this time the number of directorates increased from four to five, some funding for more posts was found through cost improvement programmes, and a review of nurse staffing was undertaken.

5.1.6 Mode of implementation

So by the late spring of 2003, when the research team visited the trust to introduce the project to the senior nursing staff, 15 posts were considered by the Director of Nursing to encompass some of the duties of matrons. Five of these were at SNO level for each of the Directorates (Women's and Children's Services, Intensive and Critical Care, Emergency Care, Surgical Specialties and Medical Specialties). These five (all on the Senior Management pay spine) were considered to be matrons in some respect because they were responsible for standards of service. However, their assistants really carried out more of the matron functions; at the time of the case study only seven out of the ten planned assistants (appointed at H grade) were in post. Three assistant posts were allocated to Women's and Children's Services, two to Intensive and Critical Care, two to Emergency Care, two to Surgical Specialties and one to Medical Specialties.

Amongst the 15 posts considered by the Director of Nursing to be "matrons", two were new posts for which staff already in the trust were invited to apply; the remaining 13 were allocated redefined responsibilities, although a total of three posts were unfilled. (ie number of matron posts during the study was 12). Ten of these post holders (83%), replied to the questionnaire for all matrons in case study trusts; nine of whom were female. Half of them were in their 30s, with three in their 40s and two in their 50s. Nine were of white British ethnicity; one respondent did not give gender or ethnicity. The questionnaire revealed variations in spans of responsibility and facilities offered. Spans of responsibility of the matrons varied from one to ten wards or departments, and line management of from 20 to over 200 staff. Half of respondents were responsible for less than 50 patients on a daily basis, but the remainder were responsible for between 176 and over 300 patients each. All respondents had their own office space, but levels of secretarial and administrative support varied to some extent; however all had at least part-time assistance.

5.1.7. Interpretation of the role

Seven respondents to the questionnaire believed there was clarity regarding their role and responsibilities, the remainder felt there were ambiguities. Senior managers in the trust are enthusiastic about the new matron role but some admit that there is not always clarity about its operation.

5.1.8 Views on matrons' impact

One champion of the matron role was a senior facilities manager. He felt that boundaries had blurred between clinical managers (the matrons) and general managers, creating a real sense of team spirit, and an ability to make changes in service provision to enhance the patient experience. This manager reported that since the introduction of the matron role there was much more regular and frequent informal dialogue between himself and his staff with the matrons, both in person and over the telephone, over cleaning, linen and catering issues, because those things are seen much more clearly to be their concern. Matrons were empowering ward sisters to make their views known, and at ward level sisters could influence the cleaning staff to fit their routines around patient needs.

5.2 Trust B: A Primary Care Trust (PCT)

5.2.1 Background

This Primary Care Trust (PCT) formed in 2001, provides primary care and community hospital services across a semi rural area, comprising four small towns of about 20,000 population. The trust supports 16 GP surgeries and three community hospitals. The first of the hospitals has three wards, two of which are managed by the PCT and a third by a neighbouring mental health trust. The second hospital has 23 beds, providing rehabilitation, medical / nursing care, respite care and palliative care, with a minor injuries unit (MIU) located within the hospital. The third hospital has 27 beds and also provides a minor injuries unit.

Employment in the area used to be concentrated in mining but the dominant sectors are now service industries and manufacturing. The population is predominantly (99%) white, there is a high level of owner occupancy (77.6%) and unemployment is below the national average. Of the 775 staff employed within the trust, 277 are nurses, 69 are doctors, and 135 are health care assistants or support staff.

5.2.2 NHS Performance

The annual operating costs for the PCT are around £114 million of which £100 million is spent on commissioning and £13 million on service provision. The trust has yet to receive its first formal inspection by the Commission for Health Improvement (CHI) but it achieved a 3 star rating in the July 2003 NHS performance ratings.

5.2.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

Patient Advice and Liaison Services (PALS) were established in April 2002, and are considered an integral part of the organisation's customer care programme. The trust actively welcomes the comments and views of users in order to improve both the services provided by the PCT and those commissioned from other organisations.

5.2.4 Complaints

In the year 2002/3 the trust received 64 formal complaints (not all nursing related), 94 % of which received a full response within 20 working days. The main areas of complaint were identified as staff attitude, behaviour and clinical treatment, and customer care training was initiated in response to these concerns.

5.2.5 The picture before implementing the modern matron initiative

Prior to the creation of matrons posts, the clinical areas had ward managers; these were individuals who were highly thought of and seen as leaders within the respective hospitals. These individuals were encouraged to apply internally for the new matron posts, they were not simply rebadged and through the selection process they had to demonstrate that they had the skills and abilities required for the matron role.

5.2.6 Mode of implementation

The Director of Nursing explained that back in the spring of 2002, the trust had intended to appoint a matron on each of the three hospital sites. Given the size of the respective hospitals it was anticipated that the matrons would be graded at H, with the sisters working on the wards and minor injuries units graded at F. It was recognised that the "hierarchy gap" arising between the F and H grades would require a review of the designated roles and responsibilities of both ward sister and matron.

Since the posts were introduced two have been filled by permanent staff, but following the promotion of the original third matron to another post within the trust, that post has been filled by a member of staff in an "acting-up" capacity. All three original matrons were already working within the trust as ward managers when they applied to become matrons. Although they were interviewed prior to appointment they had been involved in determining the job description and person specification for the new posts. They were subsequently each given responsibility for one of the hospitals within the trust overseeing between 23 and 59 in patient beds; the matron with the lowest number of beds also had responsibility for minor injuries services.

The main responsibilities of the role were to provide a PALS lead for the hospital sites, raise the profile of the hospitals and to develop a career structure for trained nurses within the trust below H grade. Each matron had managerial responsibility for up to five sisters / charge nurses and up to 30 qualified staff; in addition to nursing staff, the matrons were also directly responsible for clerical staff (receptionists) and ward housekeepers. They were managed by one of two general managers who had shared responsibility for the trust, and on professional matters they reported to the lead nurse.

Upon appointment the matrons were allocated their own office spaces on their hospital sites, in one case this was adjacent to the main reception area thereby promoting availability and visibility. The matrons were given a uniform but considered that they maintained a high level

of visibility by frequently being present in the clinical areas and given the layout of the hospital they could undertake such visits relatively frequently. Professional development opportunities were also made available to the new matrons prior to and following their appointment.

Since undertaking the fieldwork the acting matron is no longer in post and her role is being undertaken on a temporary basis by one of the other matrons.

5.2.7 Interpretation of the role

The two appointed matrons were interviewed as part of the study. They described their role as being managerially responsible for nursing, housekeeping and ward based clerical staff, but they both saw leadership of staff as an important requirement of the post.

One matron identified her role as providing clinical and professional leadership for these employees, she felt her key responsibilities were very much in line with the '10 key responsibilities for modern matrons' on which the job description had been based. The second matron stated that the main responsibility of the role was to oversee patient care in all areas of the hospital, and this in itself meant it was an all encompassing role.

It was evident that whilst the 10 key responsibilities had been used to determine the job description that there had also been scope for the matrons to modify their role as they felt appropriate.

5.2.8 Views on matrons' impact

The views of staff interviewed within the trust were very positive. Despite the strong consensus amongst those interviewed that the trust already performed well, the new matrons were seen by clinical staff as more approachable and likely to "get back to them" when concerns or problems had been brought to the matron's attention. The fact that the matrons now had managerial responsibility for the housekeeping staff was also seen as a positive development since this had created a more integrated team. It was particularly notable that both ward based staff and senior managers had a similar view of the value of the matron role. This "organisational consensus" was a strong characteristic in trust B.

5.3 Trust C: A Partnership NHS Trust (for mental health and learning disabilities care)

5.3.1 Background

This Partnership NHS Trust was established in June 2002 when the countywide Healthcare Trust and mental health social services, provided by the County Council, were brought together through a section 31 partnership agreement of the Health Act (1999) to create a new mental health, learning disabilities and substance misuse service for the county. The trust's three operational divisions share the same boundaries as three Primary Care Trusts (PCTs). The trust covers several thousand square miles and serves a population of over 600,000 with around 100 GP practices serving the community. There is a mix of urban and rural areas with a population that is predominantly white with fewer people from ethnic groups than the national average. The trust employs 2000 staff (wte) and annual financial turnover for 2003/4 is expected to be around £59 million.

A range of services are provided, including child and adolescent mental health services (CAMHS), assessment, care planning and treatment of adults with learning disabilities, older people's mental health services, primary care mental health services, specialist forensic inpatient provision, mental health and social care services for adults of working age, and substance misuse services for adults of working age. These services are provided both within the hospital setting and within the communities themselves. The services are delivered from over 40 premises by a multidisciplinary team of professionals including nurses, psychiatrists, social workers, community support workers, occupational therapists, psychologists and psychotherapists.

5.3.2 NHS Performance

The trust underwent a Commission for Health Improvement (CHI) inspection during 2003. The overall impression that CHI received was of an organization that had a strong commitment to further develop and deliver services to meet the needs of service users. The CHI report was mainly favourable and concluded that there was a strong leadership at senior levels to drive forward and build clinical governance into the organizational agenda. There was also a view that the trust was making progress in developing systems and procedures to allow staff to gain ownership of clinical governance. However the report did observe that there were a number of different cultures across the organisation, which were attributed in part to the recent merger but also to the diverse geography of the trust.

5.3.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

A Patient Advice and Liaison Service (PALS) is fully established and actively promoted. During 2003, the trust undertook a major review of its rehabilitation services for adults of working age. The results of this were collated into a report in January 2004 and the public are now being consulted on the recommendations arising from this review.

5.3.4 Complaints

Within the calendar year 2002-3 the trust received 131 complaints; response times have significantly improved during the course of the year with 70% now being responded to within 20 days. The trust also recorded an increasing number of compliments during the same period, which it believes is a consequence of the policy of encouraging service users to raise their concerns.

5.3.5 The picture before implementing the modern matron initiative

Prior to introducing matrons the units providing services across the trust had identified managers (unit managers); the focus of their managerial activity was mainly on staffing and clinical issues.

5.3.6 Mode of implementation

The Director of Nursing saw the modern matron initiative as an opportunity to develop the service. He believed that there would be a significant issue within mental health services around the matron terminology but felt that the potential benefits to the organisation outweighed this. Unit managers were invited to apply for matron posts and, with the exception of one; they were selected through a process of interview and presentation beginning in April 2002. The job title used within the trust was matron / unit (or ward) manager and the posts were graded at I with the exception of one post, which was graded at H (this post covered a single 16 bedded unit provided for adults with learning disabilities).

Successful applicants, once appointed, still had managerial responsibility for their home unit or ward but their matron duties were spread over a larger area, in some cases covering more than one of the base units within the trust (often the geographical area for which they were responsible was significant and this had an impact on the time spent travelling between sites). In due course the dual function attached to the job was identified as problematic in allowing the matrons to effectively fulfil their role.

5.3.7 Interpretation of the role

Postholders stated that they did not have a detailed job description. They were however given responsibility for introducing "Essence of Care", raising standards of cleanliness and improving the environment. There was a general feeling that the role had more of a clinical focus rather than a managerial one, and this was considered to be appropriate. Despite the logistical difficulties the new matrons met frequently and worked collaboratively to determine how they would meet this broad target and over what timescale; the group was also seen as invaluable for providing peer support and in due course established itself as an effective voice within the organisation.

Most of the postholders had managerial responsibility for between one and five ward sisters / charge nurses and up to 20 qualified nursing staff, with corresponding patient numbers of up to 50 (one matron dealt with up to 125 patients). Although the postholders had budgetary responsibility this was in line with their unit manager role and not as a matron. There was some provision made for clerical support but this was not considered to be comprehensive and in some cases matrons relied on ward clerical staff to provide this informally.

Matrons had some managerial accountability to the divisional manager for their geographical area but this arrangement appeared to be largely informal and the trust's director of nursing and clinical governance was the person to whom they reported directly. Some matrons saw this lack of clarity in line management as problematic.

5.3.8 View on matron's impact

The staff interviews revealed that, despite the geographical complexities of the organization, the introduction of matrons had been very successful. The importance attached to selection of individuals seemed to have been a crucial factor since the postholders were seen in a very positive light by staff within the units, with a strong emphasis on appropriate available support and effective leadership behaviours.

Some difficulties had been encountered where the desire of the matron to improve environments had been hampered by difficulties faced by the estates department. The trust occupied a number of sites and the impression was that the over reliance on services contracted from the private sector had made it difficult to respond to the new emphasis on better ward environments.

5.4 Trust D: An Acute Teaching Hospital

5.4.1 Background

This large acute teaching hospital occupies an extensive site a few miles from its city centre, surrounded by a mixture of post-war local authority estates and private housing, but not far from deprived inner city areas. The hospital premises are of mixed types and ages, many older "workhouse style" buildings having been gradually replaced over the past 30 years, but more remains to be done. Together with an outlying orthopaedic centre, a rehabilitation unit a couple of miles away and a satellite renal dialysis unit within a DGH in a town some distance away, the hospital group became a Teaching Hospital more than 30 years ago, and an NHS Trust in 1992. Its catchment population for general services is 650000, but for certain specialties it is a regional centre serving 2 million people. The population is ethnically mixed, with waves of immigrants from all parts of the Commonwealth arriving over the years as well as numbers of refugees from Eastern Europe during and after the second world war.

5.4.2 NHS Performance

The trust achieved 3 star rating in the 2002/3 NHS "league tables". It was reviewed for clinical governance by CHI in 2001 and received quite an encouraging report, with particular commendation for staff commitment and motivation. Some shortcomings were attributed to the need for further rebuilding. However, the need for a higher profile for patient involvement was stressed. So it is not surprising that two years later, when our case study took place, that researchers noted both very active patient involvement schemes, and a strong emphasis on quality and staff development – 80 senior members of nursing and midwifery staff have been through the RCN Leadership Programme.

5.4.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

The new Patient Advice and Liaison Service (PALS) became operational in the year 2002/3, and an innovative Patient Involvement Action Group (PIAG) canvasses patients for their opinions on care (both positive and negative) and makes sure concerns are remedied.

5.4.4 Complaints

In the period 2002/3, 350 formal complaints were received, compared with 418 in the previous year. The trust, in its Annual Review for 2002/3 attributes this fall not only to PALS but also to the work of the "modern matrons" (not the title used in the trust). In the three

quarters so far recorded in the year 2003/4, the number of complaints has fallen to 163, compared with 267 in the same period of the previous year.

5.4.5 The picture before implementing the modern matron initiative

In September 2001 the trust was restructured into four divisions – Medicine, Surgery, Family Health and Clinical Support. Each of the first three had a clinical director, a divisional nurse and a service manager and then a varying number of directorates within each division; most directorates had an overall Clinical Director and then several specialty teams. It was decided to institute the matron role (although not using the title) at that level; each specialty team is led by an Associate Clinical Director and a matron.

5.4.6 Mode of implementation

There were 20 matrons in all, nine in the Medical Division, seven in Surgical and four in Family Health. More than half of these were appointed late in 2001, after national advertisements were placed; over a quarter were appointed some months later and the remainder during 2003. The vast majority were on I grade for pay, with a few others on other scales due to individual circumstances. 75% of matrons replied to our questionnaire for all matrons in case study trusts; of the 15 respondents (all female), over half were in their 30s, nearly all the remainder in their 40s, with just one in her 50s. Most are of white British ethnicity with one of Caribbean origin. The questionnaire revealed variations in spans of responsibility and facilities offered. Over half of respondents were responsible for less than 100 patients on a daily basis, but the remainder were responsible for between 176 and 275 patients each. Similarly, two thirds of respondents managed up to 100 qualified nurses, but a third more than 141 qualified nurses. Nine of the 15 respondents were responsible for six or more wards or clinical areas, the rest for four or less. 80% of respondents had their own office space, but levels of secretarial and administrative support varied greatly, and not always in proportion to the span of responsibility. Two thirds of respondents believed there was clarity regarding their role and responsibilities, the remainder did not.

5.4.7 Interpretation of the role

When interviewed at the beginning of the project the Director of Nursing (DoN) stated that the matron roles were different from previous nurse manager roles, with the main objective being patient centred care. When appointing the matrons, the DoN was looking for candidates exhibiting leadership, vision, a passion for quality, change management skills and some financial management knowledge. The matrons were expected to be clinical experts, setting and monitoring standards, leading teams and developing staff. They had an

operational and corporate role as on-site managers, for trouble-shooting, and were all involved in checking and maintaining staff competency levels, clinical supervision, benchmarking care standards, and recruitment and retention. All matrons in post by April 2002 participated in the RCN Leadership Programme for one day each week, and there was a monthly forum where the matron postholders met with the DoN and the divisional nurses. The matrons met together without senior managers each month as well, for mutual support and problem solving.

5.4.8 View on matrons' impact

The DoN hoped that in a few years time, there would be measurable indicators of effectiveness such as improved complaints figures, better recruitment and retention of staff, lower sickness and absence statistics and improved communication at all levels.

5.5 Trust E: A District General Hospital

5.5.1 Background

Trust E achieved NHS trust status in 1993, and operates from two sites; most of the work is done at the medium sized district general hospital, which provides all medical, surgical, paediatric, obstetric and gynaecological services, and there is also a rehabilitation centre, located on a separate site. The trust serves a population of a quarter of a million; in an industrial town and its surrounding villages. The decline of heavy industry within the local area has left a legacy of above average unemployment and deprivation. The proportion of the local population belonging to ethnic minority groups was 2% according to the 1991 census.

5.5.2 NHS performance

The Commission for Health Improvement (CHI) reviewed trust performance between November and April 2001, focusing on four clinical teams. The Commission found committed, enthusiastic and keen leadership for clinical governance at senior level, with strong team working. They observed an open, friendly culture throughout the trust, ready to take on the challenge of the clinical governance agenda. The trust was considered to be strong in its provision of education and training opportunities, and in the management of its staff. The review concluded that there was work to be done in the areas of risk management and involving patients and other stakeholders in the business of the trust.

The Commission noted that in general, the hospital was very clean with some excellent signage. There was a friendly atmosphere, with staff pleasant and accessible to visitors across the board. Patients were generally very complimentary about the excellent nursing and medical care they received. It was noted that the trust had worked hard with other agencies on various strategies to ensure low levels of delayed discharge. However in many specialties, emergency re-admission rates were significantly higher than the national rates. Deaths in hospital within 30 days of surgery (all ages) for emergency admissions were among the highest in the trust's NHS hospital cluster and CHI found that the trust was not analysing clinical performance information and using it effectively to improve patient care.

The trust achieved a 3 star rating in the 2002/ 03 NHS "league tables" and this success was repeated in 2003/4. The trust scored particularly highly on clinical governance and risk management.

5.5.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

The Patient Advice and Liaison Service functions well, and has set up a number of user groups including one specifically for older people. In the in-patient survey carried out in the winter of 2003/4, there were improvements in several areas since 2002, and 90% of respondents would recommend the trust to others.

5.5.4 Complaints

The number of complaints has been reducing over recent years, and a full response was provided within the national standard of four weeks in 89% of cases, a marked improvement from the previous year.

5.5.5 The picture before implementing the modern matron initiative

Before implementation, at the end of 2001, the Director of Nursing met with all senior nurses to discuss matron appointments and key aspects of their role. It was planned that the specific targets set for each post holder would vary from individual to individual but overall there was to be a particular emphasis on clinical governance and maintaining a visible profile. The objectives set by the trust were to improve the patient experience, reduce complaints, reduce risk and implement "Essence of Care" indicators. The trust also established a voluntary and community health network to involve chairs of user groups in the modern matron initiative.

5.5.6 Mode of implementation

The first matron posts were created early in 2002 with further posts following in April of that year; a total of 18 appointments had been made by June 2002 (with the decision not to refer to post holders as modern matrons). The new posts were mainly graded H with the exception of two at G. The majority of matrons worked in the trust prior to appointment with a range of approaches being used to select and appoint them. Some post holders were selected by interview, whilst others were already considered to be doing the job of matron - these individuals were effectively "rebadged". An in-house development programme was provided by the trust for these staff.

5.5.7 Interpretation of the role

(This section relies on information from the matron survey, because it was not possible to conduct a full range of fieldwork, due to shortage of time).
In the matron survey, 15 out of the 18 matrons replied, a response rate of 83%**.** Of these 15 respondents (all of whom were female), four were in their 30s, eight in their 40s and three in

their 50s. Fourteen were of white British ethnicity and one Irish**.** Eighty percent had been in post for between one year and two, and 14 matrons (93%) were on H grade, with the other one on G grade. Two thirds were paid between £25,000 and £29,999, the remainder were paid between £30,000 and £34,999. All except one had been working in the trust prior to appointment in their present position. The majority of these matrons (73%) managed up to 10 sisters / charge nurses, whilst a small number of others identified larger areas of responsibility. With regard to the number of qualified nurses they managed, half managed 30 or less whilst the other half managed between 30 and 60 ward staff, in addition most of the matrons also had managerial responsibility for ward clerks and had some budgetary responsibility. A quarter of respondents were responsible for less than 50 patients on a daily basis, a fifth for between 51 and 100, but the remainder were responsible for between 101 and 225 patients each. In the survey, the matrons identified that they were accountable to the general manager of their directorate or to the director of nursing.

Amongst the five activities taking up most time in the two weeks before filling in the questionnaire, 87% listed meetings at trust or directorate level, 60% listed direct patient care and a similar proportion risk management and the processing of incidents, 40% listed educational or training activities or clinical supervision, an equal 33% listed personnel issues such as managing sickness absence and also administrative work, and 27% listed both ward staff support and dealing with complaints. Seventy three percent of respondents had their own office space, but levels of secretarial and administrative support were very low indeed; 27% had minimal support and 73% none at all. Only 11(37%) of respondents believed there was clarity regarding their role and responsibilities, the remainder did not. 63% said the trust provided funded education or training, and 80% said professional development opportunities were available.

The view of the matrons on the clarity of the role suggested that there was significant role ambiguity. Many commented on the "grey areas" between the role of matrons, directorate managers and ward managers. Others felt that they were being handed the jobs that "no one else wants or has time for", and many commented on the significant variation in responsibility that individuals had been given.

As outlined earlier (Section 3) it was not possible in this trust to undertake interviews with staff and explore the implementation of the matron in greater depth. However comments in the survey questionnaire reveal a clear dissatisfaction with the way the matron posts were introduced. This principally concerned uncertainty about the responsibilities of the job but

there was also dissatisfaction associated with perceived differences in workload within the role set.

5.5.8 Views on matrons' impact

The clinical governance manager in a personal communication reported that matrons had made a significant impact in care of the elderly, particularly in reducing risk and improving patient education programmes. More generally matrons had successfully revised the "patients' comments cards" and played a constructive part in reviewing incidents and complaints and improving environmental conditions. Unfortunately in some clinical areas, funding for matron posts was not forthcoming without drawing on existing establishments and so some ward staffing levels were depleted.

5.6 Trust F: An acute teaching trust

5.6.1 Background

Trust F, an acute, teaching trust with nearly 2000 beds, was created in 2000, bringing together into one organisation three hospitals which each had a distinct culture. The trust has 12 clinical directorates, organised round specialty groupings. Each hospital houses regional or sub-regional specialties, and the city centre hospital has a busy A&E department. The second hospital three miles from the centre has a mixture of old and new buildings on a very large site, and the third hospital, slightly further away, is modern. The trust has an annual operating income of over £400 million, and serves a population of over one million; living partly in a city which is ethnically very diverse and has pockets of deprivation, and partly in affluent rural areas.

5.6.2 NHS Performance

The trust failed to achieve any stars in the ratings for the 2002/3 NHS "league tables", but improved dramatically in 2003/4 to three stars. The trust was reviewed by CHI in 2002, and was commended for its commitment to high quality care and encouraging patient involvement in decision making within the trust. CHI found a culture that valued learning through formal education and research and noted that senior nurses were improving staff morale and empowerment and were active in ensuring that patients' needs and wishes were met. They also noted good standards of cleanliness.

5.6.3 Patient Advice & Liaison Service (PALS) and Public &Patient Involvement (PPI)

The trust established its Patient Advice and Liaison Service (PALS) in 2002. The PALS team members include a Voluntary Services Co-ordinator, an Information Co-ordinator, a Bereavement Adviser and a Service Equality Manager. The trust published its Patient and Public Involvement Strategy in 2003, and is currently developing its system of patients' forums.

5.6.4 Complaints

This very large trust received 1122 formal complaints in the year 2003/4. Seventy nine percent of these were dealt with fully within the recommended 20 day period, an 11% improvement on the previous year.

5.6.5 The picture before implementing the modern matron initiative

Because the matron initiative began soon after the integration of the three hospitals into one trust with a new overall Director of Nursing, it was not possible to gain a picture of the situation before implementation. This difficulty was increased because it was not possible to conduct a full range of fieldwork, due to shortage of time.

5.6.6 Mode of implementation

Matrons began to be appointed from December 2001 onwards, and at the time of the study numbered 44 in all, over the three sites. Many posts were re-designated from existing ones, and the title of matron was not used. A modern matron project group developed a competency framework for matrons (with a strong clinical focus) to provide guidance for training and education. The Director of Nursing believed that three key areas (patient experience, staff perceptions and clinical standards) would reflect expected improvements through the modern matron initiative

5.6.7 Interpretation of the role

(This section relies on information from the matron survey, because it was not possible to conduct a full range of fieldwork, due to shortage of time.)

In the matron survey, 30 out of the 44 matrons replied, a response rate of 68%. Of these 30 respondents (27 of whom were female), 11 were in their 30s, with 12 in their 40s and seven in their 50s. Seventeen were of white British ethnicity and one Irish; the remaining 12 respondents did not reply to this question. Forty three percent had been in post less than a year, and 83% were on H grade, with the remainder on I grade or not answering the question. Half were paid between £25,000 and £29,999; the remainder were paid between £30,000 and £34,999. All had been working in the trust prior to appointment in their present post. Amongst the five activities taking up most time in the two weeks before filling in the questionnaire, 83% listed direct patient care, 63% listed ward staff support and 57% meetings at trust or directorate level. Twenty percent of respondents are based on more than one site. The questionnaire revealed variations in spans of responsibility and facilities offered; 43% of matrons in Trust F were responsible for three or less wards or clinical areas, 40% for between four and six, and 17% for between seven and twelve ten wards or departments. Seventy seven percent of matrons line-managed five or fewer sisters or charge nurses, and 60% 30 or fewer staff. Forty three percent of respondents were responsible for less than 50 patients on a daily basis, 27% for between 51 and 100, but the remainder were responsible for between 101 and

225 patients each. Seventy seven percent of respondents had their own office space, but levels of secretarial and administrative support varied greatly; one had a full time secretary, ten (33%) had part-time assistance, often shared, 11 had minimal support and eight (27%) none at all. Only 11(37%) of respondents believed there was clarity regarding their role and responsibilities, the remainder did not. 63% said the trust provided funded education or training, and 80% said professional development opportunities were available.

5.6.8 Views of matron impact

The Trust Board obviously believes that matrons (although not using the title) have helped improve the clinical process for patients because in their plans for 2004/5 they state their intention to recruit more matrons "to provide clinical leadership".

The matrons themselves give a mixed picture in their questionnaire responses. Some are enthusiastic about the combination of clinical and managerial roles and their potential to improve services, whilst others feel overloaded and as though higher levels of management pass on any task to matrons when they do not know what else to do with it.

5.7 Trust G: A district general hospital

5.7.1 Background

The trust came into being in 2001. The district general hospital had beds largely on one site, with patient services organised into 6 directorates. It provided hospital services to a highly diverse population (total 450,000), with the proportion of ethnic minorities, for example, more than three times the national average. There were also high numbers of refugees and asylum seekers. Deprivation levels varied within the region and local illness and death rates were lower than the national average.

5.7.2 NHS performance

The trust attained a one star rating in both 2001/2 and 2002/3 NHS Performance Ratings but this disguised improvements. In the previous year, the trust needed to attain only 6 out of 9 targets to achieve a one-star rating, whereas in the more recent assessment, they achieved eight out of nine targets and therefore fell just short of two stars.

In 2002, problems identified by CHI included the maintenance of privacy and dignity and unsatisfactory methods for dealing with complaints (both issues relevant to matrons). At the same time, the attitude and loyalty of staff were acknowledged and significant improvements were noted in infection control, and in communicating with patients and staff.

In terms of other DoH indicators, the trust has done well in terms of the low percentage of children readmitted within seven days of discharge; compliance with NHS guidelines on junior doctors' hours; and seeing 100% of new patients with potential angina within two weeks of GP referral.

5.7.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

A Patient and Public Involvement (PPI) strategy and Patient Advice and Liaison Service (PALS) were launched in May 2002. Subsequently, a PPI manager was appointed to help circulate information trust-wide, relay the views and ideas of patients to staff, and publicise useful initiatives and best practice. The PAL service helped more than 1,000 patients in the year April 2002 –3 and a local Patients Panel has provided direct input on specific problems and developments.

5.7.4 Complaints

Between April 2002 and March 2003, the trust received 394 complaints, a reduction of 11.3% on the previous year. This continued the overall downward trend characteristic of the previous two years. There were 98 complaints in the first quarter of 2003/4, compared with 113 during the same quarter in 2002/3. The main reasons for complaint in the first quarter of 2003/4 were all aspects of clinical treatment (23%), outpatient appointment delays and cancellations (14%), and attitudes of staff (13%). This represented an improvement on the corresponding quarter in the previous year for clinical treatment (31%), while complaints about outpatient appointment problems were at almost the same level as before, and complaints about the attitude of staff were previously lower (8%).

5.7.5 The picture before implementing the modern matron initiative

When the trust was reconfigured in 2001, nursing morale was low and there was a perception that the service had lost the confidence of patients. There was little emphasis on practice development. An impending CHI visit was focusing attention on standards of care. A new Director of Nursing (DoN) came into post and the Chief Executive agreed to invest in a new tier of senior nurse management. It was therefore a good time to review nursing structures and to plan the introduction of matron posts.

5.7.6 Mode of implementation

After a consultation process including staff and patients, an initial pilot was set up in which matrons were given clear targets such as improving ward environments and standards of nutrition and giving priority to achieving visibility and negotiating a contract with ward sisters about role boundaries and expectations. The success of this pilot scheme helped to reduce resistance to the matron role that had been prevalent across the trust, particularly from existing ward managers. The initiative was fully implemented across the trust through a 'big bang' approach in which senior nurse posts were replaced by18 matrons who all took up their posts in the trust on the same day. Posts were filled mostly by H grade nurses or G grade ward sisters, although a few matron posts with more extensive responsibilities were graded at I. According to findings from our Directors of Nursing survey, eleven of the trust's matrons (by this time n=20) fell into the salary band of between £30,000-34,999 p.a. and had a clinical grade of H, while were employed at I grade and were in the band of between £35,000-39,000 p.a.

Our survey of matrons in the trust (n=10) indicated that the majority managed up to five ward sisters or charge nurses, while their span of responsibility for patients varied enormously: two

matrons for example were responsible for up to 25 patients at any one time, while one was responsible for between 226 and 250 patients.

5.7.7 Interpretation of the role

At the time of the annual report on modern matrons (2002/3), there were 20 matrons in post across the trust. In our survey of matrons, many reported a lack of clarity about the nature and extent of matrons' responsibilities. Initially, matrons had focused on the standards of care, particularly emergency care. This had led to a significant increase in operational activity at the expense of time in the clinical area. Matrons were seen as fundamental in ensuring the trust met its targets (e.g. 96% of patients seen within 4 hours in A & E) and NSF requirements (e.g. setting up a Rapid Access Chest Pain Clinic and a Chest Pain Assessment Team). Our survey found matrons were often involved in new and unfamiliar activities such as budget and financial planning, directorate workforce planning, purchasing and organising contracts for equipment and corporate responsibilities.

5.7.8 Views on the matrons' impact

The role was seen to have brought results that were not as tangible or as easy to quantify as meeting targets. Matrons were thought by PALS, PPI and senior nursing staff to have significantly reduced the number of complaints received, and had done important work through their involvement in patient forums. Standards of food had improved as a result of a number of matrons working collectively with representatives from different departments, such as Facilities. Standards of cleaning had proved more difficult to improve, partly because of a high turnover of staff. No matrons in the study were directly involved in negotiating contracts for domestic or catering services with external service providers.

5.8 Trust H: An acute teaching hospital

5.8.1 Background

Trust H is an acute, teaching trust which provides a range of secondary and tertiary clinical services from two sites (recently reduced from three). It has 1,200 in-patient beds, and its local catchment area includes inner city and suburban areas; patients are referred from much further a-field for highly specialised care. The trust employs a total of 5,000 staff, including over 1,800 nurses.

5.8.2 NHS performance (2003)

- overall mortality index: 89.8 (low)
- staffing levels: 59.4 doctors per 100 beds; 152.5 nurses per 100 beds
- two stars in latest NHS performance ratings
- PEAT results for hospital cleanliness in three sites: all 'acceptable'
- PEAT results for hospital food in three sites: all 'acceptable' (one moved up from 'poor' in 2002.

A full CHI review (early 2003) found that the trust's staff was motivated and enthusiastic about providing high quality care to patients, and that the trust provided good opportunities for staff training and development. It was, however, finding it difficult to comply with the New Deal for junior doctors' hours. The report praised the good start the trust had made to developing structures for clinical governance, but identified weaknesses in systems of clinical audit. The trust scored highly for improvements in reducing the rate of MRSA infection. The review was highly critical about the way in which privacy and dignity for some patients was compromised on some mixed-sex or Nightingale-style wards. In the A&E department, patients often experienced long waits before being assessed, and many had to wait on trolleys in full view of staff and other patients. Public areas were often cluttered with equipment, and the standards of cleanliness and maintenance were found to be poor in some areas. (Since the CHI report, the trust has succeeded in reducing waiting times in A&E and has scored highly in a PEAT assessment of the A&E department.) The report was particularly critical of the dangerously inadequate system for managing clinical waste.

5.8.3 Patient Advice& Liaison Service and Public & Patient Involvement (PPI)

The trust has a well-regarded Patient Advice & Liaison Service, originally established as one of 12 national pilots.

5.8.4 Complaints

- complaints per 1000 patients admitted: 6.3
- percentage of written complaints receiving a full response within 20 working days: 56.3%

The trust's latest annual report attributes the rise in the number of complaints received during 2002/03 to its improved procedures, which ensure better central reporting of complaints, better staff awareness and easier access for complainants to the complaints process

5.8.5 The picture before the implementation of the modern matron initiative

The deputy Director of Nursing expressed the opinion that, because this type of trust has extra income from tertiary services, it retains more flexibility in funding its nursing establishment. Consequently, the trust had managed to retain a tier of highly-experienced nurses during the 1980s, a time when there was a high attrition rate of senior posts in many NHS hospitals. It had established a system of management posts at clinical level (H grade 'senior sisters' or I grade 'nurse managers') which pre-figured the matron role.

5.8.6 Mode of implementation

The trust was an 'early implementer' of the modern matron initiative. The first two matrons were appointed in the surgical directorate, when two senior nursing posts became vacant. The deputy DoN developed core competencies and a generic job description (based closely on the Department of Health guidance) and these have continued in use with slight modifications according to specialism. Following this, nursing structures across other directorates and sub-directorates were reviewed and standardised and 35 matron posts were established across the trust. Originally, the trust had wanted matrons to spend 50% of their time in clinical care; but over time this has proved unfeasible. In the main, matrons worked within the boundaries of one specialist sub-directorate, but a few matrons worked across these boundaries.

Consequently, only two of the new matron posts were advertised externally, the rest were filled after in-house staff only had been invited to apply. Three quarters of the matrons are on grade H, with the rest on grade I. Initially, matrons were managed operationally by senior nurses within directorates; a recent restructuring within the trust means that matrons in some directorates are now operationally accountable to general managers. They remain directly accountable professionally to the Director of Nursing, through the Deputy DoN. In their turn, matrons line manage ward sisters and maybe a few other staff, such as ward clerks or clinical nurse specialists. The number of staff line managed by one matron ranges from five to ten, and the number of clinical areas covered by one matron varies from one unit (such as ICU) to six wards.

5.8.7 Interpretation of the role

Since the first matron posts were established, they have been kept under review, although not formally evaluated. Some adjustments have been made to individual responsibilities with an additional 'assistant matron' being appointed to share the burden of an exceptionally busy clinical area. At one stage, serious consideration was given to merging the role and responsibilities of matrons with those of business managers in sub-directorates, because of the apparent overlap in their functions. This idea was not pursued, although there have been other major restructuring exercises involving nursing roles at a senior level. The gradual establishment of nurse consultant posts in the trust meant that clear guidelines had to be developed so that they and the matrons could complement each other's role. Broadly, this means that nurse consultants are responsible for developing evidence-based guidelines for practice, whilst matrons are responsible for ensuring that nurses implement the guidance.

The matrons wear a special uniform, with a practical version for when they are involved in direct care. The trust invested extra resources for this purpose, as well as for administrative support and office facilities (although visits suggest that these are still not adequate in some cases). The trust has consistently invested in leadership training for its ward sisters and matrons. The first wave of matrons attended an induction course specifically organised for them; more recently, new matrons have joined courses with managers from other departments, which they find a valuable way of making personal contacts. The trust is in the course of inaugurating a new project to devolve more authority to its G grade ward sisters. This is partly because the sisters themselves want to put into practice the leadership skills they have acquired, and partly because responses to the National Patient Survey suggest that the public wants ward sisters to have a higher profile and more authority.

5.8.8 Views on matrons' impact

Senior nurse managers are very pleased with the impact of matrons. As a group, they have been proactive in forging close links with department such as Estates and Facilities, and in improving the standards of domestic cleaning in the hospital. A recent PEAT assessment in the A&E department produced a top score, attributed by the Director of Nursing to the influence of the trust's matrons, who had been instrumental in getting the contract for domestic cleaning awarded to a new provider. On an individual level, matrons are considered to have improved standards of care, particularly in the care of older patients, by conducting *Essence of Care* audits for pressure ulcer prevention and nutrition. However, there is real anxiety that matrons might end up with so many operational responsibilities within the

organisation that they lose the initial, clinical focus of the role. The DoN has identified the need to develop rewarding career pathways for nurses who go into matron posts.

5.9 Trust I: A specialist mental health trust

5.9.1 Background

Trust I is a specialist mental health trust, created four years ago from a merger of services formerly provided by three separate trusts. The new trust established four geographical directorates in order to integrate with the relevant local authority social services areas. It has five other service-based directorates (for example, child & adolescent services and addictions services) which span geographical boundaries within the trust. One of the major initial challenges faced by the trust was the implementation of the national service framework (NSF) for mental health. It provides mental health and substance misuse services for people in four local authorities, which cover both inner-city and suburban areas and include some pockets of extreme social deprivation. The trust also provides some specialist mental health services for people from across the UK. It operates from a total of 183 sites, with in-patient services concentrated on six main sites; some smaller in-patient facilities are lodged within hospitals belonging to other NHS trusts. Due to the number and age of many of its buildings, the trust has a huge maintenance bill and a backlog of routine work which needed to be done to meet health and safety requirements.

5.9.2 NHS performance

In July 2002, the Commission for Health Improvement (CHI) conducted a review of the trust's adult health care provision in two local authority areas, as well as its overall performance in relation to ease of access by people with specific needs, such as homelessness. It found that the trust had made good progress in establishing management structures and lines of accountability, both between the trust board and directorates and within the different directorates. It had made a good start on developing systems for clinical governance. Some services had been successful in establishing good working partnerships with service users and service user groups, and involving service users in research and the research process as advisors.

On the negative side, the trust was required to take immediate action to: ensure safe practice and reduce stress levels amongst staff and service users in areas where there were staff shortages; improve the complaints procedure for service users; and review service users' access to support workers such as care managers and advocates. It was advised that it should try to ensure that its patient and public involvement policy was fully integrated into practice, and that it should develop an action plan to ensure systematic involvement of carers in all aspects of service planning and delivery.

5.9.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

At the timer of the report, the trust was finalising its strategy for these services. The trust has demonstrated its commitment to involving service users and carers in research projects, and it involved them in discussions about the 'modern matron' initiative.

5.9.4 Complaints

Patient complaints were increasing, with a total of 586 for the previous year. 77% of the total came from in-patient or residential services, and 54% of the total from the 'adult' acute wards. The majority of complaints were about waiting times and issues of poor staff-patient communication. Only 44% of complaints were responded to within 20 working days (since these figures were recorded, the trust's Complaints Department has been re-structured).

5.9.5 The picture before implementing the modern matron initiative

The trust was commended for its staff training & development in an recent Improving Working Lives review. However, it has a history of difficulty with recruiting and retaining nurses for acute adult in-patient services, made more difficult by the expense of travel and accommodation in a large city. Staff shortages and reliance on agency nurses caused concern about standards of nursing care in some areas.

5.9.6 Mode of implementation

The initial reactions of nursing staff were mixed, and largely negative, particularly to the title 'matron'. A reconfiguration of services in one directorate offered the opportunity to pilot a 'modern matron' post, following discussions with service users and staff. The success of the pilot stimulated interest in other directorates. The Director of Nursing made a positive and proactive response to the initiative by drafting out a paper containing implementation proposals and costs for the trust board. In such a large and complex organisation, it was judged inappropriate to develop a generic job description, or to prescribe the role in too much detail. The only common feature was that all matron posts should be at 'I' grade, or equivalent. Seventeen 'first wave' matron posts were established, with different directorates taking their own approaches to establishing the role and lines of managerial and professional accountability. This meant that the posts were a mixture of new, 're-badged', and re-designed models.

Early matrons were appointed from existing staff, following written application and interviews. The trust routinely sent all staff in leadership posts on the Leading Empowered

Organisations (LEO) programme, so most of the new 'matrons' had already attended this course. On one of the larger hospital sites, one of the matrons was made responsible for co-ordinating her colleagues. The same person (promoted to a more senior grade) later took on the responsibility for co-ordinating all the trust's matrons. Recently, two matron vacancies were advertised externally; the quality of applicants was high and – in a break with most of the early matron appointments - the successful applicants were in jobs removed from clinical practice, one being a nurse educator and the other a social worker.

One of the trust's intentions was to minimise the line management responsibilities of matrons. These are affected by the type of services in which the matrons work: those matrons with in-patient areas tend to manage ward leaders and possibly a few senior staff nurses, whilst those who cover community-based services area manage larger multi-disciplinary teams. Professionally, all matrons are accountable to the Director of Nursing, through the Deputy DoN, who meet with trust matrons and other senior nurses every two months. Matrons are accountable to general mangers for the operational aspects of their work.

The matrons are encouraged to meet as a peer group and to learn from each other, particularly in view of the lack of standardisation in their roles. However, the large distances involved and the pressure of work makes it difficult for matrons to attend group events. At the beginning of 2004, it was decided to re-classify four 'I' grade management posts in one geographical directorate as 'modern matron' equivalents. Two of the new matrons are trained social workers and two are trained nurses.

5.9.7 Interpretation of the role

The cross-trust variation in job titles and value of the matron role within the organisation is being recognised, and the trust is looking to its matrons to help meet corporate targets for improving the patient environment, involving services users in service planning, reducing formal complaints, improving infection control and strengthening clinical governance. The emphasis on these 'systemic' aspects of quality opens up the possibility that the trust may appoint future matrons from the ranks of other heath professions as well as nursing.

5.9.8 Views on matrons' impact

In 2003, matrons were invited to complete a questionnaire assessing their own performance. This showed that the majority thought they had made most impact on supporting ward managers/team leaders (this was confirmed in conversations with ward leaders and other nurses), but had found it more difficult to make an impact in areas such as improving the

environment, or supporting service users and carers. The comments of senior staff in the trust about matrons' impact were very favourable, but there was general agreement that the boundaries between the matron role and other nursing roles across the trust should be made clearer. Early in 2004, an away-day for all matrons was organised; one of the outcomes of the day was the development of a more sophisticated assessment tool for matrons and their managers to use to evaluate performance.

5.10 Trust J: A primary care trust

5.10.1 Background

Trust J, a primary care trust, was established in late 2000 to provide community nursing services including specialist services; community based child health services, child and adolescent mental health services; learning disability services; and local adult mental health services. In addition, the trust had established a community hospital with in-patient service, rehabilitation unit, and physical disability services including medical loans; podiatry, speech and language and occupational therapy services; a family planning service and a community dental service.

The trust provided services to an estimated population of 240,000, registered with approximately 30 General Practices. The population was on average younger than the rest of the country and was rapidly expanding. Deprivation levels varied within the region and the local authority ranked roughly midpoint on the National Index of Deprivation 2000. There was however almost full employment in the area, a factor that, together with high house prices, has increased problems of staff recruitment and retention for the trust.

5.10.2 NHS performance

As of October 2003 there had been no CHI review of the PCT. It was star-rated for the first time in 2002/2003 and received no stars for its community services. The trust was rated on nine performance areas for community service and achieved its targets in five of them. The trust's annual report argues that missed targets represented a capacity rather than a competency issue, as the city's health budget had seriously lagged behind the rapid population growth.

5.10.3 Patient Advice & Liaison Service (PALS) and Public & Patient Involvement (PPI)

The trust was in the process of setting up a Patient Advice and Liaison Service and appointing a Public Involvement and Liaison manager during the study.

5.10.4 Complaints

Between April 2002 and March 2003 the trust received 73 complaints, a reduction of 11.7% on the previous year. The highest number of complaints in the 2002/3 period concerned equipment, appliances and premises (36%); aspects of clinical treatment (21%); and attitudes

of staff (19%). In the previous year, the main cause of complaint had been attitude of staff (31%), with complaints about premises and equipment at only 6%.

5.10.5 The picture before implementing the modern matron role

At the time of the matron's appointment, the community hospital was facing a number of problems, partly stemming from its isolation. The hospital was relying on relatively junior nursing staff, with, for example, few G grades. There had been major investigations into a charge of racism amongst staff and standards of care. The hospital premises had been poorly maintained, fire safety was inadequate and health and safety in general was poorly monitored. In addition, there were no development plans for staff, training for managers and no system of appraisal. Problems had been identified with staff attitudes, punctuality, workloads and planning of annual leave. On taking on the role, the matron had to manage a very difficult period in which many staff left the hospital and among those who remained, a number had to be performance managed.

5.10.6 Mode of implementation

Matron posts were introduced through gradual, staged implementation and not part of an overall restructuring of nursing services. There were two matrons within the trust, (one I grade and one G grade) covering community and day hospitals and mental health services. Salaries were on the band £25,000 to £29,999 pa.

One of the matron posts was newly created, with both external and ‘in-house’ staff invited to apply. The second post was newly created with only ‘in-house’ staff invited to apply. There was no difficulty in filling the posts.

While the trust invested extra resources for mentorship arrangements and action learning programmes, these were not provided by ‘new money’.

5.10.7 Interpretation of the role

Matrons were, in principle, managerially accountable to the Director of Service (Primary Care) or the Head of Service (older people’s mental health), and professionally accountable to the Chief Nurse (also the Director of Service) or the Head of Service. However, we found that the line manager (and their area of responsibility) for the matron interviewed in our study frequently changed.

Our case study focused on the matron responsible for the community and day hospitals (I grade), who had been in post for 19 months. She had her own office and was supported by a personal secretary (20 hours per week), with access to a senior administrator. She had full responsibility for the community hospital (50 beds at the time of the modern matron survey but about to be reduced to 30) and a day hospital for older people (about 10 miles away), with a particular focus on rehabilitation and intermediate care. On appointment, this matron was given targets of efficient bed usage and occupancy, and developing referral and admission criteria. In addition, she set her own targets of Essence of Care benchmarking, developing accountability and leadership within the team, budgetary management, and recruitment and retention of staff (in the face of considerable vacancies). This matron managed seven ward managers (F and G grades), 26 D and E grade registered nurses, 6 rehabilitation assistants, seven health care assistants and one housekeeper. Split sites and the work associated with restructuring the service (including bed reductions) meant that it was difficult to maintain visibility to patients, although our matron tried to work a clinical shift once a fortnight. In future, following service redesign, the matron would become responsible for negotiating domestic and cleaning contracts.

5.10.8 Views of matrons' impact

Formal evaluation of the matron role in the PCT had not been arranged. According to the Director of Nursing survey data, the matron role was thought to offer a model for the development of services that put the patient/client first. The role had helped to increase the visibility and credibility of core nursing skills. Clinical nurses told us that staff felt better informed about developments in the trust and new policy initiatives. There was a new emphasis on staff development and clinical supervision and standards. It was thought standards of care were improving, especially in terms of nutrition and safety. However, it had been difficult to deliver quickly enough on all the opportunities that this role offered and there were indications that front line staff had found the working environment harder as result of changes associated with the matron role, especially given the pressure that services were already under.

Table 6: Trust profiles and comparative data

	Trust A	Trust B	Trust C	Trust D	Trust E	Trust F	Trust G	Trust H	Trust I	Trust J
Type of Trust	DGH	PCT	Mental Health & Learning Disability	Teaching	DGH	Teaching	DGH	Teaching	Mental health	PCT
Population	400,000	130,000	700,000	650,000	250,000	1,000,000	450,000	650,000	1,100,000	250,000
Beds	600	110	440	1000	850	2000	850	1200	930	110
2002/3 NHS Performance Ratings	***	***	**	***	***	0	*	**	***	0 Community
Overall mortality rate (Nov 2003)	100	70		85	100	103	105	90		
Staff WTE	2500	780	2000	5000	3000	10,000	2500	5000	5000	1300
Percentage of staff who are nurses	80% staff involved in direct pt care	70% staff involved in direct patient care		70% staff involved in direct patient care			70% of staff involved in direct patient care		57% Nursing & HCAs	46% of staff involved in direct patient care
Nurses per 100 beds (Nov 03)	135			130	110	115	94	153		
Annual turnover (millions)	£100m	£102m	£60m	£215m	£207m	£410m	£145m	£202m	£170m	£170m
PEAT score (environment)	Good	Good	Good	Acceptable	Good	Good	Acceptable	Acceptable	Good	N/A
PEAT score (food)	Acceptable	Acceptable	Acceptable	Acceptable	Acceptable	Good	Acceptable	Acceptable	Good	N/A

Trust	Response rate to matron survey within individual trusts *	Speciality	Key contact interviews	Diary	Shadowing	Patient Questionnaires
Trust A Acute 4 trust wide interviews 2 matron meetings	n = 12 response = 10 response rate = 83%					
Matron 1		Medical	4	Yes	No	Yes
Matron 2		Surgical	3	Yes	No	No
Matron 3		Emergency Admissions	0	No	No	No
Trust B PCT 4 trust wide interviews 1 matron meeting	n = 2 response = 2 response rate = 100%					
Matron 1		Hospital 1	4	Yes	No	Yes
Matron 2		Hospital 2	3	Yes	No	Yes

Trust	Response rate to matron survey within individual trusts *	Speciality	Key contact interviews	Diary	Shadowing	Patient Questionnaires
Trust C Mental health and learning disability 2 trust wide interviews 1 matron meeting	n = 7 response = 5 response rate = 71%					
Matron 1		Learning Disability	1	Yes	No	No
Matron 2		Elderly and Rehab MH	2	Yes	No	No
Matron 3		Acute MH	6	Yes	No	No
Trust D <u>Acute</u> 3 trust wide interviews 1 matron meeting	n = 20 response = 15 response rate = 75%					
Matron 1		Sexual Health	2	Yes	No	No
Matron 2		Renal	11 questionnaires	Yes	No	Yes
Matron 3		Rehabilitation	7	No	No	No

Trust	Response rate to matron survey within individual trusts *	Speciality	Key contact interviews	Diary	Shadowing	Patient Questionnaires
Trusts E Acute	n = 18 response = 15 response rate = 83%	At each trust one matron meeting was visited. Only questionnaires distributed, no interviews were conducted.				
Trust F Acute	n = 44 response = 31 response rate = 70%					

Trust G Acute 4 trust wide interviews.	n = 21 response = 10 response rate = 48%					
Matron 1		Paediatric Emergencies	5	No	No	No
Matron 2		Midwifery	4	Yes	No	No
Matron 3		Intensive Care	4	No	Yes	No

Trust	Response rate to matron survey within individual trusts *	Speciality	Key contact interviews	Diary	Shadowing	Patient Questionnaires
Trust H Acute 6 trust wide interviews	n = 30 response = 22 response rate = 73%					
Matron 1		Acute and Respiratory Medicine	5	Yes	No	Yes
Matron 2		Paediatric Medicine and Surgery	4	Yes	No	Yes
Matron 3		Oncology	3	No	No	Yes
Trust I **Mental health** 4 trust wide interviews	n = 20 response = 10 response rate = 50%					
Matron 1		Acute Mental Health	4	No	No	Yes but none returned
Matron 2		Affective Disorders	4	No	No	Yes but none returned
Matron 3		Eating Disorder Service	4	Yes	No	Yes

Trust	Response rate to matron survey within individual trusts *	Speciality	Key contact interviews	Diary	Shadowing	Patient Questionnaires
Trust J **PCT** 1 trust wide	n = 2 response = 1 response rate = 50%					
Matron 1		Intermediate Care and Rehabilitation	5	No	No	Yes

*

Questionnaires were either mailed directly to matrons in each trust or distributed personally at matron meetings, except in trust I where distribution was undertaken by the Deputy Director of Nursing.

Table 8: Profile of matrons and key contacts in case study trusts

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST A						**Trust-wide** Director of Nursing; General Manager, Central Services; Head of Clinical Audit & Clinical Governance Support; Patient & Public Involvement Co-ordinator.
Matron 1	Senior Management Pay Scale, Grade 27	Female	6 acute medical wards, Coronary Care Unit, 4 Medical OPD areas including GU unit, endoscopy suite, anti-coagulant service	Medical	10 months	Senior Sister, CCU; Senior Sister, Medical Unit; Practice development advisor; CNS Infection control.
Matron 2	H	Female	7 surgical and orthopaedic wards, day surgery ward, surgical OPD, including pre-assessment, orthopaedic, ophthalmic, ENT, and maxillo-facial clinics, and Nurse Practitioner team	Surgical	9 months	Clinical Educator; Matron ITU / HDU; Senior sister, Surgical Ward.
Matron 3	H	Female	Emergency Management Unit	Emergency Medical Admissions	2 months as matron, but was senior nurse in same area	Contacts not provided: EMU opening delayed

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST B						**Trust-wide** Director of Nursing; Hotel Services Manager; Clinical Governance Officer; PALS officer.
Matron, Hospital 1	H	Female	2 wards	Medical elderly, Orthopaedic rehabilitation for elderly, Day care unit for elderly.	15 months	Hospital 1: General manager; Operational Service Manager G grade sister; F grade staff nurse.
Matron, Hospital 2	H	Female	1 ward, Minor Injuries Unit (MIU) and Out Patients Department.	Medical/ Minor Injuries Unit	15 months	Hospital 2: General manager; 2 nurses.

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST C						**Trust-wide:** Director of Nursing; Estates manager.
Matron 1	H	Female	4 x 4 bedded bungalows	Adults with Learning Disabilities	10 months	Learning Disability Unit: Nurse/Lecturer Practitioner.
Matron 2	I	Female	2 Rehabilitation Mental Health wards 1 Day hospital (Elderly)	Adult Mental Health	10 months	2 ward nurses.
Matron 3	I	Female	Mental health 4 In-patient units (Adult and child) 1 Day Hospital, 1 Resource Centre	Adult, Adolescent and Child Mental Health	15 months	3 Unit managers; Complaints manager; Staff Nurse Resource Centre; Human Resource manager.

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST D						**Trust-wide:** Director of Nursing; PALS Officer; Assistant Director of Nursing.
Matron1	H	Female	Sexual health department, OPD	Sexual Health	18 months	Clinical Director (Sexual Health); Nurse Consultant.
Matron 2	I	Female	Renal HDU, Nephrology ward, 3 Dialysis units, Renal OPD	Renal Services	18 months	Too difficult to arrange interviews so 11 senior clinical nurses filled in questionnaires.
Matron 3	I	Female	3 Rehabilitation wards, 2 Stroke Units, 1 day hospital, 1 Neuro-Rehabilitation Unit	Rehabilitation, elderly, neurological and stroke services	13 months	2 Ward managers; Clinical co-ordinator; Practice Development Nurse; Head of Physiotherapy; Head of Occupational Therapy; Physiotherapy Clinical Specialist
TRUST E **TRUST F.**	**No detailed case studies**					

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST G						**Trust wide:** Director of Nursing; Infection control lead; Estates manager; Domestic supervisor .
Matron 1 (Left trust during study)	H	Female	Accident and Emergency	Paediatric emergency service	12 months	Senior staff nurse; Paediatric consultant; Senior sister; Junior sister; Health Care Support Worker.
Matron 2	I	Female	Midwifery	Antenatal care and community	7 months	Director of Midwifery Services; Community child protection midwife; Ante-natal Clinic Sister; Obstetric consultant.
Matron 3	H	Female	Intensive Care Unit (ICU)	Intensive care unit and 3 surgical wards (temp)	12 months	Nurse consultant; Medical engineer; ICU medical lead; Ward sister.

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST H						**Trust-wide:** Director of Nursing; PALS Officer; Complaints & Improvements Officer; Two infection control sisters; Estates officer.
Matron 1	I	Female	2 wards & medical admissions ward with Medical Assessment Unit	Acute & respiratory medicine	18 months	Four Ward Sisters; Assistant General Manager.
Matron 2	H	Female	4 wards	Paediatric medicine & surgery	14 months	Two Ward Sisters; Head of Nursing; Consultant.
Matron 3 (Left for promotion in another trust)	H	Male	1 ward, day care unit & outpatient services & palliative care team	Oncology	18 months	Sister (day care unit); Two Ward Sisters.

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST I						**Trust-wide:** Deputy Director of Nursing; 'Modern matron' co-ordinator; Estates Manager; Chief Dietician.
Matron1 (left trust for another post during study)	I	Male	2 in-patient wards, outpatients services, psychology & psychotherapy services, community teams	Range of acute mental health services for Local Authority area	12 months	Practice Development Nurse ('G'); Consultant Psychiatrist; Team leader ('H'); General manager.
Matron 2	I	Male	In-patient & out-patient units.	Affective disorders	12 months	Charge nurse; Business Manager; Nurse adviser; Clinical co-ordinator ('I').
Matron 3	I	Female	One in-patient ward. Four community teams. One day hospital.	Trust-wide eating disorder service	'10 years' ('Rebadged')	Senior Occupational Therapist; Business Manager; Community team leader; Ward leader ('H').

Trust	Grade	Gender	Clinical areas	Speciality	Time in post	Key contacts
TRUST J						**Trust wide:** Executive Director.
Matron 1	I	Female	Community hospital (Two wards). Day hospital.	Intermediate care and rehabilitation.	19 months	Consultant nurse; Staff nurse (‘F’); Ward manager; Domestic services supervisor; Night sister.

SECTION 6 FINDINGS FROM THE MODERN MATRON SURVEY IN TEN NHS TRUSTS

6.1 Sample and response rate

Following the Directors of Nursing survey, ten trusts in England were chosen for further investigation. As described in Section 3, purposive sampling was employed to enable us to explore the matron role in a representative range of NHS organisations across the four English regions. These included Teaching Hospitals, District General Hospitals, Primary Care Trusts and Trusts concerned with Mental Health and Learning Disabilities Service provision. A questionnaire was sent out to all matrons in these 10 trusts. (n=176). The following is a summary of the responses in the 121 questionnaires returned (an overall response rate of 69%).

6.2 Sample characteristics

In response to questions relating to the personal characteristics of post-holders we were able to establish that 10% were under 29; 31% were within the 30 to 39 age range; 31% were within the 40 to 49 range; and 14% were over 50. The majority of responding post-holders were female (80%) and 80% identified themselves as white.

6.3 Matrons' job titles reported

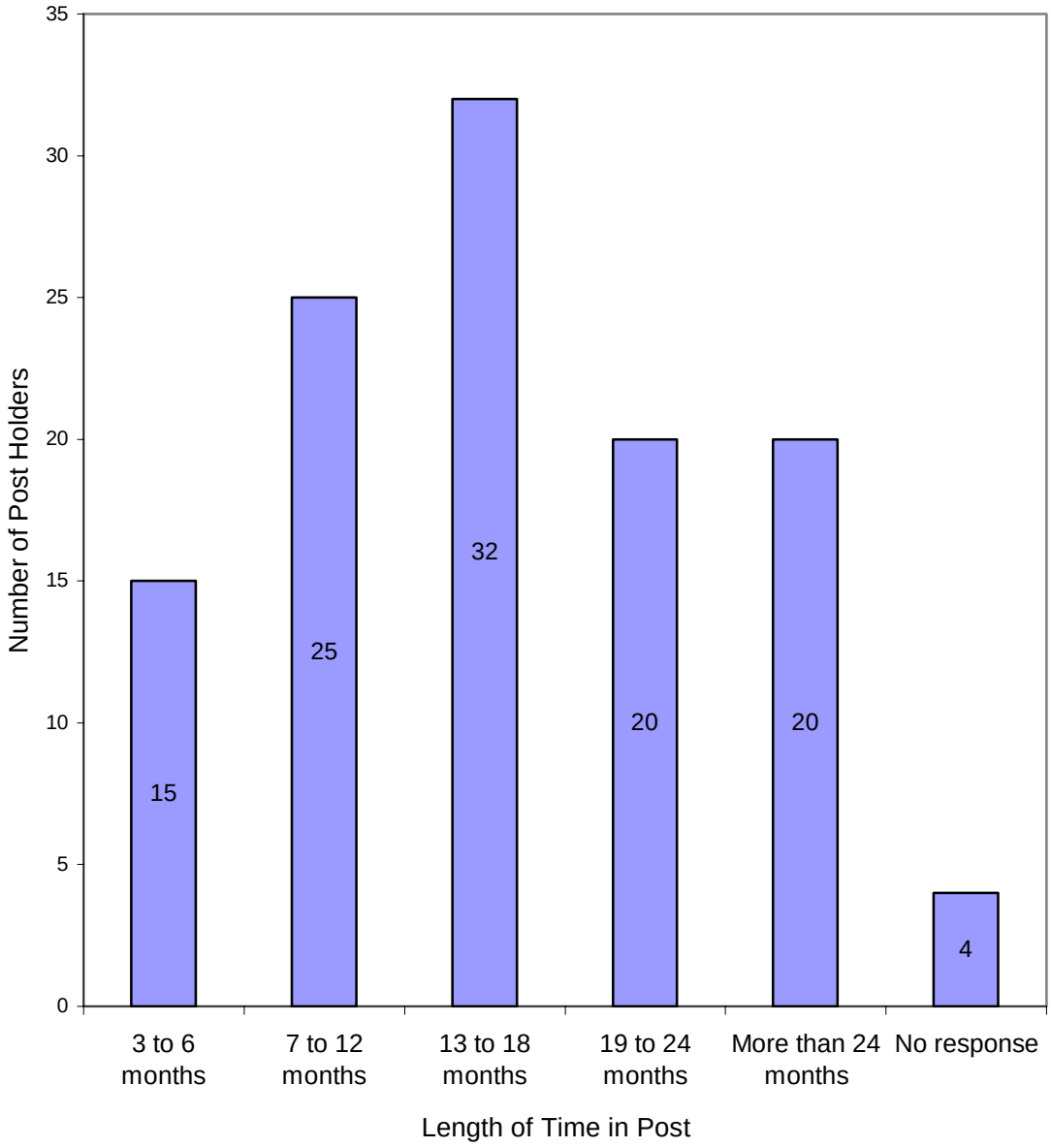
As seen in the responses to the national survey of Directors of Nursing (Section 4.4) a plethora of different titles have been created. Amongst the ten case study trusts, three used the title "modern matron" or "matron" either on its own or with another title appended. These trusts were a PCT, a mental health and learning disability trust and a teaching hospital. A further two trusts used another title sometimes (but not always) followed by "matron" or "modern matron" e.g. "head nurse/ modern matron". Amongst other titles, "head nurse" or "head of nursing" was found in three trusts" and "senior nurse" in two. Another trust used the title "clinical nurse manager" and the remaining trust, which provided a number of community mental health services, used a variety of titles often linked to the geographical location.

6.4 Length of time in post and terms of appointment

The survey revealed that matrons had been appointed throughout the two-year period following the announcement by Alan Milburn in April 2002 that the Government intended to

introduce the role. Most of the post-holders (60%) stated that they had been in post for more than 1 year. Figure 8 shows the length of time that the post holders in the case study sites had been in post.

Figure 8: Length of time in post of matrons in 10 surveyed trusts



The majority (88%) of appointments were substantive posts with 10% working in an acting capacity. The grade profile within the 10 trusts correlated strongly with the national profile, revealed by our national (Directors of Nursing) survey, with 85% of matrons at H or I grade and 12% working outside the clinical grading structure (for example, local trust grades or senior manager pay). The majority of post holders (81%) were on nationally recognised pay scales whilst 12% were on local trust determined grades. Salary bands also correlated with those adopted nationally with 88% of respondents receiving a salary of between £25,000 and £34,999. The detailed grade and salary profiles of the post holders in the case study sites are shown in figures 9 and 10.

Figure 9: Grade profile of matrons in 10 surveyed trusts

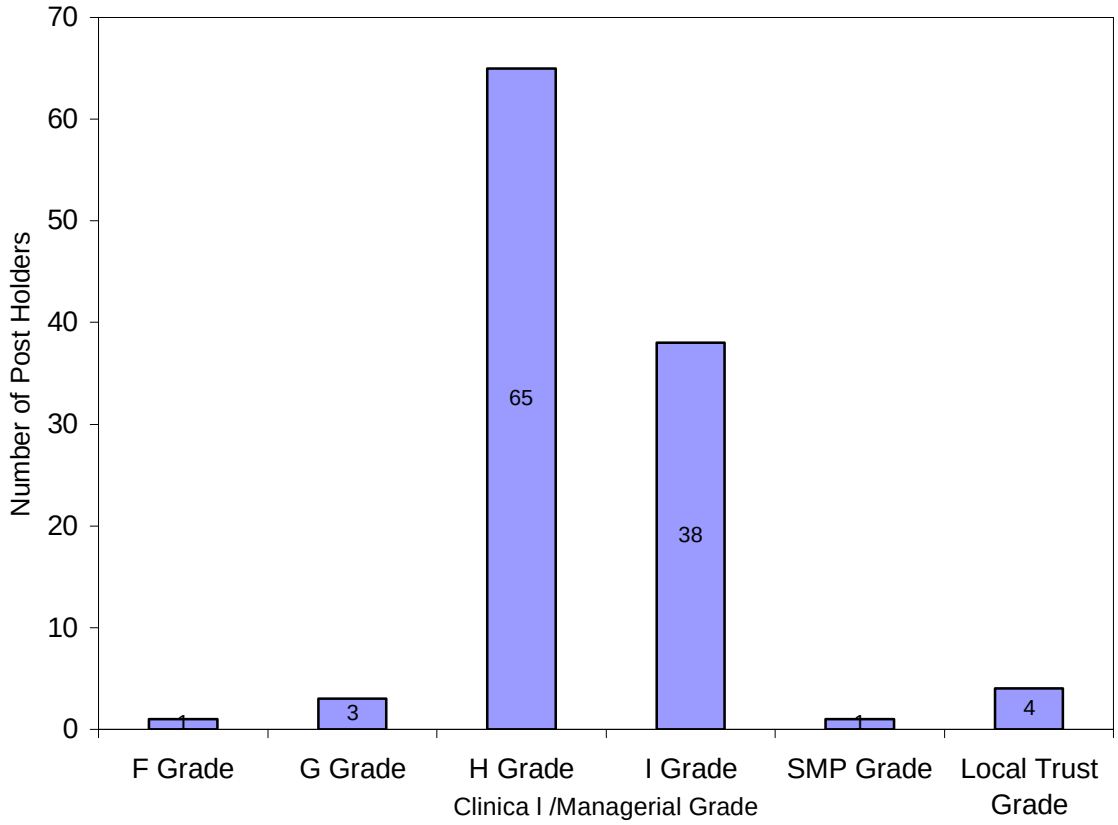
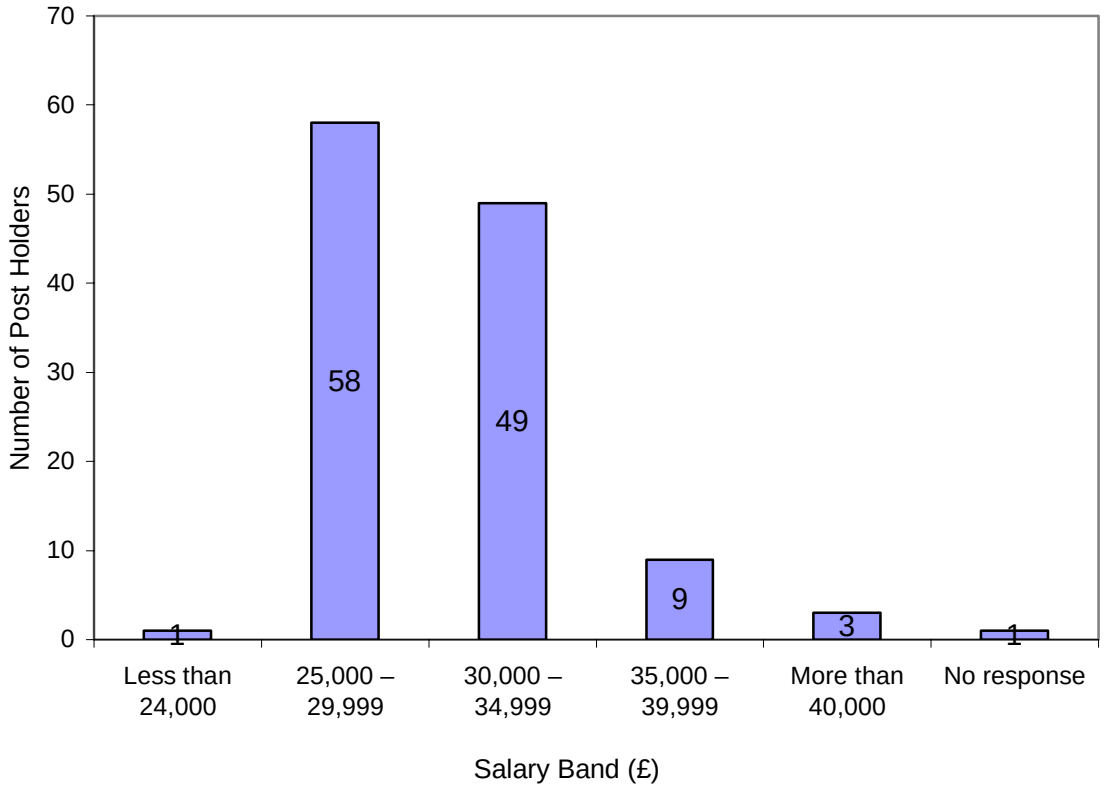


Figure 10: Salary profile of matrons in 10 surveyed trusts.



Our survey of the post holders in the 10 trusts revealed that 89% had a written job description and that 92% were already working within the trust on their appointment. We explored the methods of appointment in further detail; most (57%) had to submit a written application and 64% had a formal interview, whilst 22% had been invited to take up the post with no formal selection procedure. On appointment 45% of matrons were given specific targets to achieve, whilst 50% stated that they were given the discretion to set their own targets.

6.5 Main activities in previous two weeks

In order to evaluate the work undertaken by post holders more fully, our questionnaire asked them to identify the five areas of activity, which had taken up most of their time over the previous two weeks. The five most frequently identified activities were:

- attendance at meetings at trust / directorate level (cited by 77%of respondents)
- providing ward staff support / liaison (49%),
- delivery of direct patient care (44%),
- administration (e.g. dealing with e-mails, paperwork etc) (35%)
- handling of complaints (27%).

Other specified activities were recruitment and selection of staff (cited by 24% of matrons), management of sickness (22%), patient liaison including PALS involvement (22%), incident processing (15%), management of staffing levels (14%), clinical education / supervision (14%), bed management (12%) and targets / waiting list management (5%).

Significantly neither dealing with the cleanliness of the clinical environment nor involvement in catering standards appeared prominent activities; only 9% of post holders identified these as among the five activities that took up most time during the two weeks in question. A range of other activities, not included in the above categories, were named by 44% of respondents.

6.6 Responsibilities for staff and patients

The questionnaire to the matrons in the 10 surveyed trusts also sought information on their level of responsibility within the trust or directorate. We used the number of patients in the area covered by the post holder, together with the numbers of sisters / charge nurses and qualified staff line managed, to measure level of managerial responsibility.

There was variation in the span of responsibility, but the majority of matrons (55%) stated that they were responsible for between one and 50 patients. Most of those who had responsibility for more than 100 patients (22%) worked in the community.

Table 9: Matrons' responsibility for patients in 10 surveyed trusts.

Number of patients	Number of Postholders	Percent
0 - 50	66	55
51 – 100	18	15
101 – 150	9	7
151 – 200	9	7
201 – 250	5	4
251 – 300	2	2
301 +	2	2
No response	10	8
	121	**100**

In response to questions about managerial responsibility for staff there was also variation, but the majority (65%) were responsible for between 0 and 10 sisters / charge nurses. A small number (5%) managed more than 26 sisters / charge nurses and again these were mostly community based. A similar profile was evident in the numbers of all qualified nursing staff for which matrons had responsibility.

Table 10: Number of Sisters / Charge Nurses managed by matrons in 10 surveyed trusts.

Number of sisters / charge nurses	Number of Post holders	Percent
0 - 10	79	65
11 – 20	24	20
21 – 30	4	3
More than 31	3	2
No response	11	9
	121	**100**

Table 11: Number of Nurses managed by matrons in 10 surveyed trusts.

Number of qualified nurses	Number of Post holders	Percent
0 – 20	72	60
21 – 40	11	9
41 – 60	12	10
61 – 80	3	2
More than 80	14	9
No response	9	7
	121	**100**

6.7 Budgets

Using budgetary control as an indirect measure of managerial responsibility, our questionnaire revealed that 53% of post-holders had responsibility for budgets and slightly fewer (51%) shared responsibility for budgets.

The majority of appointed matrons (60%) felt that there was a lack of clarity about the role and 58% believed that they were undertaking completely new activities since their appointment.

6.8 Support

Responses to questions relating to the provision of development opportunities, support and resources revealed that 54% considered that employers had provided or funded education / training. Slightly more, 59% believed that employers had made professional development opportunities available and 77% had their own office space.

In the next section, we go on to discuss the findings of our thematic analysis of the data collected in our case studies of eight NHS trusts.

SECTION 7: FINDINGS FROM CASE STUDIES ARRANGED BY THEMES

Overview

This section is a thematic presentation of findings, rooted in our case studies but also drawing on qualitative data from the matron survey and data from the national survey of Directors of Nursing. There are nine themes:

- Modes of implementation
- Selection and recruitment
- Preparation for the role
- Remit of the role
- Understanding of the role
- Working relationships
- Experience of the role
- Power and authority
- Impact of the role

7.1 Modes of implementation

We gained a picture of the considerations that influenced strategic responses to implementation from replies to the national survey and interviews with Directors of Nursing (or their deputies) in our case study trusts.

7.1.1 Availability of funding for new posts

A decision to develop and establish new matron posts, supernumerary to existing nursing establishments, had financial implications for directorate *and/or* trust nursing budgets. This had presented a problem for some Directors, who felt that the lack of ring-fenced funding to support the matron initiative made it impossible to establish any additional nursing posts. In one of the mental health trusts, for instance, the Director of Nursing had first to convince her hostile fellow executive directors of the need to establish new nursing posts. She then had to draw up detailed plans for implementation and costings, and present the case to the Trust Board. She was admired by colleagues for the strong lead she gave on this initiative. However, the weighty support of non-executive directors was critical to obtaining extra funds.

7.1.2 Re-deploying existing staff

If there was no prospect of obtaining new money, the establishment of matron posts meant finding ways of redistributing clinical leadership and managerial responsibilities between

existing staff. This led to 're-badging' exercises, with nurses being given the title of 'modern matron' (or the local equivalent) on the grounds that their existing job descriptions already fitted broadly with the Department of Health's guidance. Another approach was to add extra responsibilities – and a new job title - on to existing nursing roles. We also found that some apparently 'new' matron posts were amalgamations of two previous posts (for example, an 'I' grade matron appointed in place of one former 'I' and one 'H' grade nurse).

In one of the mental health trusts, where some of the first matrons assumed a new job title but continued in their previous roles, some limitations of this approach are emerging. It has acted as a constraint on critical and creative thinking, in that new matrons continued to focus on their own clinical areas – often with great success – but had not been challenged to think constructively about the wider potential of the matron role. This limited their ability to network with other matrons, and diluted the potential of matrons as a group to press for change within the wider organisation. On an individual basis, the imperceptible nature of the change in their status curtailed the matrons' authority to influence staff in other functions. These issues are now being addressed within the trust, which following a review of its 'first wave' appointments is about to launch a fresh initiative to clarify the roles and responsibilities of all its matrons.

7.1.3 A mix of approaches

Trusts tended to adopt a mixture of approaches to appointing their matrons, so that matrons in newly-created posts work alongside colleagues who have either been re-badged, or else have acquired matron-style responsibilities in addition to their former role. This can be a source of some discontent. In one of the acute trusts, for example, the matron survey revealed that some matrons were on G and some on H grades and workloads varied greatly, with some matrons responsible for 60 or 70 patients and others only for 8 patients. One matron commented,

> "I feel that my trust did not approach the implementation of modern matrons effectively. Ward sisters were re-badged and still manage individual wards. Others like me took up a brand new post with a specific patch to cover."

7.1.4 Fit with existing nursing strategy

Top nursing managers had to consider how well the initiative fitted with their existing nursing strategy. For example, if they considered that they had already established a strong *cadre* of ward leaders, it seemed less feasible (or desirable) to introduce a new role into the nursing structure. By definition, all of our case study trusts had established matron posts, but some of the respondents to our national survey indicated that some Directors were reluctant to disturb recently-established structures.

7.1.5 Timing of implementation

If a major re-structuring exercise was on the horizon, as with many Primary Care Trusts, the decision as to whether and how to establish matron posts was likely to be deferred. In one of our acute trusts, the timing of the initiative had been fortuitous, as it allowed an in-coming Director of Nursing to review existing nursing roles and structures using the principles set out in the guidance. Once a decision to establish matron posts had been taken, Directors had to decide whether to pilot a few matron posts and phase them in gradually- as in some of our case study trusts, - or to introduce them all at once. One acute trust adopted the latter approach; in September 2001, the trust was restructured into four divisions. Three of these have a Clinical Director, a Divisional Nurse and a Service Manager, with a varying number of directorates within each division; most directorates have an overall Clinical Director and then several specialty teams led by an Associate Clinical Director and a matron. There are 20 matrons altogether, many of whom were appointed late in 2001, after national advertisements were placed. The Director of Nursing stated they were different from previous nurse manager roles, with the main objective being patient centred care.

7.1.6. Attitudes of staff and patients to the idea of modern matrons

Not all of our case study trusts had discussed the initiative with either staff or patient groups, whilst some discussed it with both constituencies before implementation. There had been considerable resistance from two staff groups in particular: ward leaders, who feared that their own authority might be undermined and did not like the idea of someone coming on to their wards to inspect standards of care; and nurses managers in the next level up, many of whom considered that they were already undertaking the major responsibilities envisaged for matrons.

7.1.7 Relevance of the initiative to immediate needs

Our information suggests that trusts' enthusiasm for implementing the matron initiative varied according to their perception of the potential of the role and its potential to solve certain organisational problems - for example, serious difficulties with staff recruitment and retention, recent problems with poor overall standards of nursing care, or poor performance against national targets for waiting lists and waiting times. This can put matrons under pressure from the trust to deliver quick solutions to problems which often require a whole-systems approach.

7.1.8 Choice of job title

This issue proved very contentious, as the range of job titles in our surveys demonstrates. Patient groups, when consulted, had usually favoured a title containing the word 'matron'.

Staff groups had been divided on the issue, with some strong feelings reported against the re-introduction of the 'matron' title. There were different grounds for this: many nurses (both male and female) thought it had a 'sexist' bias; others thought that it had inappropriate associations with what nurses now perceive as the remote, autocratic matrons of the past; and amongst some mental health nurses, there was a perception that the title summoned up visions of the discredited asylum-based services of the Victorian era. Other groups of staff tended to favour the 'matron' title: one Patient Advice & Liaison officer remarked that people seemed reassured that a 'matron' was coming to talk to them, rather than a 'nurse manager' or 'senior nurse'.

7.1.9 The question of uniform

This was another contentious issue. Whilst most general hospitals seem to have favoured the idea of a distinctive uniform for their matrons, difficulties arose over the questions of style, colour and practicality (the latter being very important if matrons were required to engage in direct patient care). One solution has been to provide two sets of uniforms, one for clinical work and the other for activities on non-clinical days. We heard of one trust where an unfortunate initial choice of uniform was exposing the matrons to some gentle ridicule; a new uniform is now being designed. On a more serious note, some of our matrons doubted whether having a distinctive uniform made them more easily identifiable to patients, amongst the already wide variety of other nursing uniforms. It was also put to us by non-nursing staff that some matrons tended to 'hide behind the uniform', by which they meant that a matron might assume that staff and patients instantly recognised them, and so did not take care to introduce themselves.

7.1.10 Top-down prescription or devolved decisions about implementation

One option (as in one acute trust) was for top nursing managers to develop a generic job description and generic competencies to guide the development of matron roles at directorate level. In retrospect, the Director of Nursing felt that this had been a successful approach, apart from the initial stipulation that all matrons should spend 50% of their time in clinical practice. This had been a mistake, as it proved impossible to implement in many areas and had put the early appointees under a lot of pressure.

In another trust, the Director of Nursing really led the implementation of the matron roles, stating that they were different from previous nurse manager roles, with the main objective being patient-centred care. Senior staff in the trust were aware of this, and a newly appointed Clinical Director who was unsure what the role of the matron in her directorate should be, went to the Director of Nursing and said:

> "Look you know I want this clearly defined - you tell me what you expect of the modern matron, and the nurse consultant, and let's do it and sort it out rather than it being very blurred".

In this case, a prescriptive approach was felt to have worked well.

Another approach (as in one of the mental health trusts) was to leave directorates and sub-directorates to establish matron posts in accordance with their own requirements and resources. The Director of Nursing here made the deliberate decision that, in such a large and complex trust, it was not feasible to be over-prescriptive. One drawback to this devolutionary approach was that it had proved difficult for top management to keep pace with changes over time, leading to some confusion over who the matrons were and where they were working – this was a particular problem when a 'rebadged' matron left, and it was not clear whether his or her successor perceived themselves as having a matron role.

7.1.11 Decisions about the ideal span of responsibility

The Department's guidance for in-patient matrons suggested that they should be in charge of a group of wards on which they could 'walk the floor' on a regular basis. In the case of in-patient hospital wards, there are usually natural groupings of wards according to broad clinical specialisms, such as children's services, or cardio-thoracic services. The picture is more complex when establishing matron posts with service-wide responsibilities which include community-based and out-patient settings as well as in-patient areas.

Finding the balance which enables matrons to perform most effectively seems to have been a matter of trial and error with 'first wave' appointments. For example, a matron in an acute trust (already an experienced middle manager) started off with responsibility for six acute medical wards, all on the same site. This was an area which involved responsibility for a large number of nursing staff and patients, and also generated a significant volume of work dealing with patient concerns and complaints, and bed management problems. It proved to be too demanding. Another matron was appointed to take on the responsibility for three of the wards, a move welcomed by ward sisters who had felt rather unsupported by the initial arrangement. A matron in another acute trust, who only worked three days a week, had responsibility for the rehabilitation directorate which consisted of three wards, two stroke units, a day hospital and a neuro-rehabilitation unit. Some parts of this diverse "patch" were situated at opposite ends of a very large hospital site. Both the matron and her senior nursing and therapy staff acknowledged that because of the workload she just could not be visible to patients. These examples suggest the importance of keeping decisions about the responsibilities of individual matrons under review, and making changes if necessary.

7.1.12 Should matrons be line managers?

The DH guidance suggests that matrons should have supporting, monitoring and co-ordinating functions, which do not necessarily require direct line management of other nurses. One of the first matrons appointed in one of the mental health trusts was given responsibility for a whole-hospital site, but was given no line management authority. This was because top nursing managers in the trust believed that the matron role, in its purest form, was essentially an 'influencing' role. The trust was pleased with the success of this appointment, whilst conceding that the personality and skills of the (male) matron had probably been a significant factor. In contrast, we also received information from a matron in a mental health trust (not one of our case study trusts) who had originally been given a post with whole-hospital responsibility but without line management authority. He had found this made it impossible to implement changes in nursing practice; the subsequent integration of his post into the management hierarchy had proved to be a more effective and satisfactory arrangement.

7.1.13 Decisions about grading

Over half the matrons (53%) in our case study trusts were appointed on 'H' grade, and 31.4% at 'I' grade. This means that a considerable number of Directors of Nursing have overlooked the DH guidance that 'most' matrons should be appointed on 'I' grade, a level which the DH considered appropriate given the wider responsibilities of the role. We found that many 'H' grade matrons had been promoted from 'G' grade ward sister posts, whilst many 'I' grade matrons were either already on that grade in some middle management or clinical role, or were moved up from an 'H' grade post. In the acute sector, this means that many 'I' grade matrons already have experience of posts with a wider remit than ward leadership, and so have more authoritative experience with matters like managing budgets, setting establishments, and liaising with other functions.

7.1.14 Positioning matrons within the organisation

The departmental guidance suggested that matrons should have strong links with clinical settings at ward or unit level; but they are also expected to exert influence over non-nursing support services within the organisation because of their wide-ranging responsibilities for improving cleanliness, infection control procedures, and the total patient experience of care. Achieving this balance within one role has presented some challenges when establishing 'first wave' matron posts. If an 'H' grade matron post is established on the lines of a traditional 'senior sister' post, with a focus on intense involvement with patients and staff in a clearly-delineated clinical area (essentially a 'first-line' management post), will the post be sufficiently high in the organisational structure for the matron to exercise authority over the support services being provided to the clinical area, or will problems with function managers

have to be resolved finally by nurses or other managers at 'middle' management level? If a matron post is established at 'I' grade, with the expectation that the matron will have a great impact on the performance of cross-trust services as part of the trust's middle management, will he or she be too high up within the organisational structure to focus down on the clinical area?

There is no 'right' answer to these questions. It is clear that senior management in some of our trusts have found it difficult to decide at which level it is most appropriate establish matron posts, and are keeping their initial arrangements under close review. We came across one example of a compromise approach (below), where the trust had established a two-tier system of matrons.

7.1.15. A two-tier approach

In one of our acute trusts, the Director of Nursing explained how the original plan (early in 2002) had been to designate the senior nurse managers in each of the then four directorates as matrons. However, over the next year, as more direction was given by the Department of Health about the content of the matron role, it became obvious that these senior nurse managers could not fulfil all the required responsibilities on their own. During this time, the number of directorates increased from four to five, some funding for more posts was found through cost improvement programmes, and a review of nurse staffing was undertaken.

By the late spring of 2003, when the research team first visited the trust, the Director of Nursing had identified a total of 15 posts which were judged to encompass some of the duties of matrons. Five of these were the senior nurse managers for each of the directorates who were considered to be matrons in some respect because they are responsible for standards of service; the other ten posts, at a lower level within the directorate hierarchy, were designated as 'assistant matron' posts. However, we found that in practice the 'assistant' matrons were carrying out more of the matron functions; at the time of our fieldwork, only seven out of the ten planned assistants were in post. Although this arrangement solved some of the dilemmas of positioning matron posts in the organisation, it was found to cause confusion for both staff and patients as to who were really the matrons.

7.1.16. Ensuring accountability for matrons' performance

One acute trust had managed to keep its 'first wave' matrons within the nursing management hierarchy, reporting to senior nurses at clinical directorate level. However, this arrangement has recently been altered in some of the trust's directorates, where the matrons are now *operationally* accountable to general managers. Their *professional* accountability is through

senior nurses in their directorates, who report to the Director of Nursing. We found this system of dual accountability was already prevalent in other trusts, with matrons reporting directly to general managers, business managers (some of whom may, by chance, also have a nursing background) or clinical directors.

7.1.17. Preserving the professional line

In large and complex NHS trusts, it is no longer feasible to for all nurses to function within a traditional, uni-professional management hierarchy, headed by the Director of Nursing. The development of clinical directorates, and of multi-disciplinary clinical teams within directorates, has led to a situation where senior nurses and other healthcare professionals are likely to be line managed by staff from non-clinical backgrounds. Directors adopted different strategies to ensure that matrons retained their professional accountability to them. In two trusts the directors set up regular forum meetings with their matrons and other trust wide senior nurses. In another two trusts, the directors delegated responsibility for the establishment and oversight of matron posts to their deputies, who meet with the matrons on a regular basis and ensure that there are good two-way channels of communication between executive and operational levels. When possible, the Directors also attend meetings with matrons. In general, we found that Directors of Nursing in our trusts had been enthusiastic and proactive about implementation, and kept themselves well informed about progress. However, there may be a risk of a director becoming too closely identified with an in-house matron 'project', particularly if he or she has not convinced other senior nurses of its importance. If the director moves on, there may be no-one else in the top levels of nursing management prepared to champion the matron workforce, and morale may drop.

7. 2. Selection and recruitment of matrons

In the matron survey, we asked all matrons in case study trusts about their selection processes, and explored this in more depth in our follow-up interviews.

7.2.1 In-house appointments

Almost without exception, the matrons in our case studies were part of the first wave of such appointments in their trusts and were in-house appointments, with only 7.4% of our survey respondents being external appointments. This finding is understandable, given that the early matrons were piloting a new role, and that both they and their managers were feeling their way with some caution. Again, almost without exception, our respondents had been actively encouraged to fill new posts, or to extend their responsibilities in line with the new initiative. The impressive details of individual achievement and clinical experience reported by our

respondents suggest that senior nurse managers took care to identify strong candidates, who either already met the Department of Health's criteria for appointment in terms of experience and skills, or had the potential to grow into the job.

A few reported some initial reluctance to the idea of becoming a matron, either because they lacked confidence in their leadership abilities, or because they did not understand how the role would work in particular clinical areas. The balance to be struck between encouragement and coercion involves fine judgement. We came across one instance in an acute trust of a highly-regarded nurse being pressurised to take on matron responsibilities in her specialist area, but being so unhappy in the role that she eventually resigned from the trust altogether.

Many matrons appreciated the advantages of their familiarity with the trust, and the fact that they already knew most of the medical and nursing staff in their clinical area. However, new matrons who had been previously been ward-based with no cross-boundary responsibilities (as in ward sister posts) discovered that they were not necessarily familiar with the trust's management structures and systems, nor with the key people with whom they were expected to develop collaborative working relationships. In these cases, the matrons were grateful for induction courses, or longer in-house educational activities, which familiarised them with cross-trust matters and introduced them to other clinical and non-clinical managers.

In-house appointments were not without their disadvantages, mainly to do with the perceptions of other staff. For example, a former senior ward sister might find that the junior sister and other ward staff, as well as medical staff, still wanted to relate to her in the same way. It can make it difficult for nursing staff, who until recently were a matron's peers, to accept that their colleague is now in a more senior role, and this may cause initial difficulties in professional relationships. Such a situation reinforces the need for clarity about the matron role, the transparency of the recruitment and selection process, and the need to ensure that trust staff understand the matron's role and responsibilities.

7.2.2 External appointments

It was put to us by a Director of Nursing that trusts which have less generous levels of nurse staffing (whether because of size, resources, geographical location or historic difficulties with recruitment and retention) do not have a ready-made pool of potential matrons. In a few cases where the alternative was to promote comparatively inexperienced ward sisters, or where there was a need for matrons with highly specialised qualifications (such as in cancer care), the alternative was to recruit from further afield. This pattern now seems to be changing. We found that even those trusts that had successfully recruited their first wave of matrons in-house were increasingly likely to advertise their vacancies externally, and were more

confident about doing so. They were able to build on their early experiences to develop job descriptions and person specifications which reflect more accurately the qualities and skills desirable for a matron. Whilst it may take a little while for 'outsiders' to get to know their way round a new trust, they may bring with them fresh ideas and a more critical view of current systems and practices. In some ways, it may be easier for them to command the respect of staff who have not known them in a more junior role in the organisation. One matron in an acute trust who had worked as a senior charge nurse in a different trust, clearly enjoyed the affection and respect of ward sisters; they also valued his willingness to increase their responsibilities, in line with the more powerful ward sister role he had experienced in his previous trust.

7.2.3 Essential and desirable attributes of modern matrons

A selection of person specifications in the job descriptions provided by our matrons contained few surprises. There was a slight difference of emphasis, depending on the prime focus of the job and whether the post was graded at 'H' or 'I'. 'Essential' criteria included a minimum of three years (sometimes five years) senior nursing experience; degree level or equivalent professional qualification; evidence of relevant post-registration qualifications; evidence of effective multi-professional and multi-agency working (this was particularly important for posts in the mental health and primary care sectors); evidence of 'significant' management experience; demonstrable budget-management skills; evidence of highly-developed leadership skills; evidence of the application of research and evidence into practice; and the ability to manage time and work successfully in a high pressure environment.

Desirable criteria included IT skills; a sense of humour; qualifications in education or management; clinical credibility with a high profile locally; evidence of recent publications or conference presentations; and (essential in those jobs involving responsibilities across several sites) access to own vehicle.

7.2.4 Opinions of other staff

We asked our interviewees what personal attributes they most valued in the matrons they worked with. What came through forcefully was the perception that, in order for people to function effectively as leaders, they needed to possess certain personal qualities in addition to the authority conferred on them by their role in the organisation. As far as ward sisters and team leaders were concerned, 'clinical credibility' came high on their list of desirable attributes. Almost invariably, they thought it essential for a matron to have had previous experience as a ward sister. They looked for evidence of a good professional reputation, and a good command of nursing knowledge and clinical skills. This did not necessarily mean that they expected matrons to have the answer to every clinical problem, but that they would work

with ward staff to locate other authoritative sources of advice, if needed. Less experienced ward sisters, or those who did not normally manage budgets and staffing as part of their roles, valued the help of matrons who possessed those specific skills.

Other attributes listed by nursing staff included: being a good listener; possessing excellent communication skills; having a flexible approach to problems; being good at delegating and setting and reassessing priorities; being able to juggle many things at the same time; and the ability to motivate and provide inspiration for other staff. Another desirable attribute was a 'strong' leadership style, defined as decisive behaviour, and having the confidence to speak up to criticise weaknesses in an organisation's structures or systems. Junior and senior ward staff all valued matrons who were 'approachable'. The importance of a matron's calm manner when dealing with potentially tense situations was remarked upon by both ward nurses and PALS staff.

7.2.5 Formal and less formal selection procedures

We found some variation in the requirements and formality of selection procedures for our 'first wave', predominantly 'in-house' appointees. In the matron survey just over half the matrons (57%) reported that they had made written applications for their post; and 64.5 % reported having 'formal' interviews with their line managers before appointment. In one acute trust, all candidates for matron posts, whether 'in-house' or external, had to attend a focus group of staff and answer a battery of questions. One matron in that trust reported 'swotting up' for weeks to prepare for that ordeal.

Twenty-two percent replied that they had been invited to apply, and accepted, without a formal selection procedure; some of these described having an 'informal interview' with their prospective managers. It is arguable that this approach may be appropriate for an in-house appointment, where two people have worked together for some years in the same trust and know each other well.

A more formal approach was involved where external candidates were being interviewed and assessed. One of our matrons described the rigorous selection she went through as an external candidate for a post in a Primary Care Trust. She had an interview, as part of which she had to make a presentation about her approach to developing standards of care. She also took part in a focus group of about eight people, including a healthcare assistant, a therapist, and administrative and domestic staff. Her experience was that these people asked her very direct and specific questions about how she would work with them, questions that she probably would not have thought about in preparation for a formal interview.

"But it gave me quite a good feeling about the place before I started… so that was quite good."

7.3. Preparation for the matron role

The matron represents a new post within NHS trusts, with their responsibilities partly determined by the "Ten key responsibilities of modern matrons" (DH 2003) and partly by the formal and informal requirements of the local organisation. This was confirmed by our matron sample, 58% of whom said they were undertaking completely new activities. We therefore felt it was important to consider how individuals were prepared for the new role.

Information on role preparation was obtained initially from the national survey sent to Directors of Nursing. The issue was also raised in the matron survey and in our interviews with individual post holders. We covered three broad areas: firstly the postholder's formal education and training prior to recruitment, secondly their previous experience (which they would bring to the role) and thirdly the extent to which they had a clinical or managerial background. We were also interested to learn whether trusts or matrons were identifying any gaps or individual needs once the appointments had been made and whether provision had been made for these.

7.3.1 Education and training prior to recruitment

Within the questionnaires returned by matrons some (about 30%) had undertaken programmes (for example ENB courses) with a clear clinical focus. Around 10% were graduates (most of these were working in trusts in and around London).

Some postholders believed that formal educational qualifications were relevant in determining the effectiveness of the matron role - within their supporting statements the emphasis was on relevance and appropriateness (for example, management qualifications, leadership courses). However others identified critical personality attributes as equally, or in some cases more, important: as one matron said "I have a degree but feel that I make a good matron because of my people skills".

Formal training had been provided by 34% of responding trusts in our national survey, with an emphasis on leadership development programmes. Among responses to the matron survey, 54% stated that their employers provided or funded education or training, whilst 59% felt that professional development opportunities had been made available. One explanation for the difference in these figures might be that trusts might be increasing the level of support once the posts are created, or it may be that directors do not always know what is provided within their various directorates.

7.3.2 Previous experience

When asked whether there were any other factors relevant to the effectiveness of the matron role "experience" was explicitly identified by a number of respondents (20%). Some further qualified this by stating that this should be management experience or leadership experience.

The level of experience within our sample of matrons was considerable, at least 85% of those responding had previously been employed at G grade or above and a significant number had already been in post at H or I grade before taking up the role of matron.

7.3.3 Clinical versus managerial background

Overall the importance of clinical expertise did not feature strongly in our findings. There were some explicit remarks as to the importance of "clinical credibility" but the overall impression was that, with the right level of previous experience, postholders would have appropriate or 'good enough' clinical skills. The importance of a managerial background was cited more frequently but with an emphasis on ability rather than simply having occupied a management post.

7.3.4 Matrons' identified gaps in preparation for the role

Drawing on the matron survey, the following list represents the most commonly expressed topics on which matrons would like further help:

- Leadership
- Change management
- Computer skills
- Project Management
- Report writing
- Preparing bids and business case writing and planning
- NHS Policy and Planning
- Action planning
- Time management
- Financial management and budgeting
- Contract negotiation,
- Service level agreement development.
- Human resources issues
- Performance management of staff
- Workforce planning
- Interview skills training
- Carrying out investigations

- Legal issues
- Infection control
- Patient environment monitoring,
- Involvement of users in monitoring
- Patient advocacy through formal networks.

7.4 Remit of the Matron Role

Responses from the national survey and case studies illustrate the range and diversity of matrons' roles and activities. In addition to this, we obtained copies of matrons' job descriptions from all types of trust.

7.4.1 Key responsibilities

Analysis of a sample of job descriptions suggests that the following core responsibilities are being placed on matrons:

Professional standards / Clinical governance: includes setting and monitoring standards of nursing care; involvement in admission/transfer/ discharge processes; participating in audit and promoting research-based clinical practice; participating in the investigation of complaints; and initiating action over untoward incidents (in some areas - notably mental health and midwifery - matrons are expected to undertake direct clinical supervision).

Management and Leadership: ncludes providing clear leadership to professional and direct care staff within the clinical area; accepting continuing responsibility for the management of the area; ensuring high standards of administrative and support services; working with ward leaders to use staff resources effectively and efficiently; providing nursing advice and support across the clinical area; contributing to and participating in the management of the trust; participating in senior nurse on-call rotas; monitoring and managing nursing budgets; providing the directorate and trust with regular reports on standards of cleanliness, quality of food, Essence of Care standards and the development of '10 key roles' for nurses; assisting with the introduction of ward housekeepers.

Engaging with patients, families and carers*:* includes providing a visible and authoritative presence in ward settings to whom patients and families can turn for assistance; maintaining personal contact with patients, relatives and carers; liaising with Patient Advice and Liaison Service.

***Education**:* includes liaising with university departments to ensure the learning environment is appropriate for pre- and post-registration learners; ensuring that clinically-based teaching programmes are available for unit staff; and ensuring staff attendance at mandatory training sessions; ensuring that a matron's own practice is kept up-to- date by spending a specified amount of time (for example one day a week) on clinical work.

***Human resource management**:* includes ensuring satisfactory management arrangements for all junior nursing staff; ensuring good induction process for all new staff; ensuring implementation of the trust's HR policies on Individual Performance Review, capability and disciplinary issues; working collaboratively on the recruitment, selection, appointment and retention of staff; ensuring that vacant posts are filled promptly.

7.4.2 Different types of remit.

The volume of work generated by these different responsibilities, and the amount of time available to deal with them, is obviously related to the size and type of a matron's clinical area. We found a variety of arrangements within our trusts: some matrons were responsible for in-patient areas only, whilst others had a service-wide remit and were responsible for different combinations of in-patient, out-patient, and community-based settings. Some of the clinical areas within a matron's remit were in locations varying distances apart – in country districts this could involve travelling over significant distances (up to 25 miles in one trust) or, in inner-city areas, spending a lot of time in traffic-jams. We were told that the difficulties caused by split-site responsibilities can be partially off-set by modern communication systems such as email and mobile phones; but dealing with emails was also identified by many matrons as a time-consuming task which they did not enjoy.

In terms of their staff management responsibilities, the majority of our matrons were responsible for managing up to ten ward sisters (in in-patient settings) or up to twenty qualified nursing staff (in out-patient and community settings). In terms of their responsibility for patients, 66% of respondents said that they considered themselves responsible for up to 50 patients, but some matrons in acute trusts were responsible for up to 220 patients on any one day. In out-patient and community settings, this figure was higher: seven percent of matrons reported responsibility for between 100-150 patients, four percent between 200-250 patients and two percent for 250 – 300 patients.

7.4.3 Specific targets

We asked our matron survey participants whether, in addition to their core responsibilities, they were working to meet specific targets. Slightly less than half (45%) replied that their

managers had given them specific targets when they were appointed, and these were reviewed on an annual basis, if not more frequently.
These targets fell into three broad groups:
(i) corporate objectives related to NHS performance indicators, with particular reference to cleanliness, waiting times in out-patient departments and efficient bed management;
(ii) objectives designed to address specific local difficulties, such as nurse recruitment, professional development, or over-spend on the nursing budgets;
(iii) targets which reflected the responsibilities set out by the Department of Health, such as implementing Essence of Care and improving infection control.

The targets our matrons set for themselves reflected their grasp of specific local problems requiring attention: these included high staff sickness levels, problems with staff recruitment and skill mix or high rates of untoward incidents in particular wards or units. Otherwise, their personal targets tended to reflect the Departmental guidance on strengthening clinical leadership, benchmarking and engaging with patients and carers.

7.4 4 Challenges in fulfilling remit

It is clear from detailed written responses to the survey and conversations with matrons that they often find it difficult to manage all areas of their remit. Their responsibilities are at best wide-ranging, and at worst a recipe for role-overload. As one matron who described her workload as 'immense' said, 'You just feel like you're being pulled and pulled and pulled, you know like 'Stretch Man': someone has got each bit of you and they stretch'. Many respondents reported difficulties with time management and the anxiety generated by feeling that they might be called upon to take on new tasks which cut across their agreed priorities**.**

Participants reported particular difficulty with remits involving a dual (or 'added-on') role. At least three matrons in a mental health trust had dual roles, two as unit managers and one as a ward manager. One of these said: "I fully agree with the clinical focus that has been placed upon the matron role in my trust rather than a management one. However, having done the two jobs (matron and unit manager) for one year it is impossible to do both jobs adequately and effectively. The matron role should be stand alone – the clinical focus could be retained by being able to work more directly with all clinical staff and patients within my areas, and not just my own unit, as now."

Another said; "The (matron) role is being severely hindered by the demands of the unit manager job. Both jobs to be carried out effectively have to be stand alone and full time."

Finally, the third said "Having the role of matron combined with ward manager is difficult. Both posts require full time commitment. Sometimes the roles merge and I do things as a ward manager not as a matron. Ward manager responsibilities sometimes have to take priority and vice versa".

7. 5 Understanding of the Matron Role

In our interviews, we explored their understanding of the matron role with post-holders and their key contacts. In most trusts, we found that directorates had been given the freedom to develop the matron role to suit their own needs. The lack of standardisation of roles and job titles made it unsurprising that many non-nurses (and, sometimes, nurses themselves) lack a clear understanding of the matron role.

7.5.1 Matrons

The vast majority (89.2%) of our matrons had written job descriptions. In interview, most of the matrons were clear about the major responsibilities and functions of their role, as set out in their job descriptions, or as agreed with their line managers. They identified the key activities of providing leadership to improve standards of nursing care, of supporting ward sisters/team leaders, of improving the environment, and of dealing with patients' concerns. Here, we seemed be in the realm of the 'ideal' modern matron, or what matrons felt they should be doing, according to the Department's guidance and their own job descriptions.

We found a considerable gap between the ideal and the day-to-day: most of our matrons described spending large proportions of their time on human resource management issues such as recruitment and selection, discipline and capability matters, managing the nurse bank, and trying to lower sickness and absence rates. Over half (60%) of the respondents to our questionnaire reported a lack of clarity regarding their role. In some cases, it was the matrons themselves who wanted greater clarity about their roles and responsibilities, either because they had no job description at all (10%) or because their actual work was diverging significantly from their job description. In other cases, matrons referred to misunderstandings about their role on the part of other members of staff, a phenomenon which they felt was undermining their effectiveness across the organisation.

It was noticeable that a number of matrons apologised for not being 'proper' or 'true' modern matrons. In discussion, it became clear that what they were worried about was the lack of sufficient involvement in direct patient care, and (as they perceived it) their consequent failure to establish strong links with patients and carers. This failure to match up to idealised expectations of the matron role was clearly a source of anxiety to some of our interviewees.

There was a sense that in many trusts, the job of matron was under constant reconstruction. One matron said:

> 'There was a job description, but since I have been in post the role's very much evolving and changing, compared with what it was a year ago, when I first started!'

7.5.2 Patients and carers

The disappointing quality of the survey information we collected from patients and carers makes us cautious about putting too much weight on it. However, almost all of our 120 respondents (drawn from 10 different clinical areas in different trusts) completed the question which asked what they thought were the main responsibilities of matrons. Allowing for the fact that some of the replies may have been based on guesswork, rather than observation or personal experience, the majority of people thought that matrons were definitely responsible for four areas:

- ensuring cleanliness
- ensuring good patient care
- helping patients with their problems
- ensuring discipline among staff.

The majority were 'not sure' whether matrons had responsibility for four other areas:

- ensuring good food
- helping ward staff with budgets
- helping to prevent infection
- ensuring there were enough staff to give good care.

7.5.3 Top level nursing management

The Directors of Nursing (or their deputies) to whom we spoke were clear about the potential of the matron role. They understood it as an opportunity to re-focus attention on the fundamentals of nursing care, and to restore nurses' influence over services such as cleaning, catering and maintenance. It was also seen as an opportunity to introduce a clinically-focused nursing post into their trusts' operational management, making it possible to ensure that ward sisters could be line managed by nurses, rather than non-clinical managers. However, responses to our national survey indicated that, outside the acute hospital sector, Directors of Nursing had not always found it easy to understand the relevance of the matron role to their nursing services, nor to put it into operation.

In one large teaching trust, one of the nursing director's deputies had particular responsibility for taking forward the "CNO's 10 Key Roles Initiative"(DH 2002c) which had its roots in the NHS Plan (DH 2000), where it was envisaged that nurses taking greater responsibilities would lead to better and more efficient patient care. Work on these roles had already been underway for some months before the matrons were appointed, as a joint initiative between the trust and its neighbouring acute trust; the deputy DN observed that the appointment of the matrons gave the work a boost, because of the linkage the matrons provided between the top levels of management in the trust and the clinical practice level, where they worked in partnership with practice development nurses and clinical educators.

The deputy DN observed that matrons dealt quickly with any issues that arose around standards of care, but she realised that they were frustrated because they could not be more visible to patients because they were so busy. However, one area of real difference was in the way that matrons were able to confront nurses who were known for some time to be poor performers, but who previously had been unchallenged because it was just 'too difficult'. The deputy DN feared that because matrons were perceived as being successful in tackling certain problems, they would be landed with many other responsibilities on the strategic and business planning field and lose their focus on standards of patient care.

7.5.4 Ward sisters / team leaders

When questioned in interviews about their prior expectations of the matron role, a common reaction was that wards sisters/team leaders had feared either that matrons would interfere with ward work, or that they would be distant and unavailable. They were aware of the original guidance on the matron role, and had a good understanding of the intention to provide more practical and professional support for nurses at their level. They understood that, in principle, matrons were meant to have clinical credibility and to maintain a strong clinical focus, even if they did not undertake direct patient care. There was also an expectation that matrons would be role models, and that they would ensure that under-performance was dealt with, as well as incidents and complaints.

There was evidence of some concern when, in practice, they saw matrons being forced to give priority to organisational concerns (such as dealing with problems in a telephone system, or with bed management) which diluted their clinical role. When questioned about the attractiveness of matron posts as a career move, almost all the ward sisters indicated that, on the basis of experience, they perceived the matron role as being too 'managerial' and too removed from patient care.

These nurses thought the involvement of matrons in directorate or trust meetings was important, both because it helped to raised the profile of a particular service and because it enabled matrons to act as a conduit for feeding the views of ward staff up to middle and senior management and disseminating trust news and policies downwards. A common expectation was that, in wider arenas, matrons would act as 'champions', or 'ambassadors' for their own clinical areas.

We found some divergence of opinion over the nature of a matron's responsibility for patients in her area. A matron in one acute trust described having '24-hour responsibility' for patients in her area, and saw this as an important contribution to reducing ward sisters' feelings of stress. This may have been influenced by the fact that the ward sisters she managed were comparatively young and inexperienced, and one was 'acting up'. We found that more experienced ward sisters working with another matron, in the same trust, considered that they retained overall, 24-hour responsibility for standards of care.

We found some exceptions to the generally good understanding of the matron role at ward level. In one trust for example, both the designated matron (who had been 're-badged') and a team leader said that they did not understand the relevance of matron role to their work in a specialised mental health unit, despite the fact that it was an established part of the trust's nursing strategy. In the midwifery service in another trust, where the matron role had been implemented through re-badging, understanding of the role was confused. One community midwife, for example, understood all G and H grade staff to be matrons, and some staff were not aware that there was a matron (at 'I' grade) covering their area.

7.5.5 Medical consultants

We found a varied picture of consultants' understandings, depending on the local version of the matron role and to what extent it was integrated with the operational management structure within a clinical directorate. In an acute trust for instance, a consultant paediatrician was aware of the organisational responsibilities of matrons for ensuring cleanliness and improving the environment. In relation to this, he saw matrons as co-ordinators of services - and if need as 'trouble-shooters'- for their clinical area, but he thought that they had severely limited authority over resources. Essentially, he understood it as a front-line nursing role, providing an extra layer between the wards and senior nursing management. He thought that matron responsibilities had simply been added on the matrons' previous jobs as 'senior sisters'; whilst they seemed to enjoy the extra work, he considered that matrons' continuing close involvement in clinical practice meant that they were regularly used to cover for staff shortages on the wards. This restricted their ability to attend directorate meetings, and therefore their opportunity to influence developments.

In a different trust, an obstetric consultant whom we interviewed was initially unsure who were modern matrons within the midwifery division, and guessed that this role was the same as the Head of Midwifery Services. Once we identified the individuals in the matron role, he described their role principally in terms of developing and agreeing guidelines for practice.

In a mental health trust, one clinical director (named as a key contact) declined to be interviewed at all, saying that she knew nothing about matrons. A consultant psychiatrist displayed little understanding of the potential of the role for addressing clinical standards, and spoke instead of the resentment caused by the appointment of what was seen as an extra, and unnecessary, layer of nurse managers at a time when resources were scarce (it should be pointed out that his experience was of a matron who did not consider himself to be a 'proper' matron; he was an experienced middle manager with wide responsibilities for service delivery, who had taken on extra 'matron-style' responsibilities for the environment across one in-patient site). The same consultant was, however, full of praise for the effectiveness of another nurse manager who – following a recent review of matron posts by the trust – is now officially designated as a matron.

In an acute trust, in a fairly self-contained unit dealing with outpatient specialist services, the clinical director spoke quite freely of her close working partnership with the matron.

> "We've had the concept of having a senior nurse manager in a department, so I think it is not a hugely new thing for us… I think that when modern matrons came in, we were at that state in the health service where nobody wanted to take responsibility for some of these things, like cleanliness and the patients or whatever and they weren't empowered to do so. Previously of course I remember being a houseman, you know there were senior nurses around who did exactly that, who had control over all the stock, and control of other nurses and control of the environment, and what nurses did. You know, ruled the roost a bit! So we're getting back to something we have lost I think. …when I took over as clinical director, I perceived there were lots of things that needed changing and improving on and the matron and I have worked very closely together, and we are currently involved in a whole process redesign, the objectives of which are to improve access to the service and quality of the service and the working lives of the staff in the service and we are doing that process together."

7.5.6 Non-executive trust directors

The support of non-executive board members and of trust chairs was mentioned as valuable in establishing matron posts. It had been especially helpful in one particular trust, where other executive directors perceived the move as 'empire building' by nurses. Lay members understood the relevance of the matron role to achieving key objectives such as improving nursing care, reducing complaints, and improving staff morale. The danger identified by some matrons was that trust management might come (mistakenly) to regard them as the ideal solution to complex problems such as under-performance against national targets for waiting lists, or waiting times in clinics.

7.5.7 Staff in support services

The understanding of other staff groups was variable, and depended to a large extent on the advance publicity given to matrons within a trust, and the care which had been devoted by senior mangers to promoting productive relationships between matrons and managers of other functions. Where working relations were good, managers in estates, facilities and catering departments understood that matrons had a leadership function, and provided a valuable link between their services and the ward areas. The potential for misunderstanding was greater in those trusts where we found a range of types of matron post and job titles being used within different directorates, or where nurses had been re-badged, or given new 'added-on' responsibilities.

In an acute trust which had established two levels of nurse manager sharing the matron role, there seemed to be more potential for confusion; however, the General Manager for Central Services (GMCS), who is responsible for facilities management, spoke warmly of the role played by matrons in helping him achieve his objective of trying to provide high quality services for patients. He had frequent contact with both levels of matron on issues such as cleaning, linen services and catering. He observed that since the introduction of the matron role there is more dialogue about these services, that matrons are empowering ward sisters to make their views known, and that at ward level, sisters can influence the cleaning staff to fit their routines around patient needs. The manager felt it was significant that the matrons had had leadership training through the LEO scheme, which at that trust was run on a multidisciplinary basis, so opening up staffs' perspectives to look at things more corporately. He reported that since the introduction of the matron role there was much more regular and frequent informal dialogue between himself and his staff with the matrons both in person and over the telephone, over cleaning, linen and catering issues, because those things were seen much more clearly to be their concern. Although clear about the respective responsibilities of the clinical managers and general managers like himself, he felt that boundaries had blurred between them to create a real sense of team spirit, and an ability to make changes in service provision to enhance the patient experience.

7.5.8 General Managers

We found that matrons often have dual accountability for their work, reporting directly to general managers for their operational responsibilities and to more senior nurses for professional issues. We found little evidence that matrons objected to having non-nurses as line managers; a few actively preferred it. Within directorates, the general managers we spoke to valued the contribution that the matron role could make to the corporate agenda in relation to clinical governance, staff recruitment, patient satisfaction and infection control. One manager believed that it would be a mistake to use matrons to achieve certain corporate

targets; instead, they should be encouraged to keep a strong clinical focus and support front-line staff. If improvements started at the grass-roots, corporate targets would probably take care of themselves.

In other situations, managers were not so understanding of the role's clinical focus. Instead, there was evidence of 'drift' towards a generic middle management role, with a focus on meeting targets for the environment, contract monitoring and so on. At one stage in one particular trust for example, there had been a proposal to merge the roles of business managers and matrons. A review of trust management structures had re-clarified the matron role in this case. A number of matrons in all our trusts complained that their role was perceived by other staff as a 'catch-all' for any new projects that were coming on-stream.

7.5.9 New understandings of the modern matron role

Following a recent review of matron posts in one particular trust, the four middle managers who were added to their ranks included two social workers. Reactions to this were mixed; a senior occupational therapist thought this move reflected the fact that nursing did not have a monopoly on concerns about the environment and standards of patient care, and that candidates from other professions should be considered. This was in a mental health trust, where there is an established pattern of multi-professional team working. However, another matron (a nurse) thought that nurses would resent being managed by a person with a non-clinical training – a view not shared by top nursing management in the trust.

One of our acute trusts had recently appointed a physiotherapist as a matron. She works only three days a week, covering a large number of wards and departments. Despite acknowledging the pressure she was under, and the difference in professional background, ward managers in that directorate all felt supported in their work by the matron.

7.6 Working relationships

There is no doubt that good, supportive working relationships are essential for matrons, and in their questionnaire responses and interviews many cited these as one of the factors that enabled them in their role, particularly in four of our trusts. Conversely when there is confusion in relationships because role boundaries are unclear, that is viewed as a hindrance. This was evident particularly in three other trusts. However, even in trusts with good working relationships, there may be confusion at some levels. In one acute trust, the Patient Advice and Liaison Service (PALS) Officer stated that although she was clear about her own and the matrons' respective roles and responsibilities, she suspects that patients may not yet

understand that the clinical figure they know is actually the "modern matron" and can be approached to deal with problems. She does feel that matrons have contributed to an improvement in care, but the patients may not realise the reason for that improvement.

7.6.1 Relationships upward

Lines of managerial accountability in the nursing hierarchy vary: we found that many of our matrons were accountable in the first instance to a more senior nurse at directorate or sub-directorate level in large trusts, but in a small one directly to the Director of Nursing. However, we also found that it was common for matrons to be operationally accountable to a general manager, or Clinical Director, and professionally accountable only to a more senior nurse. Whilst the majority of matrons enjoyed a supportive relationship with their line managers (whether they were nurses or not), we came across some examples where this relationship was weak; in one case, this was the result of frequent changes of line manager due to people moving on to other posts, in another, to lack of clarity about roles and responsibilities following re-structuring of a directorate's management posts, which had left a matron feeling very isolated.

7.6.2 Lateral relationships (across a trust, or beyond individual trust boundaries)

Some matrons have to forge relationships across quite large distances. In answer to a section of the questionnaire about the geographical location of wards and departments, it seems that matrons in some specialties are more likely than others to have to travel long distances between their areas of responsibility, particularly mental health, child health, midwifery and renal services.

Both in questionnaire responses and interviews we found evidence that matrons had become much more involved in networking than in previous roles. However, the extent to which matrons worked across a trust partly varied according to their particular focus and, to some extent, according to personality. In one trust, for example, the paediatric matron had a largely clinical role, and prioritised work within the unit. Other matrons who were employed in a more strategic role were not necessarily widely known across the trust. Facilities staff in one trust, for instance, were only aware of one or two of the trust's matrons.

However, various examples were quoted of new or improved relationships between matrons either singly or as a matron team and trust level services. In an acute trust the General Manager for Central Services (GMCS) is responsible for facilities management (domestics, portering, catering and estates) and allied health professional (AHP) services (pharmacy, physio, OT, dietetics, speech and language etc). Amidst the pressure to achieve NHS targets

he is trying to provide high quality services that are patient focused. The GMCS has frequent contact with the matron team on issues such as cleaning, linen services and catering which they view as essential to basic care maintenance. He observed that since the introduction of the matron role there is more dialogue about these services, that matrons are empowering ward sisters to make their views known, and that at ward level sisters can influence the cleaning staff to fit their routines around patient needs (see 7.5.7).

In response to the questionnaire, a matron in another trust spoke of working with the other matrons to deliver on aspects of service for which they are responsible, such as essence of care, cleanliness, and hospital food.

Not all the trusts had established Patient Advice and Liaison Services (PALS), but where they were set up, there tended to be strong, productive relationships with matrons. In one acute trust for example, the Patient Advice and Liaison Service (PALS) Officer explained how listening patiently to peoples' concerns frequently helps to defuse situations, and paid tribute to the role of matrons in doing just that, and having the patience to unravel complicated stories to find out what can actually be done to improve the situation. She liaised with all of the 20 matrons at one time or another, by telephone, e mail or face to face, mainly in an informal manner, and found them a huge resource both as individuals but also as a group. In a different acute trust the relationship between PALS and matrons was seen as strongly reciprocal, with members of the PALS team who visited wards to publicise the service flagging up complaints to matrons and providing matrons with useful information, such as their impression of morale among ward staff. At the same time, matrons helped to improve uptake of PALS, particularly among patients who had proved hard to reach, such as patients from ethnic minorities. In yet another acute trust there was a systematic process for passing complaints on from PALS to matrons, with staff knowing which matron had responsibility for each area.

In one of these two acute trusts, one matron reported that the group effect of the cohort of matrons has been harnessed several times; when issues such as cleaning have been a problem they have all contributed evidence and produced a paper to draw attention to the issue at a high level within the trust. The matrons also collaborated to make a folder of guidance for whoever was on the "on-call" rota, especially with advice on bed management problems, which they have all found difficult.

7.6.3 Lateral relationships – within specialty or directorate

We found good examples of matrons' involvement in teamwork across disciplines in some trusts, alongside examples of matrons not being fully involved in decision-making processes

or meetings at directorate level, often due to the clinical demands of their job. In an outpatient-based directorate at an acute trust, the matron worked in a team with the Clinical Director and Nurse Consultant – all three mentioned this in separate interviews. The Nurse Consultant described the matron as like a "double sided coin" – on one side she is a line manager to staff, and on the other an advocate for patients. She also said the matron is like a sign post – pointing the way to medical and nursing consultants about the need for service improvements.

Other examples include close working relationships between matrons and medical consultants, such as in a different acute trust, where the paediatric A & E matron and paediatric consultant worked to develop a 24 hour A & E specialist service for children.

An example of difficult lateral working relationships appeared in one of the mental health trusts. A matron said:

> "Other managers find the remit of the matron role difficult - they feel that the matron's access to senior staff within the trust should be via the line management system only. This raises an issue about some managers feeling threatened."

7.6.4 Relationships with ward sisters and senior clinical staff (e.g. Clinical Nurse Specialists, Practice Development Nurses)

One feature of relationships between matrons and other members of the nursing staff was the way in which they negotiated their relationships and their spheres of influence. In one acute trust, for example, matrons negotiated a contract with their ward managers to ensure that they did not step on each other's toes or have unrealistic expectations of each other.

In another trust, some ward sisters and senior clinical nurses shared their expectations that the matron role would be a central focal point for taking the service forward in their directorate, supporting staff well, allowing them to develop, always putting the patients' views first and trying to ensure that care is delivered in the appropriate fashion; most agreed that their expectations were being realised. They also expected their matron to be a role model, to ensure that underperformance is dealt with as well as incidents and complaints and to ensure that the same problems do not keep occurring. On the whole these expectations were also realised but some expressed the feeling that matrons in the trust have to spend too much time managing beds.

One matron shared with researchers the strategy she had developed to deal with being too busy. She said "My role is mainly about transferring my skills to my ward managers to enable them to be both the role models for staff and advocates for patients. Due to the nature

of the size of my directorate this has been the most successful model to introduce the role of the modern matron".

In one very large acute trust there appeared to be a particular emphasis on matrons providing leadership for ward sisters and other G grades; their responses to the sections on target setting and on budgets in the questionnaire seemed to mention this more often than other trust responses.

In a smaller trust where there were two levels of nurse managers regarded as matrons, a senior sister commented on the support received from the more junior level matron.

> "The matron does have a supportive role - I find I can always go and ask a question or if I have got a concern or an issue I can always ask for advice or just to bounce ideas off, so she is accessible, and will obviously listen to my concerns if I feel the staffing is unsafe or anything. She supports me if there are incidents that flag up training and education issues, and she will occasionally roll her sleeves up and help if we are really desperate, in crisis situations. But she won't take over from us, if we have got a problem or an issue she will promote and encourage us to actually think about it, and deal with it ourselves. So you know we are not baby sat, in the way that she does things for us."

Relationships between matrons and nurse consultants did not feature strongly in our data, but there were good examples of collaboration between these post holders, such as the way they might jointly work to improve the environment for patients and nurse education. One trust had divided responsibilities between nurse consultants and matrons so that nurse consultants were responsible for producing evidence based standards and protocols, and matrons were responsible for overseeing their implementation. However, there was sometimes a sense of tension between these roles. In one trust, for example, it seemed that the matron and nurse consultant had needed to clarify distinct areas of authority. This was associated with a difference in leadership style: the matron tended to lead by example, while the nurse consultant was more concerned with challenging and empowering staff.

7.6.5 Relationships with other ward-level staff

Many matrons manage staff other than nurses. Responding to the questionnaire on this point matrons in all trusts have responsibility for some administrative and clerical staff (including ward clerks and receptionists) and most manage some health care assistants. In addition, matrons in five of our case study trusts have responsibility for housekeepers, and in one of those five additionally for some phlebotomists; in a mental health trust also for some psychologists, social workers, art therapists, and occupational therapists.

In one acute trust mention was made by an Assistant Director of Nursing of the role of matrons in confronting nurses who were known for some time to be poor performers but who

previously had been unchallenged because it was just too difficult. It is thought that participation in the RCN leadership programme had given the matrons the confidence to address these issues.

7.7 Experience of the modern matron role

This section aims to provide a sense of what it meant in practice for study participants to work as a matron. It begins by using the 10 key responsibilities of matrons (DH 2003) as a framework. This guidance was issued just when the researchers were beginning their case studies, and it was clear that many trusts had not begun to implement it. Furthermore, many matron roles were much broader than the guidance on the 10 responsibilities envisaged. This section goes on to explore some of the issues that shaped the way matrons fulfilled their role.

7.7.1 Matrons' 10 key responsibilities

Key responsibility 1: Leading by example

We found evidence of leadership by example amongst all matrons, but the style of leadership varied depending partly on personality and the level at which the role was being implemented. Some matrons, for example, had a more authoritative style, and others were more participative and inclusive. Those matrons who were highly clinically focused tended to lead by practical example. For instance, they demonstrated the standard for patient dignity by the way that they themselves addressed patients and their families, dealt with their concerns and ensured their privacy. There were one or two instances where we identified some frustration on the part of matrons' colleagues who felt that clinically focused matrons should lead less by practical example and work more strategically.

Matrons who had a more managerial focus and were less visible in the clinical area tended to provide a different kind of example to nursing staff, demonstrating for example how to ensure a nursing voice in decision-making at directorate and board levels. Some matrons offered an example to staff by encouraging them to raise issues, possibly further up the hierarchy and helping to instil a sense of belief that this was acceptable and desirable. There was also evidence that some matrons managed to lead by example at both clinical and managerial levels.

Key responsibility 2: Making sure patients get quality care

Beyond ensuring that patients received quality care through the example of their own clinical practice, matrons – particularly those working at more operational levels – were often involved in the development of standards and protocols. This was generally through collaboration with colleagues in multi-disciplinary teams. Matrons also helped to ensure

standards of care by their direct engagement with patients and their families, developing an understanding of their needs and addressing any complaints. In addition matrons were found to play an important part in leading implementation of "Essence of Care" and worked with PALS staff to ensure they were aware of patients' and relatives concerns.

They were seen to play a role in improving communication about care. Ward sisters, for example, saw the matron played an important role at directorate and board meetings as a champion for nursing concerns, and helped improve communication both upwards and downwards within the organisation. At the same time, there was evidence that ward staff were encouraged and enabled by matrons to raise issues affecting patient care within the organisation.

Key responsibility 3: Ensuring staffing is appropriate to patient needs

We found that matrons at all levels were heavily involved in matching staffing to patient need, although the nature of their involvement varied considerably. Most matrons assumed ultimate responsibility for clinical rosters, and worked to set up systems to ensure consistent cover, including ways of managing annual leave and, in some cases, managing the trust nurse bank. There were, however, tensions sometimes between ensuring cover and meeting certain management targets, such as the reduction of agency staff. In one context (ICU), a matron had challenged the assumption of a one-to-one nurse/patient ratio and introduced a way of working out staffing needs based on patient dependency.

There was considerable variation in whether or not matrons were involved in the selection or 'letting go' of staff. In two trusts for example, matrons were heavily involved in the 'hiring and firing' of staff, while others were frustrated that this was not part of their remit. For some, this was an area in which there was an awkward overlap with the ward sister's role.

Key responsibility 4: Empowering nurses to take on a wider range of clinical responsibilities

Matrons often played an important role in helping nurses to develop their range of clinical skills. This was sometimes through collaboration with practice development nurses. Some had considerable success in constructively challenging poor performance in staff or promoting self-esteem within individuals. More clinically-focused matrons tended to undertake a teaching role, working alongside nursing staff, while more managerially focused matrons tended to more involved in the development of protocols to guide extended practice, or example, or organising study days.

In one acute trust, an Assistant Director of Nursing Services (ADNS) is responsible for taking forward the trust's response to the CNO for England's initiative on the "Ten Key Roles for Nurses and Midwives"; this involves the matrons as facilitators. Work on these roles was already underway in the trust and its neighbouring acute trust as a joint initiative, for some months before matrons were appointed, but the ADNS observed that the appointment of matrons gave the work a boost, because of the linkage the matrons provided between the top levels of management in the trust and the clinical practice level, and also working in partnership with practice development nurses and clinical educators. Particular roles being tackled in the trust are nurse-led admission and discharge, ordering investigations and making referrals, and frameworks are being developed so there is consistency between divisions and directorates on knowledge, competencies and skills required for nurses to take on these roles. These frameworks will need ratification in the modern matron forum meetings before being widely implemented in the trust.

Key responsibility 5: Improving hospital cleanliness

We found that matrons addressed hospital cleanliness in a variety of ways, with a dilemma sometimes about whether matrons should engage in direct action or whether they needed to focus on systems and processes that did not seem to be effective. Those matrons who regularly 'walked the floor' were well aware of standards of cleanliness and would intervene directly where they found problems. This might involve speaking directly to the ward's cleaner or telephoning their supervisor. In some cases, where problems represented a hazard, we found examples of matrons tackling the problem themselves (such as cleaning dirty lavatories in the absence of domestic staff). At the same time, matrons used the strong relationships they had developed with domestic supervisors and facilities managers to help cut through 'red tape' to improve the response to complaints. Close liaison with domestic supervisors helped to identify day to day problems and, for example, address nurses' disrespectful attitudes towards domestic staff.

Some matrons were particularly innovative in finding solutions to cleaning problems. In one trust, for example, the matron of ICU had used part of her budget to buy a washing machine for the unit, so that curtains could be washed after a patient was discharged. Some problems however were rooted in the relationship between the trust and the external contractor providing cleaning services. Some matrons in our study had no direct contact with contractors for cleaning services, and no control over how contracts were awarded. However, some matrons were able to influence discussions over cleaning contracts and in some instances instil a greater confidence in ward sisters to raise their concerns directly with the facilities manager.

Key responsibility 6: Ensuring patients' nutritional needs are met

One of the more surprising findings of the study was the seemingly limited involvement of matrons in the improvement of nutritional standards. As with issues of cleanliness, the contracting out of catering services (and the lack of influence matrons had over the allocation of contracts or audit of contracted services) meant that matrons were restricted in the extent to which they could improve patients' food. In some trusts, however, matrons *as a group* were becoming more effective in influencing the contracting process, highlighting the benefits of collective action more generally. Putting the issue of catering services on one side, we had not expected to find so few matrons mention their responsibility for patients' nutrition in our matron survey or during interview. In addition, in our patient survey, most patients failed to identify hospital food as a responsibility of the matron; this contrasted with widespread understanding about matrons' responsibility for cleanliness and standards of nursing care. There were signs that, as matrons became involved in the implementation of Essence of Care nutrition standards, this area would once again have a high profile as an important part of nursing care.

Key responsibility 7: Improving wards for patients

We found good examples of matrons improving the patient environment – for instance in making dining arrangement much more congenial. There were many examples were matrons used their initiative to improve the environment, particularly where the budget allocated to matrons was not actually under their control. Even where they had funds, matrons attempting improvements were frustrated by cumbersome or inefficient trust-wide systems such as an overburdened estates management service or the contracting out of repairs which meant many simple improvements were expensive and priced beyond their resources. Similarly, matrons found they were thwarted in their efforts by poor support services. For example, they might spend money on new curtains to improve the environment, but were reluctant to have them cleaned as they could not be certain the curtains would ever return from the laundry. In this way, the impact of matrons on environmental issues was limited due to problems largely beyond their remit.

Key responsibility 8: Making sure patients are treated with respect

Matrons in the study went to great lengths to meet patients or relatives face to face, to deal with complaints. In many of our trusts, one of the main reasons for complaint was the attitude of staff towards patients, and matrons played a significant role in handling complaints. Indeed there was anecdotal evidence indicating that, of all initiatives, matrons had made the most impact on the reduction of complaints. However, we have only limited data on the processes matrons used to deal with complaints and therefore how they acted on those arising

from lack of respect for patients. The main way that we saw matrons ensuring respectful treatment of patients was by the personal example they set.

Key responsibility 9: Preventing hospital acquired infection

Other than their efforts to ensure cleanliness, the role of matrons in the prevention of hospital acquired infection did not figure largely in survey responses, or in interview. We observed a number of ways in which matrons promoted infection control. One was through personal example (for example, picking patients' items up from the floor on their 'rounds' and washing them before returning them to patients). Another was through *impromptu* teaching while observing practice. We were also aware that matrons were working collaboratively with infection control CNSs and involved in campaigns to improve hand washing.

Key responsibility 10: Resolving problems for patients and their relatives by building closer relationships

There was evidence to suggest that matrons were involved in resolving problems for patients and their families as a result of the direct contact facilitated by 'walking the floor' and had closer relationships to patients than many senior nurses were able to establish in the past. Our patient survey indicated that patients identified matrons as responsible for cleanliness, good patient care, helping patients with problems and ensuring staff discipline. Interestingly, only a few considered that matrons had any responsibility for standards of food, in line with our other findings. These findings however, should be considered in context. Both our survey and interviews with other staff suggest that, although many patients may have had some grasp of the role, very few seemed to be able to recognise their local matron, even where the matron regularly walked the floor or was directly involved in patient care.

The vast majority of matrons worked hard to establish close working relationships with individual members of staff across their directorate and trust which helped to facilitate the resolution of problems. These relationships helped to cut through bureaucratic processes and 'oil the wheels' of service delivery. This emphasis on networking and personal engagement helped to offset some of the problems matrons faced arising from a shortage of resources.

7.7.2 Issues that influenced fulfilment of the matron role

Among the various factors that impinged on matrons and their capacity to carry out the role, the most prominent were the level and nature of support available to them; available resources; the relationship between clinical and managerial components of the role; their approach to patient engagement; and the degree of clarity that existed about the role.

7.7.2.1 Support

Matrons suggested that they sought, or were offered, support to carry out their role from a variety of sources. These included the matron's line manager, administrators or secretaries, members of trust networks and ward staff. Matrons also spoke about the support they gained through continuing professional development.

i) Line management

Matrons frequently referred to the valuable support they received from the Director of Nursing or Midwifery Services, to whom they were professionally accountable, and with whom they had regular meetings. The general manager, usually the matron's line manager, also emerged as a key figure. For example, the general manager might provide support by organising staff recruitment or dealing with finances, but a good general manager might also provide an alternative perspective, borne from their managerial experience, and act as a helpful sounding board. The potential significance of the general manager role is highlighted, for example, by a matron in a Paediatric A & E department, whose general manager was relocated in a restructuring exercise and not replaced. As a result, the matron in the department had to take on new responsibilities, without any preparation or support. As she described it "I feel very alone, as if I'm floating out there on my own".

The situation was rather different for the matron in a PCT who acted as a general manager for the community hospital. Her line management was provided, in theory, by one of the Directors of Services within the PCT. However, frequent restructuring meant repeated changes in her line management and, consequently, fragmented support. She had initially sought peer support from other senior nurses but was now looking more to matrons for this. Unfortunately she was excluded from a matron group at the local acute hospital but had recently found other external sources of support, such as through the National Performance Agency. We came across other instances where matrons experienced a serious lack of continuity in their relationship with their line managers: a matron in one trust, for example, had worked with three different nurse senior managers in the course of his eighteen months' tenure.

ii) Administrative support

There was considerable variation across our sample in terms of the administrative or secretarial support they received. This reflected findings from the matron survey, which found that although 76.9% of respondents had their own office space, many complained of having to share their office space with far too many people. This was particularly the case in two of our acute trusts. There were also instances in which there was no office space at all dedicated to the matron. There was also wide variation in the secretarial or administrative support available to matrons. One matron in a PCT for example, who covered a community

hospital, had a personal secretary (20 hours per week) as well as a senior administrator (30 hours per week) to support herself and the service. In contrast, within some trusts the majority of matrons had no secretarial support and the rest only minimal assistance.

iii) Networks across trusts

One of the most important sources of support for matrons we spoke to came from collaboration with other matrons, and nurses in the role developed both formal and informal ways of working together as a group (discussed more fully under 'authority'). In the matron survey, the matron's peer group emerged as one of the factors that contributed to matrons' effectiveness. However, this collaboration proved difficult in some contexts, for example where one matron was responsible for a single site or where matrons were scattered over a wide geographical area, although data from one such trust suggests that distance did not always prevent matrons from networking. Additionally, most matrons built supportive relationships where they found opportunities to do so. For example, following the departure of her supportive general manager, a paediatric A & E matron strengthened links with paediatricians (rather than, say, A&E doctors) as they shared the same priorities, such as the development of A & E services to provide 24 hour specialist care for children.

iv) Staff within the modern matron's area

Both in interviews and in the matron survey, when asked to say what factors helped matrons to be effective, many spoke of the support they derived from members of staff within their own area. In addition to ward staff such as ward sisters, this included practice development nurses, nurse consultants and lecturer practitioners. In highly specialised areas such as oncology, lead nurses provided good sources of support to matrons.

v) Continuing professional development

Our National Survey shows considerable variation in the level of investment trusts made in the role in terms of administrative support, formal training, mentorship or action learning programmes. The matron survey revealed that several trusts provided preparation for their staff prior to taking up the matron role; one trust sent many nurses on the RCN Leadership course and also the course for Leaders in Empowered Organisations (LEO), also continuing to second those who had missed the RCN and Leo courses. Four trusts provided in-house courses. Since taking up the role, matrons in three other trusts received financial support and time to take courses tailored to their individual needs. Another trust supported several matrons on appropriate part-time MSc courses.

In our case study trusts, many of the matrons had already been on some sort of clinical leadership course by virtue of their previous posts as ward sisters. In interviews, a number of

matrons said how much they valued attendance at these courses. Those who had participated in action learning sets found them a very helpful aid to problem-solving, and ideally would have liked the opportunity to establish them in their own workplace, had time allowed.

7.7.2.2 Available resources

The resources that were important to fulfilment of the matron role fell into two broad categories: financial and human resources.

i) Financial resources

One of the most consistent findings across trusts was the difficulty that matrons experienced in the face of financial constraints. Our matron survey found that just over half (53%) of our respondents reported having control of budgets for staffing and the environment; almost all of these shared that budgetary responsibility, either with ward sisters or (more usually) with their own line managers; whilst 44% of respondents had no responsibility for budgets. We found further variation regarding the size of budget that matrons controlled: some had the minimum environmental budget of £5,000, while others had budgets as large as £2 million (in a large mental health trust). For some it permitted minor improvements in the environment, such as new curtains for a ward, while for others the budget covered the costs of staff and supplies for their unit. In one PCT, for example, the matron managed all the staff and services of the community hospital and thus controlled a comparatively large budget. The flexibility associated with control of these larger budgets allowed some matrons to work more holistically, and to rethink the organisation of care. However, the transfer of successful innovations developed in one area to others across the trust was not always possible, as other units did not necessarily have the same resources to do this.

Lack of finances within a trust played a considerable part in shaping the role of some matrons. For example, in one acute trust, the paediatric A & E matron post was funded from the main A & E budget for a nurse practitioner (NP). This meant that the paediatric post holder was required to spend 50% of her week on the clinical roster, working as an Emergency NP and it proved to be very difficult for her to carry out her matron responsibilities in the remaining time. At the same time, lack of funding to provide adequate staff and equipment led to a particularly heavy workload and considerable overtime for this matron. In the same trust for example, the midwifery matron spoke generally of being restricted in implementing change because of a lack of funding, and gave the specific example of being unable to improve the security of community midwives who worked alone.

ii) Human resources

Resources were not only understood in financial terms. As the estates manager in one trust observed, the enthusiasm of staff, for example, was seen as an important resource, without

which matrons were largely ineffectual. In addition, as mentioned before, matrons as a group provided an important resource for individual matrons.

7.7.3 The relationship between clinical and managerial components of the role

One of the most striking findings of the study was the way in which the matron role was interpreted varied, not only across trusts, but also within trusts. This variation was particularly evident in terms of whether emphasis was placed on the clinical or managerial aspects of the role. Broadly speaking, there were three forms of interpretation.

7.7.3.1 Modern matron as a member of the clinical team

In this scenario, the matron had a heavily clinical focus, with little scope for manoeuvre as he or she was permanently included in the unit's roster for clinical nurses. One example of this is the Paediatric A & E matron referred to above, who was expected to spend 50% of her time in 'routine' clinical activity (as opposed to making clinical activity a medium for staff development or teaching). This particular matron was keen to retain a largely clinical role and had been persuaded to take on the matron post on the understanding that this would remain an integral part of her job. In reality, however, it proved very difficult to work in this way as she was constantly pulled away from clinical work to deal with operational issues, and felt uncomfortable about leaving the clinical team beleaguered. This variant of the role prompted some non-nursing colleagues to express fears about the potential loss of clinical involvement among experienced nurses. For example, as one consultant said:

> "I think we're seeing very good clinical nurses dragged into ever increasing management roles and budget control whereas, from my point of view, I prefer to see them doing more clinical work and hands-on organisation and leading of their team in a more similar way to the way consultants work – we're still very involved clinically".

7.7.3.2 Strong clinical focus but not included in roster

In this variant of the role, the matron was entirely supernumerary to the nursing team, although clinical involvement - albeit of a more *ad hoc* nature - was a central element of his or her work. Within this interpretation of the role, however, there was wide variation in the balance between clinical and other aspects of the role. This, to some degree, depended on the size of 'patch' covered by the matron: the larger the sphere of responsibility, the less clinical involvement was feasible. At the same time, there was no standard interpretation of 'clinical involvement'. For some matrons, it was largely a matter of covering meal breaks or staff shortages. Others, however, provided specialised support for certain groups of patients (for example, in one acute trust, the ICU matron focused on patients requiring critical care in the surgical wards that she covered), while a small number of matrons chose to set aside a day a week for clinical work, often in a supernumerary capacity. Alternatively, a matron might

become involved in sorting out a clinical problem as a result of being approached by staff, or engaging with patients, while 'walking the floor'. Some matrons made spontaneous use of such clinical problems to teach, or they used these moments as opportunities to indicate acceptable standards of practice by example. However, all these matrons were additionally, and significantly, involved in more operational matters such as bed management, ensuring their trusts met certain targets, developing systems for ensuring cost-effective nurse-patient ratios and representing nursing priorities at trust-wide committees. This operational activity could be highly specialised. In the case of the ICU matron referred to above for example, operational involvement included becoming involved in ensuring the most appropriate cardiac monitoring equipment and becoming involved in the detail of warranties and contracts with suppliers. The matron in this interpretation of the role was often described by their key contacts as in a special position - namely between clinical and managerial worlds - but at risk of being edged into an assistant general manager role.

7.7.3.3 More operational/strategic focus

Some matrons had little direct clinical involvement other than helping out in times of crisis. Instead they largely concentrated on operational issues or shaping clinical practice (interestingly, not exclusively nursing practice) through the development of standards and protocols. One example of this form of implementation occurred in a trust where matrons in the midwifery division undertook a very similar role to their predecessors, senior midwives. In a PCT, the matron was seen by the Director of Services we spoke to as having more seniority than other matrons across the trust, and was working as a senior nurse/general manager.

The emergence of one form of interpretation rather than another was influenced by a range of factors, including:

- ***type of service*** (for example, where the matron covered a large geographical area, as with community services, clinical involvement on a routine basis was impractical);
- ***the rationale for implementation*** (for example, where the matron was essentially a re-badging exercise, it tended to replicate previous priorities, usually those of an unambiguously management role); and
- ***the specialism*** (for example, a matron responsible for a group of acute medical wards told us that she believed matrons working in more highly specialised areas, which were likely to be smaller and self-contained, had the most chance of developing a ‘pure’ matron role. Arguably, it was easier for them to retain significant clinical involvement, and act as a clinical leader rather than an all-purpose operational manager).

Matrons in our sample seemed comfortable in any of these three varieties of the matron role, provided that they had known in advance whether they were taking on largely clinical, largely managerial or mixed responsibilities. In one acute trust for example, the matron in Paediatric A & E was deeply disillusioned with the matron role when it emerged that she was unable to engage in clinical practice to the extent she had anticipated. In contrast, the midwifery matron in the same trust had agreed on a predominantly managerial role before her appointment and was enthusiastic about the way the role was working out.

7.7.4 Engagement with patients

All matrons saw their role as essentially concerned with improving patient experience and, as outlined above were involved in addressing issues such as cleanliness of the clinical environment or appropriate staffing. There was evidence that many matrons were closely involved in initiatives such PALS, or occasionally forums such as patient advisory groups. However, we found that the means of carrying out improvement was often through focusing on staff, and the development of strong clinical teams, for example, rather than individual patients. Engagement with patients depended on a number of variables, such as the size of the clinical area a matron covered, that together influenced the matron's visibility.

7.7.4.1 How visibility was achieved

The majority of matrons aimed to be visible to patients and their families through 'walking the floor', although the extent to which walking around the clinical area and engaging with patients was a routine element of the matron's day varied considerably even within any one trust. In terms of frequency, matrons spoke of doing 'rounds' of their clinical areas either on a regular basis from one to three times a day, or on a more ad hoc basis, depending on their other commitments. Yet our patient survey data suggests that the majority of patients, even those who were in hospital long-term, remained unaware of the matron. This may be because not all matrons wore uniform on each ward visit and were therefore difficult to distinguish, and not all ward notice boards identifying members of the nursing staff included the matron. At the same time, patients may have been aware of certain, relatively authoritative figures visiting the wards, but remained unsure of their role or did not realise that they had the status of matron. In one of the PCTs, for example, it was said of the manager of the community hospital that she was highly visible as a senior nurse, but not necessarily as a matron. Key contacts interviewed in the course of the study suggested that many patients knew staff by sight, and may have had certain expectations of them, but were unaware of their precise role. In other words, patients may have been no more, but no less either, perplexed by the matron role than they were by many other nursing roles.

7.7.4.2 Contexts in which visibility was not easily achieved

There were areas where visibility of the matron was especially hard to achieve. These included those areas where patients were short-stay, such as out-patients, and in-patient areas which a matron could not visit frequently because of responsibilities for patients in other parts of the trust. One way of resolving this difficulty on a ward in one of the mental health trusts, was for the matron to organise a regular weekly 'surgery' at which she tried to meet with all the patients who wanted to talk to her. We heard of matrons who held similar surgeries in the community, where they had discovered that, to be most useful to service users and carers, meetings had to be organised for the evening, out of working hours.

In addition, there was some suggestion that matrons lose visibility where they are routinely involved in clinical work. In the case of the Paediatric A & E matron in one of the acute trusts, for example, working as a regular part of the nursing team meant that there was little to distinguish her from other nurses; as one health care support worker said, she came across as "just another member of the nursing staff". Significantly, many matrons acknowledged that they were more visible for staff than patients.

7.7.5 Clarity of roles

We have described how differently the matron role was played out in different trusts, and within different directorates of the same trust. One aspect of this difference concerned the way the matron role related to other roles and confusion about role boundaries – either between nursing roles, or between the matron's role and certain non-nursing roles. The nature or basis of this confusion varied, but most notably related to the relationship between the matron and the ward sister, the nurse consultant, and the general manager.

7.7.5.1 Role confusion within nursing

i) Modern matron - ward sister role

There was a certain amount of confusion about the relationship between the matron and ward sister roles. There was some suggestion, for example, that matrons worked at a strategic level while senior sisters operated at a local level. Yet data from participant observation and interviews indicated that in some settings, clinical staff and patients might turn to the matron rather than the ward sister for guidance on what might be regarded as local issues. Interview data showed that at least one matron took on the post believing that the content of the role would be largely the same as that of a ward sister, and was unable to see that she had achieved anything more than she might have done as a senior sister. Similarly, in some instances, key contacts of matrons saw the role as similar to the traditional ward sister in

terms of the mix of clinical and managerial responsibilities, and these key contacts were unclear why the ward sister had not been given the title of modern matron.

ii) Modern matron - nurse consultant role

Although clinically competent, matrons were not necessarily expected to have significant clinical expertise in the area for which they were responsible. In some trusts, it was the managerial and leadership skills that they brought to the post that were of primary importance. In other trusts, their clinical expertise was far more central to the role. However, where matrons *were* clinical experts, the boundary between the matron and the nurse consultant role could become blurred. In one such instance, the ICU matron and nurse consultant for critical care identified discrete areas of work, such as different patient groups, or different approaches to supporting clinical staff caring for acutely ill patients.

iii) Modern matron - midwife supervisor role

In one trust, the role of midwifery matron had certain points of overlap with other roles for example, in terms of child protection issues or the supervision of midwives' practice. It was unclear how this overlap was viewed by staff – whether it helped to integrate the matron into the team or raised issues of parity.

7.7.5.2 Other role confusion

In the matron survey, respondents were asked to comment on clarity within their trust about their roles, responsibilities and working relationships. There were indications of poor understanding of the role. This seemed to be a particular problem for one mental health trust, where matrons highlighted grey areas between the role of matrons, directorate managers and ward managers. In addition, because of variation in the number of wards covered, skill mix across wards and so on, each matron's role was different and therefore difficult for others to grasp. On top of which, the matron's role had been poorly introduced across the trust and many members of staff (such as doctors) remained unaware of their remit.

i) Modern matron- general manager/business manager role

We have already referred to the potential 'slide' from matron to general manager feared by medical colleagues, and the trust which at one stage considered merging the matron and business manager roles in a directorate. We found one example where a matron covered a single site (in a PCT) and the role was essentially that of a senior nurse/general manager with various aspects of the matron role 'tacked on'.

7.8 Power and authority across trusts

This section deals both with matrons' perceptions of their authority and the perceptions of those they work with. We have already discussed the lack of clarity about the matron role and remit that exists in many trusts (Sections 7.4, 7.5 and 7.7.5). Given that authority rests upon clear understandings of what an individual in a particular role can or cannot do within an organisation, it is not surprising that we found differences of opinion about the precise nature and extent of matrons' authority. In general, it seemed that matrons tended to underestimate their own authority, in comparison with the perceptions of others. It is possible that, in the case of matrons who were given limited line management responsibilities for staff, they were initially uncomfortable in a role where they were expected to lead rather than to manage; to negotiate their way through complex service level agreements; and to influence rather than instruct. Many of our participants were comparatively new in the role, and maybe had not yet tested their authority to the full.

7.8.1 Matrons' perceptions about authority

Matrons' views of whether or not they had authority to make changes, or power to support their decision-making, varied from trust to trust. In general, we found that matrons perceived themselves as lacking in sufficient authority to make fundamental changes: for example, they were not able to make decisions over hiring and firing staff, management of budgets, or improving the environment. A common source of dissatisfaction for some matrons was a sense of disappointment about their level of authority; they had been led to believe they would have real authority when they took on the role, but in practice they either had to appeal to a more senior person in the management hierarchy, or had to engage in protracted negotiations with middle managers in other services to bring about change.

The following are some of the comments people made on our questionnaire:

- Matron in a mental health trust: 'I do not have enough authority – only lip service is paid'
- Matron in another mental health trust: 'The idea that a modern matron would be a figure that had power to change presents difficulties – this has not been the result.'
- Matron in an acute trust (who largely enjoyed the role): "I have no authority to act without going through the Directorate Manager or the Clinical Management Team for improvements".

A similar sense of frustration was expressed by a matron in a PCT who said: "I have lots of autonomy and freedom to make decisions, but not always sufficient authority to change processes, etcetera."

Answering the question about hindrances to effectiveness of matrons, a respondent in an acute trust cited 'lack of real authority to make change' and the same person later said: "I

think there should be clarity of matrons' role nationally – there should be a national matrons' job description which allows for authority within the role to make a difference".

Such matrons felt unable to take appropriate control of services and there were indications that this impacted on standards of care. In a different acute trust for example, one matron stated:

> "In terms of achieving a standard of care, there are certain things outside of my remit which impact on that and I don't have any direct control over – I can only highlight the issues".

Another aspect of the deficit of authority was the sense that other people held the power that should be vested in the matron. A survey respondent in the same acute trust said: "I feel in some areas we do not have the authority to improve things – for instance, in the cleanliness of wards – we are not involved in cleaning services".

Similarly, matrons from across the trusts talked of their frustration about the way that decisions which directly affected patient care were being made by non-clinical staff.

A further sense of disappointment stemmed from the public perception of matrons as powerful figures, whereas matrons saw the disparities. For example, a matron in a large acute trust made these remarks:

> "We do not actually have the authority which the public think we have, especially with regards to cleanliness and food. This can make it extremely difficult to fulfil our roles".

A colleague in the same trust followed that with:

> "I would challenge some of the underlying principles of my role. For instance that I have authority to address poor cleanliness - because the services are contracted out, I find I have very little influence to change certain elements, and also due to financial constraints, aspects such as poor food".

Finally, a rather different perspective on authority came from a respondent in a trust where spans of matron responsibility are uneven, which suggests the dangers of diluting the authority of the matron role either by appointing people at too low a level in the nursing hierarchy, or by giving them too small an area of clinical responsibility to match the 'matron' status:

> "There are large variations in levels of responsibility and some areas have matrons where they are not needed; this detracts from the authority that matrons are supposed to have".

Occasionally in an interview a matron would come out with a definitive and very positive statement – for instance in one trust a matron who had been in post 18 months but had not previously had a managerial role, suggested that she was enjoying a new-found sense of authority:

> "Now I do think about things and I don't make rash decisions; but once I make a decision I am quite happy with that and I do feel like I have got the clout! I found that difficult at first, taking decisions, but I think you grow and learn".

7.8.2 Colleagues' perceptions of modern matrons' authority

Although matrons were often disillusioned about the degree of their authority, their colleagues tended to see things rather differently. Senior nursing staff, in a trust where matrons had expressed that disillusionment, agreed that the matron in their directorate had enough authority to get make changes at a local level to improve the patient care pathway, and that, usually, their decisions were not over-ruled. Matrons were seen to have the authority to introduce or support change that impacted on the nursing workforce. A consultant in that trust thought it was particularly useful in this context to have a nurse driving change rather than a business manager, for example:

> "I think it is useful to have somebody who is a who is a nurse in that (matron) position to then go and try and influence other nurses, because I think sometimes they can be a powerful obstacle to change - as a group they find it very threatening".

Some key contacts stated that those matrons who were appointed from within a trust (as was largely the case with our sample) had authority partly because they were known figures with established reputations concerning clinical credibility. However, some respondents posed a contrary view, suggesting that a matron appointed from outside the trust might have heightened authority by dint of being 'an unknown quantity'.

7.8.3 The concept of 'personal power'

A number of respondents made a distinction between 'personal' and 'positional' power in the matron's job. Personal power is seen as an important factor which helps matrons to make effective use of the authority vested in their role by the organisation. Our interviewees gave various explanations of what they meant by this: personal power was seen to rest on matrons' personal qualities (such as leadership, patience, calmness, friendliness, energy) as well as on their clinical knowledge and expertise. When asked whether a particular matron had enough authority, one sister in an acute trust said:

> "I think authority possibly depends on the personality of the person in the job and how they use it - my perception is that our matron does have that quality and is able to make things happen.' As another ward sister said, 'It's not just about having authority; it's how they use it".

Matrons, too, showed some insight into the importance of individual power; a matron in a different directorate in that same trust said:

> "I think personal power is actually quite an important attribute. Position power I think is very questionable; I don't think that it automatically produces any good results".

7.8.4 Personal power and leadership style

An important dimension of the matron role is both to provide leadership and to encourage it in others. The following example illustrates the importance of leadership style, which ultimately relies on the personal qualities (or personal power) of an individual. In an acute trust, a Clinical Nurse Specialist (CNS) who relates to all the matrons, observed the changes in power relationships in the trust when two senior managers left who had been very autocratic in nature; under their management things appeared to have got done more effectively in the short term because people did as they were told. Then the matrons were appointed, and the CNS said:

> "I think now things don't appear to be moving on as quickly as they could be, but the matrons are getting people on board and encouraging the change from within rather that insisting on it from above so probably it is a long term change, so that's obviously better in the long run".

A matron in a different acute trust spoke of the connection between leadership and personal power in an implied way when she said:

> "I think you have got to be a good leader first and foremost if you want the service to run properly. It has got to run from the top and you have got to be a good leader. I am not the sort of person that dictates - that's not the way that I am. The way that I manage personally is, I think you have got to be open and friendly".

There was a suggestion that the authority of matrons was less of an issue for ward sisters than their leadership style. A ward manager in that same trust, for example, thought that what mattered was the distribution of authority across the nursing team:

> "If the matron is doing a good job and empowering the ward managers, then that authority will come through the ward managers. And if the matron contributes to the quality of care, it is by the empowering of the staff".

We found that most of the matrons in our study espoused what is commonly referred to as 'transformational leadership', an approach which owes more to the values, sensitivity and interpersonal skills of an individual than to his or her position in the organisation's management hierarchy.

7.8.5 Organisational level and extent of authority

We found that, according to the needs of the organisation, matron posts were established from the outset at different levels in the management hierarchy and with different levels of authority. A clinically-focused matron at H grade, working close to ward or unit areas managed by a more senior directorate-level nurse, needed to have a level of authority over the work of support staff and over other resources which would enable her to support the ward sister. A matron at directorate level with strategic responsibilities, or one working in a mental health trust, with a largely managerial role and an extensive geographical remit, both needed more extensive authority within the organisation. As a general manager in a mental health

trust commented, in answer to the question as to whether the matrons in his directorate had enough authority:

> "I would say they did – they control budgets. They've got a big chunk of money….they can suspend people, they can discipline people, they can do all those things….. they're not wishy-washy facilitators".

It is important for trusts to be sufficiently clear about their expectations of matrons to ensure that they establish the role at an appropriate level within the organisation. In one acute trust for instance, we found evidence of some confusion. There were two levels of nurse management who were described by the Director of Nursing as sharing the matron role. A matron who was at the more senior level, when interviewed, declared that she had enough authority to do her job but that her assistant, who took on more of the matron functions, did not. One reason that the authority of the junior matron was limited was due to a lack of control over resources; the control rested with the more senior matron.

7.8.6 Group power

An important development, which had not been anticipated by trusts, was the discovery by matrons of their power to enforce changes when they acted as a group; for example, a matrons' group which was very effective in changing the contract for domestic cleaning. This group power was viewed positively and sanctioned by the organisation, at least in relation to the achievement of corporate objectives.

7.9. Impact of the matron role

7.9.1 Identifying impact

The study aimed, where possible, to identify the impact of matrons on patient care. The researchers faced some difficulties with this, both because of the time constraints on our fieldwork and the comparatively short time that most of our matrons had been in post. Very few trusts, nationally or in our case studies, have attempted to evaluate the impact of their matrons. Much of the work of matrons although ultimately directed at improving patient care, focuses on 'invisible' operational activities such as staff management. In addition, many matrons devoted much time to achieving corporate objectives. As researchers we have to acknowledge the difficulty of measuring outcomes in the ever- changing and complex clinical environment. At an anecdotal level, however, most managers we spoke to felt that improvements, such as a reduction in complaints or improved PEAT scores (notably concerning the A & E department in the trust mentioned above with regard to group power) were attributable to matrons.

We asked both the matrons and their key contacts about their impressions of the impact that the role had made. Some of this impact was attributed to individuals but it also emerged that matrons were particularly effective where they acted as a group. Of course, not all of the improvements attributed to matrons can be credited to them alone (whether as individuals or as a group). It was also observed by many involved in the study, that the success of those who were effective as matrons might be linked to their personality and not necessarily the potential offered by the role. As one key contact said of the matron in a PCT, "Has the modern matron role given her the opportunity, or would she have developed that authority because of her style, and is that why she was selected to be a modern matron?"

Some matrons, particularly, it seemed, those who were essentially re-badged, or who had large areas of responsibility, felt that they made little discernible impact. Significantly, their key contacts did not necessarily agree with this negative finding. Thus the paediatric A & E matron in an acute trust felt that she had achieved no more than she might have done as a senior sister, but the paediatric consultant considered that she had “taken the unit from a few cubicles tacked on to an adult A & E to a unit that functions well, with nurses happily taking on a more extended role than you see [with] the other paediatric nurses”.

Where matrons seemed more able to see the impact of their work, the nature of this impact varied as follows:

***Standards of care**:* this included setting levels for standards of care, and developing new guidelines and protocols where existing practice was seen as inadequate. It was suggested in one acute trust that practice had become more evidence based and aspects of basic care were thought to have improved. Many staff spoke of the work done in relation to *Essence of Care*, and benchmarking (such as in relation to pressure area assessment). The role played by matrons in enabling staff development and improving staffing levels were seen to have contributed to improvements in standards of care in two particular acute trusts.

***Consistency across clinical areas**:* one achievement was improved consistency of standards across shifts within a unit or across units, with clearer understandings of what was expected of staff. In addition, it was thought that in some areas, role definition across grades had improved. An interesting example of achieving consistency came from one particular acute trust, where the matron in the renal directorate insisted on a degree of staff rotation around different areas such as dialysis and nephrology, and so skills and experiences were shared to everyone’s benefit, most of all patients.

***Compliance with procedures**:* in some areas, training for use of equipment had been brought up to date with improved care and handling of equipment and more compliance across the trust with decontamination procedures.

***Infection control*:** we found matrons involved in tighter enforcement of uniform policy and the removal of jewellery and better control of hygiene and hand washing. As mentioned above, there were also indications of increased compliance with procedures for the decontamination of equipment. In one acute trust, one matron was credited across the trust with playing a significant role in eradicating MRSA from one of the wards, while a clinical nurse specialist for infection control in another trust claimed that management of outbreaks of infection had been greatly improved by collaboration between the trusts' CNSs and its team of matrons.

***Staff development**:* nursing staff spoke of the encouragement received from matrons for staff to take on new responsibilities; matrons had been able to find money to finance appropriate courses. Individual matrons were described as 'empowering'. In a PCT for example, the matron had found a nursing workforce unable to act without checking with someone more senior. She had enabled them to recognise their own capabilities and become more selective about when they sought advice from more senior staff. Other matrons were described as supportive without being interfering.

Improving the quality of the workforce: in some areas, matrons were seen to take a lead in assessing the performance of individual members of staff, undertaking performance management where necessary, helping ward sisters to manage poor performance, identifying training needs and 'letting go' those members of staff who were not achieving high enough standards of care.

***Skill mix*:** skill mix was seen to have improved. In the case of one acute trust, for example, the ICU matron had introduced a way of planning staffing levels on the basis of patient dependency rather than assuming a one to one nurse-patient ratio for patients in ITU. This had led to a dramatic decrease in the number of agency staff employed. In a further example, in another trust, the matron in the rehabilitation directorate led a team which created a new, multidisciplinary B grade post to improve staffing levels and flexibility of care.

Staffing levels: the improved reputation of some units, attributed in part to the matron, had made it easier to recruit staff. In the ICU mentioned above, the costs of employing agency nurses had dropped dramatically by between 50 and 80%. By giving attention to recruitment and retention, one of the matrons in another acute trust had reduced staff vacancies from nine

to two over a period of months. There were also indications that matrons in that same trust had been able to influence the level of domestic staff cover.

Addressing bullying/staff conflict: in some contexts matrons were attributed with helping to create a more open environment and addressing issues of bullying within the service. In the context of one acute trust one of the consultants described this as 'indispensable'. A general manager in a mental health trust described how, in his opinion, matrons were using their professional conflict resolution skills to the benefit of staff, by 'containing organisational anxiety'. Staff morale had been shaken during the course of recent major re-structuring, and teams had not been working together across boundaries as effectively as they should; he believed that the matrons were making a major contribution to improving the situation.

Staff morale*:* some key contacts observed how staff had been dissatisfied in the past because they had been unable to bring their concerns to senior staff. However, matrons appeared to be helping to improve staff morale by ensuring the views of staff were listened to. Staff reported how much they appreciated it when a matron greeted them by name, and showed some interest in them as individuals. A consistent finding was that nurses of all grades valued the matron as a source of information about trust policies, and said that their horizons had been widened beyond their immediate clinical areas.

Improving seamless care across trusts: some respondents suggested that the way that matrons established good working relationships across trusts helped to facilitate seamless care.

Improved communication: One example of the way that matrons had helped to improve communication was through their relationship with PALS co-ordinators. We were told, for example, of how liaison between matrons and members of the PALS team was helping to reassure relatives about patients' treatment or care, and thus raise their confidence in the health care team.

Oiling the wheels: it was observed by a number of participants in the study that matrons had a good overview of services and had the seniority and understanding of the issues to cut through problems, redesign systems and 'oil the wheels' of the organisation. In a PCT for example, one ward manager spoke of how clinical staff now had increased autonomy and were able to make decisions quickly, without having to have these checked out across various levels of management. In another trust, in an ICU, domestic services managers suggested that as a result of matrons' input, nurses' attitudes towards domestic staff had improved and they now worked better together.

***Improvement in environment**:* improved levels of cleanliness were noted by many of those involved in the study and thought attributable to the matron.

***Patient experience**:* nurse-led protocols had been developed by some matrons to improve patient experience. In some trusts, matrons had been seen to influence the way staff dealt with patients. For example, the reputation of the A & E department for sub-standard care of children in one trust had been overturned as a result of the paediatric matron's influence; attendance had increased (previously local residents had tended to travel to other hospitals for what they saw as better A & E services) and complaints were relatively rare.

Use of beds: bed occupancy rates had increased in some areas and nurse led protocols introduced by matrons were thought to have led to reduced patients' length of stay.

Improved clinical leadership: Leadership styles of matrons varied. Some led by example or as one key contact put it, from 'inside', demonstrating the standards of care they expected, for example, through their own clinical practice. This style of leadership was not always seen positively: one key contact thought it did little to bring about change in the broader systems and processes that might undermine the provision of quality care. Others led more by challenging practice, or encouraging staff to reflect on what they were doing and acting as a resource. One matron spoke of targeting individual members of staff who appeared receptive to change, with the expectation that they would then be able to assist her in persuading colleagues to review their practice.

***Service development**:* matrons were seen to play a key role in the development of services. For example, in one acute trust, the paediatric A & E matron was working closely with medical consultants to extend the opening hours of the unit to ensure all children arriving in A & E, day or night, had access to a specialist paediatric team. Similarly, in another acute trust, the matron in the sexual health directorate was working with the clinical director and nurse consultant on redesigning the clinic's functioning, and in the rehabilitation directorate, the matron worked with a team to re-design day-hospital services.

Raised profile of nursing: the paediatric A & E matron referred to above was described by one key contact as helping to raise the profile of nursing by clarifying who was the key nursing person to approach.

7.9.2 Context in which impact was not seen

Not all matrons or key contacts felt that the matron role had made any noticeable impact. In some instances this was because implementation of the role had taken the form of re-badging: there was, in effect, no new post and no discernible difference in the activities of the post holder. In the case of one trust, for example, it was felt that midwives had always had considerable autonomy and that senior midwives had carried out many of the functions of the matron before the new role was announced and job titles changed. In other scenarios, it was difficult for staff to identify the impact of the matron role because it was seen as little different from that of a ward sister. In addition, some matrons referred to problems that they were unable to overcome as they were beyond their remit, and yet these problems limited their effectiveness. For instance, in the trust mentioned above with the paediatric A & E department, the matron had repeatedly notified senior managers of the need for a paediatrician to be specifically allocated to the unit because A & E doctors were not skilled in treating acutely ill or traumatised children. The lack of skilled medical presence impacted on the work of nurses in A & E and yet the matron had not been able to influence a change in staff, despite her efforts over a number of years.

7.9.3 Matrons' reflections on their effectiveness

The matron survey revealed some interesting views on facilitators and barriers to effectiveness. We quote the most commonly cited features, beginning with facilitators.

7.9.3.1 Facilitators of effectiveness

These are largely centred on supportive working relationships.

- Excellent working relationship with senior nursing managers and senior sisters
- Good communication with colleagues
- Support from matron peer group
- Good supportive consultant team
- Good and dynamic team
- Rapport with ward sisters and medical staff
- Good working relationships with operational manager
- Trust recognition of the role and backing for it
- The support of the Divisional Management Team
- Clear corporate objectives
- Freedom to practice and make decisions
- Being a manager as well as matron – having total responsibility for area
- Mentorship, action learning
- A sense of humour

- Personal resourcefulness
- Secretarial support, own computer, email

7.9.3.2 Barriers to effectiveness

When asked about barriers to their effectiveness (either in the matron survey or during interviews), matrons identified the following major factors:

- Role overload; lack of time; too much time spent on bed management
- Too extensive a clinical area
- Too tight prescription about time spent in direct patient care
- Having to work to differing agendas (by which they meant pressure to meet trust performance targets rather than address their immediate priorities)
- Constantly being disturbed; constant phone calls
- Too much project work and reports to write with short deadlines
- Lack of clarity about role boundaries
- Constraints on any decisions involving extra resources; lack of resources
- Poor working relationships with other departments and other professions (especially doctors)
- Lack of adequate preparation for the role
- Lack of feedback about performance
- Poor accommodation (office space), lack of up to date IT equipment, and clerical and administrative support
- Lack of cover for off-duty and holidays
- Having to provide cover for matron colleagues in highly specialised clinical areas
- Unhelpful or inaccessible line managers, causing a sense of isolation
- Overblown expectations of what could be achieved in a short time
- "Having to be everything to everybody all of the time!"

7.9.4 An exercise in self-assessment of performance

We formed the strong impression that, in the struggle to allocate time for all their responsibilities, matrons were finding it difficult to maintain an active clinical presence, and in this way to establish good relationships with patients and families. In general, they felt that they had been most successful in supporting ward sisters and carrying out personnel functions for other staff. This view was borne out by the results of a survey of matrons and their managers in one of our mental health trusts – one of the very few that had attempted any kind of formal evaluation of their matrons' work. Asked to evaluate their own performance, the matrons rated themselves most highly in the area of 'supporting ward leaders/clinical leaders and clinical staff'.

They felt they had achieved reasonably well, if patchily, in the two areas of ‘securing and assuring the highest standards of clinical care’ and ‘supporting service users/carers’. The one area that these matrons had consistently found most difficult was ‘ensuring/improving the patient environment’; this was partly attributable to slow progress in making links with support services and external contractors, and delays in establishing systems to meet PEAT targets. It should be noted that, in comparison with the comments from senior managers, the matrons had tended to underestimate their impact.

The next section of the report turns to a discussion of ways of working for matrons.

SECTION 8: DISCUSSION OF WAYS OF WORKING

Overview

As we saw in our review of the literature on nursing management roles, the 'modern matron' role is not a completely new idea, but has its predecessors in the nursing officer roles of the 1970s and the senior sister role. Both of these initiatives were designed to help ward sisters/charge nurses fulfil what has always been a demanding and multi-faceted role on the front-line of patient care. However, policy and guidance on the matron role suggests that it is not simply a reworking of nursing officer and senior sister roles but is distinctive in its combination of management and clinical components, and in its reliance on clinical leadership, most notably transformational leadership. However, the introduction of matron posts has introduced a new level into the nursing structure of many trusts; one challenge here is to avoid re-creating a bureaucratic nursing structure, which inhibits rather than empowers ward leaders. A second challenge is to avoid matron posts becoming exclusively managerial in focus, as happened with nursing officer posts.

If one of the key distinctive features of the matron role is the emphasis on clinical leadership, a further challenge concerns the way that this form of leadership is understood. We found a tension between, on one hand, matrons providing clinical leadership by undertaking direct care and, on the other hand, forms of leadership which focused more on setting standards or establishing better processes. We have evidence to suggest that matrons' ways of working are, apart from other factors, shaped by the context in which they work and therefore, in some areas, it makes more sense for them to be practically engaged. However, if clinical leadership is understood as something that happens at all levels, this also suggests that, irrespective of context, part of the role of the matron is to develop leadership in others across the clinical team.

We found that the question of matrons' clinical credibility was important to them as well as to more junior nurses. It was felt to add to their 'personal power', and to enhance their authority. This question became more complicated when we found that some trusts are now appointing matrons from disciplines other than nursing (social work and physiotherapy in our case study trusts). It is arguable that given the current emphasis on the patient's total experience of care, the fundamentals of care and the physical environment, there is no reason why 'matron' posts should not be open to managers from health professions other than nursing. This is a particularly telling argument in the mental health and learning disabilities sectors, which rely heavily on multi-disciplinary, multi-agency teamwork. In the acute sector, nurses are the largest group of staff, and traditionally take a 'holistic' approach to patient

care; furthermore, Directors of Nursing usually carry the responsibility for areas such as the quality of patient care, or the quality of the patient's experience. Whilst nurses do not have a monopoly on these concerns, there would seem to be strong arguments in favour of matrons with a nursing background, or (at the least) a background in clinical practice. The issue of non-nurse matrons raises the possibility of different kinds of matron roles, characterised by different approaches to accomplishing the 10 key responsibilities in different contexts.

Many of our participants felt strongly that there should be standardisation of the role and title nationally. Maybe their views were reinforced by the wide variation of roles and responsibilities to be found both within trusts and across them. At the same time, this variation reflects the attempts of organisations to fit the role to organisational needs. The next section identifies the different ways in which matrons worked that we identified in the study, that is, different models of implementation, with a view to exploring how these models differ, and whether, given different organisational needs, standardisation of the role is appropriate.

8.1 Models of working

We found huge variation, not only in the way the matron role was interpreted across our sample of trusts, but also within each trust. However, these variants can be distilled into a small number of models of implementation. Each model is built from a number of characteristics. During data analysis a number of characteristics were identified with the way that the role was implemented. These relate to the matron's

- degree of clinical involvement
- visibility
- leadership style
- scope of responsibility
- focus
- approach to problem solving
- mode of operating (operational or strategic)
- line management
- nursing development role
- authority, and
- autonomy to develop the role.

While the nature of these characteristics, and their different permutations, provide a number of representations of the role that are almost identical to the number of matrons in our sample, they can be organised into a typology in which there are three essential forms or exemplars.

These are a) an essentially clinical role, b) an essentially managerial role, and c) a mixed mode role.

8.1.1 Model A: an essentially clinical role

In this model of implementation, the matron is a clinical leader in a role that is not sharply delineated from that of a ward leader.

Model A: An essentially clinical role	
Clinical involvement	Matrons may be included on the clinical roster for a set percentage of their time and have a high level of clinical expertise in the areas for which they are responsible.
Visibility	They have high visibility to staff, and are highly visible to patients as a clinical nurse, but may be less visible as a matron.
Leadership style	Matrons working in this way generally lead by role modelling. They provide an everyday example of nursing excellence [often demonstrating the principles of "essence of care"] for other staff to emulate.
Scope of responsibility	Their scope of responsibility is relatively small, and extends from one to perhaps three wards or units.
Focus/profile	The matrons' focus tends to be intra-departmental rather than trust-wide and may not be well-known beyond their own areas.
Approach to problem solving	Problems such as staff cover may be addressed by relatively rapid, local re-organisation (such as redeployment of existing staff or using the matron to cover absences) instead of more strategic solutions.
Operational or strategic	The emphasis is on day to day operational work.
Line management	Matrons line may line manage the majority of nursing staff in their unit.
Nursing development role	Matrons have a strong clinical teaching role, working alongside more junior nurses, with a sound grasp of the developmental needs of staff.
Authority	They have great authority within their area of responsibility and moderate levels of authority beyond this.

Variation of the model:

In Trust G, the Paediatric A & E the role was implemented with the matron practising as emergency nurse practitioner for 50% of her time. She took on the post expecting it to be a strongly clinical role, but found the operational aspects took up the majority of her time, leaving her overworked and disillusioned (this example is discussed in more detail in Case study G:- see Annexe).

8.1.2 Model B: An essentially managerial role

In this model, the role is closer to that of the traditional senior nurse.

Model B: A largely managerial role	
Clinical involvement	Matrons tend to be supernumerary, with little time spent in clinical work, usually during shortages or emergencies.
Visibility	They are not highly visible, perhaps because they cover a large geographical area.
Leadership style	Matrons are supportive figures, leading from afar.
Scope of responsibility	They may be responsible for widely dispersed services, often over a number of sites.
Focus/profile	The focus of matrons is on both their clinical area and the wider trust. They have a fairly low profile within the clinical area and relatively high profile across the trust.
Approach to problem solving	They look more to processes and systems when faced with problems, use networks and contacts across the trust and beyond to address issues, and work collectively with other matrons.
Operational or strategic	Matrons tend to focus more on strategic than operational levels, with involvement in service and policy development.
Line management	Matrons tend to line manage senior clinical nursing staff, who in turn line manage more junior staff. Matrons may report directly to DoN.
Nursing development role	Work focuses on the development of policies and protocols, on organising educational courses for staff, and training other staff members to carry out IPR.
Authority	Matrons have considerable authority both within their area of responsibility and across trust.

Variations on the model:

- Trust G: Midwifery matron whose authority was undermined by lack of adequate budget.
- Trust A: Two tier matron system; 15 posts were considered by the Director of Nursing to encompass some of the duties of matrons. Five of these were the most senior nurses in each of the five clinical directorates. These five (all on the senior management pay spine) were considered to be matrons in some respect because they are responsible for standards of service. However, their assistants really carry out more of the matron functions.
- Trust C: Dual role: postholders double as matron and ward or unit manager. Matrons have a "home unit" where they are the designated unit manager for 50 to 60% of the time. They provide matron cover for their "home unit" and a number of other small units, sometimes at a distance of up to 25 miles.
- Trust H: One matron (in charge of three acute medical wards) had previously held a nursing officer role in the directorate. She found it impossible to distinguish between her former role and the matron role. She described feeling guilty about the fact that she was not involved in direct clinical care but her heavy responsibilities for operational management did not permit her to do more than visit the wards once daily and talk to the ward sisters (but not to patients). All the wards were very satisfied with her way of working but they were all highly experienced and did not feel the need for a higher level of involvement, especially as she was easy to contact.

8.1.3 Model C: mixed mode of implementation

This model reflects the development of a new role, rather than the refashioning of an existing one.

Model C: Mixed mode of implementation	
Clinical involvement	Matrons are supernumerary but have a strong clinical input on an *ad hoc* basis, and with perhaps a regular session devoted to clinical activity.
Visibility	Matrons are highly visible, 'walking the floor' once or twice a day and using this as an opportunity to both meet patients and pick up clinical issues with staff.
Leadership style	They lead largely by example.
Scope of responsibility	Matrons are responsible for one to four units.

Focus/profile	Matrons are strongly focused on the clinical area, with moderate involvement in broader trust arenas. They have a strong profile both within their area of responsibility, across the directorate and amongst members of trust staff such as Facilities
Approach to problem solving	Matrons are both reactive to local problems and work more strategically, for example, with other matrons.
Operational or strategic	They have a strong operational role, ensuring equipment and supplies, infection control, and appropriate skill mix, for example. They are also involved in managing bed occupancy, meeting trust targets etc.
Line management	They line manage senior clinical nursing staff who, in turn, manage more junior staff. Matrons are often responsible to a general manager and professionally accountable to the DoN.
Nursing development role	Staff development is integrated into day to day work with nursing staff.
Authority	Matrons have a high level of authority in the areas for which they are responsible, and moderate authority in other contexts.

Variation of the model:

Trust H had established a version of this role for its in-patient wards, modelled closely on the original DH guidance about matron roles. Many of the matrons appointed to these roles (normally at H grade) had been in 'senior sister' roles immediately beforehand, with responsibility for a group of wards, but based on one ward and included on the nursing rotas. Once they took on matron posts, with responsibility for three or four wards, it became difficult to sustain a ward-based, 'hands-on' role to this extent. A year after implementation, it became clear that a few matrons had been given too many wards to look after (as many as six) and this was reduced.

Trust B provides another "mixed mode" interpretation of the role. The matrons had a clear managerial role, derived in part from their familiarity with the small community hospitals, and from the flat organisational structure. They were seen as the interface between ward and trust board. However, they believed that clinical involvement and ward presence was very important in the pursuit of high standards of care; they saw themselves as role models. This level of clinical involvement was achievable at least partly because of their offices' close proximity to the ward areas.

Trust D demonstrates several kinds of mixed mode implementation. Matron roles shared the main objective of patient centred care. They were expected to be clinical experts, setting and monitoring standards, leading teams and developing staff. They had an operational and

corporate role as on-site managers, for trouble-shooting, and were all involved in checking and maintaining staff competency levels, clinical supervision, benchmarking care standards, and recruitment and retention. In one specialist directorate, there was very close partnership between the matron and 11 senior clinical nursing staff. In another dealing with specialist outpatient services, there was a particularly collegiate relationship between the matron and the clinical director, which sometimes drew in the nurse consultant too, aimed at process redesign. In the rehabilitation directorate the matron was a physiotherapist by profession and worked closely with all the multidisciplinary team including increased input from practice development staff.

8.2 Models and the impact of modern matrons

Findings about the impact of matrons are tentative, given the relatively short time that matrons had been in post and the difficulties of isolating their impact from other influences/variables. Nurse managers, matrons and their key contacts provided examples of areas in which matrons were seen to have been effective. These included improved standards of care, and consistency of standards and role definitions across clinical areas, skill mix and staffing, compliance with trust procedures, staff development, infection control, working relationships with other groups such as domestics, staff conflict, bullying, the environment, patient and staff experience, patient stay, clinical leadership and development of services. In addition, in some trusts the introduction of the matron role was seen to have had a significant impact on staff morale, because nurses felt confident that their concerns would be genuinely acted upon. Matrons were seen to be able to cut through organisational barriers and bureaucracy and make the wheels of the organisation run more smoothly. Most noticeably, matrons were attributed with reducing complaints and improving PEAT scores.

However, not all matrons were equally involved in addressing these issues, and probably not equally effective in how they addressed them. For example, matrons appeared to be less effective where their post had been simply ‘re-badged’, or where their impact was restricted by factors beyond their remit (e.g. an inability to ensure the appointment of appropriate medical staff).

The models identified from practice and outlined above provide different configurations of the way we found the matron role to be implemented. We are loath to propose these as ideal examples, or to suggest that one example provides a more appropriate model for role implementation than others. This is partly because no one model is ideal in all its parts for all situations. A matron working in line with model A, for example, who has responsibility for a small clinical area, and considerable emphasis on the clinical component of the role, may help

to drive up local standards of practice, but may have little impact or authority beyond the unit. In contrast, matrons in model B tend to have a high trust profile, with considerable authority, but at the expense of visibility for patients.

Which model seems most appropriate, and thus where matrons will be positioned within the management structure of the trust, will depend in part on the trust's priorities and their interpretation of the matron role and how they can best address the matron's 10 key responsibilities. Thus, if a trust decides they want to emphasise the visibility of matrons and their potential for dealing with complaints and environmental issues on a local and day-to-day basis, they may find that model A (mainly clinical) is appropriate. On the other hand, if the trust emphasises the potential of matrons to work strategically to improve patient experience (by systematic involvement in trust-wide forums for example), they may favour Model B (mainly managerial). The value of these exemplars, therefore, is to help show the ways in which the role varies, and to indicate something of the relationship between these variables. As trusts will have different priorities that shape their expectations of matrons, these models may help trusts to think about the role, and also act as a reminder that matrons cannot meet every need of the trust. These models may also help to clarify the particular formulation of the role in advance and help to ensure the most suitable staff are recruited for specific posts. For example, we found disillusionment where matrons had anticipated a largely clinical role and found their particular role to be more akin to that of a general manager than a clinician.

Our findings thus argue against standardisation of the role, given that trust priorities and local circumstances may influence the way implementation of the matron role is approached. On the other hand, our findings suggest a need for greater clarity about how the role needs to be implemented in any particular context, and a need for better communication within trusts to ensure that all staff and patients are aware of matrons' responsibilities. We have no evidence that one model of implementation is necessarily more effective than another. Findings suggest however that successful implementation is linked to a number of processes and inputs, some of which (those set out in the study's terms of reference) are discussed in more detail in the next section.

SECTION 9: SUMMARY, CONCLUSIONS AND MESSAGES FROM THE STUDY

Overview

In this section we summarise the key findings that have emerged from the study. We focus particularly on those matters that relate to the study's terms of reference. However, our investigation has raised a number of other interesting issues, some of which are not explicitly within our remit, but which we believe also deserve consideration here.

Our terms of reference were to:

- Describe the experience of a sample of matrons
- Identify models of working related to achievement of objectives (and impact)
- Identify messages about processes and inputs to allow matrons maximum influence over
    - Cleanliness
    - Standards of basic care, and
    - Patients' experience

These terms of reference help to structure this section, which concludes with a number of messages which may help in the further development of the matron role.

9.1 The experience of modern matrons

The study's findings highlight enormous variability in the ways in which the matron role is implemented and the experience of matrons in carrying out the role. These experiences range from the highly positive, such as the matron in Trust B who described her post as "the ultimate job", feeling that she had been given a welcome opportunity to use her skills and experience to bring about change for the benefit of patients, to others who found that working as a matron involved many frustrations and (for one interviewee) 'the worst job of my life'.

What we aim to do in this section is to identify some of the particular challenges matrons faced, with a view to recommending how trusts might be able to minimise some of their difficulties. The main areas we identified were:

- Role conflict and tensions
- Lack of clarity and lack of shared understandings about the role
- Fragile sense of authority
- Competing priorities
- Role overload
- Blurred interface with other roles
- Leadership role
- Inequitable grading and responsibilities

9.1.1 Role conflict and tensions

Matrons had to find the right balance between tensions inherent in their role, such as between a mainly clinical role and an operational management role; between focusing mainly on staff or on patients; whether to be stronger on discipline than support; whether the matron should influence staff or take a more prescriptive stance. Some matrons were seen in a very positive light by their junior colleagues; they were seen to demonstrate leadership that was characterised by the empowerment and enabling of staff, with a limited use of direct authority to get things done. They were also seen as highly approachable and very supportive individuals.

9.1.2 Lack of clarity and lack of shared understandings about the role

Slightly less than half of trusts in the study had set specific targets for their matrons. While the majority had developed generic job descriptions for matron posts, this did not mean that there was clarity about the role. We had mixed messages from matrons on this: in interview matrons seemed largely clear about their major responsibilities but in survey responses, they described a lack of clarity. A particularly contentious issue was the nature and extent of the matron's clinical involvement. Some senior managers did not understand the clinical requirement of the role, and as a consequence, matrons focused on middle management responsibilities, with a primary emphasis on operational issues such as targets. Rather differently, some trusts started out by expecting post holders to spend a considerable amount of their time (up to 50%) in clinical activity, only to find this was impractical. One trust had come to recognise that, as a highly complex organisation, it could not be prescriptive about the role across all settings, but managers also found it difficult to keep track of how the role was evolving. It also emerged that there was some confusion about the matron role amongst non-nursing staff, especially where the role was the result of rebadging. Confusion was also unsurprising given the freedom that existed to develop the role differently across directorates and units.

9.1.3 Fragile sense of authority

The previous paragraph describes a lack of understanding about the matron's role and responsibilities; inevitably, this situation threatens to undermine their authority in the organisation. Added to this, we found many matrons were appointed at 'H' grade, a comparatively low point in the nursing administrative hierarchy. Although many of the matrons we interviewed were regarded as authoritative (or potentially authoritative) figures by their key contacts, few of them seemed convinced that they had enough authority to achieve the changes they wanted. The most frequently cited reasons for this were financial constraints and lack of direct control over support services such as cleaning, catering,

maintenance and human resources. In addition, matrons did not always have the support of their colleagues. For example, we picked up mixed messages about medical consultants; at one extreme, they were valuable allies for matrons who were developing and improving a service; at the other extreme, they were hostile to what they perceived as another layer of nursing management and behaved in an undermining way towards matrons in directorate meetings.

9.1.4 Blurred interface with other roles

There was also a lack of clarity in some contexts between the matron role and other roles. The most frequently mentioned area of conflict was between matrons and senior ward sisters, many of whom had undergone leadership training. In some trusts, problems with recruitment meant that one of the priorities of matrons was to support inexperienced F grades in ward management. Where matrons took a strong clinical focus, some respondents (both matrons and sisters) were unable to identify a difference in the role, and in some instances it seemed there was a danger that matrons were undermining the authority of ward sisters. Another interface which required careful handling was that between matrons and their line managers, where the latter were nurses. There was scope for overlap both upwards and downwards in the nursing hierarchy; in most cases, we found that working relationships were good and that, after a period of settling and negotiation, serious conflicts were avoided. Outside the nursing hierarchy, it was clear that many matrons were working at the boundary between nursing management and general or business management; in two of our trusts, serious consideration had been given at some stage to merging the roles of matrons and staff in the general management hierarchy. In neither case had this idea been taken forward, but it suggests that in some circles of management there is a focus on the corporate aspects, as opposed to the clinical aspects, of the matron role.

9.1.5 Competing priorities

To some extent, a matron's remit was influenced by the priorities of the trust; it was clear that matrons often felt a tension between these priorities and those of their role. In some trusts there was a lack of support at board level for implementing the matron role, and in others, the initiative was seized by some as a way of solving many organisational problems, such as recruitment, poor standards of care or poor performance against targets, or in a more strategic way to promote more effective leadership at key points within the organisation. Only some of these trust priorities reflect matrons' 10 key responsibilities.

The majority of respondents to the matrons' survey (82%) had job descriptions; analysis of these suggested that the main activities trusts expected matrons to cover were professional

standards and clinical governance, management and leadership with regard to ensuring high standards of care, engaging with patients: such as providing a visible and authoritative presence and working with PALS, education, and human resource management. In practice, we found that most matrons were undertaking work in all these areas, to varying degrees. Other activities reported were associated with operational matters that were clearly important to the trust, but are not included in the 10 key responsibilities of modern matrons (DH 2003). These operational activities, such as bed management, incident processing and meeting targets such as waiting list times, appear to take precedence over other, clearly defined responsibilities of the matron role, such as the improvement of cleanliness and nutritional standards (only 9% of our matron survey respondents recorded dealing with cleanliness and catering in the specified period). Survey responses suggested that a number of matrons were worried about their lack of involvement in direct patient care and that they were not developing strong links with patients and their families.

9.1.6 Role overload

Lack of ring-fenced money to support the modern matron initiative meant that it was very difficult, if not impossible, to introduce matrons as new posts in many trusts. This meant trusts often resorted to adding additional responsibilities to existing posts (perhaps while merging I and G grade posts to create one position), or rebadging existing roles. In both cases, the lack of perceptible difference between the old and new post had implications for the authority of the post holder.

In addition to working to competing agendas, many matrons felt over-stretched because their remit was continually expanding as new areas of work and new problems were identified within the trust. There was some suggestion that the matron role was coming to be seen as a solution to broader problems within trusts such as under-performance. Some matrons' day to day activities had therefore deviated from their formal job description over time. Comments from ward sisters supported this impression – a number spoke of how matrons were pressured to prioritise organisational concerns rather than fulfil their clinical role.

9.1.7 Inequitable grading & responsibilities

In the national survey and our case study trusts we found there was significant variation in both the salaries and grading of matrons, with many trusts overlooking the DH guidance that most matrons should be appointed as I grade. This variation occurred between trusts, and also within trusts where it might exist despite any clear rationale for different gradings, such as being linked to a matron's scope of responsibility. Unsurprisingly, this led to resentment in some contexts. In some instances, matrons were promoted into the role from G grade posts.

Variation in grade and scope of responsibility reflect a wider issue of how the matron was positioned within the trust. There was a dilemma about whether a strong clinical focus ('senior sister' variant) within a clearly delineated clinical area was compatible with sufficient authority over relevant support services. Alternatively, if the post holder held primarily operational responsibility, it was not clear if they would be able to give sufficient attention to the clinical aspects of the role.

9.2 Models of working

Section 8 identified a number of models that represent the way that the matron role has been put into operation. These fall into three main types – the essentially clinical, the largely managerial and the mixed mode models – and a number of examples of how these models may vary in practice were sketched out.

The models were identified from practice and provide different configurations of the way we found the matron role to be implemented. No one model is ideal in all its parts, or for all situations. Which model seems most appropriate, and thus where matrons will be positioned within the management structure of the trust, will depend in part on the trust's priorities and their interpretation of the matron role and how they can best address the matron's 10 key responsibilities. The value of these exemplars, therefore, is to help show the ways in which the role varies, and something of the relationship between these variables. As trusts will have different priorities that shape their expectations of matrons, these models may help to think about the role, and also act as a reminder that matrons cannot meet every need of the trust.

At the same time, while trust priorities may influence the way implementation of the matron role is approached, and we have no evidence that one model is necessarily more effective than another, findings do suggest that successful implementation is linked to a number of factors (processes and inputs), discussed below.

9.3 Identifying messages about processes and inputs

The research team's terms of reference required us to identify messages about processes and inputs to allow matrons maximum influence over cleanliness, standards of basic care and patients' experience. One aspect of the modern matron initiative which was new was its emphasis on the cleanliness and comfort of the physical environment. It is many years since these services have been under the direct control of nurse managers; in the intervening years, the delivery of many of these services has been contracted out of the NHS. Therefore enforcing good standards in this situation requires good communication and influencing

skills. We interpret processes to mean systems of working within trusts, such as policies, procedures, job descriptions, channels of communication and organisational structure. For inputs we focus on the "raw materials" the trust provides, that is resources, including staff and their capabilities (partly determined by development opportunities), finance, space, premises and workplace environment. We begin this section with the specific topics in our terms of reference but continue with others arising from the study. It follows that if matron roles can be made more effective, by taking account of the more general messages, that standards of care and the patient experience should improve.

9.3.1 Cleanliness and patient environment

- Matrons should be involved in developing and monitoring cleaning specifications.
- Matrons should take into account the views of staff about specific requirements in different clinical areas when setting service specifications for cleaning.
- Whether cleaning services are provided in house, or by external contractors, there should be clear and agreed channels of communication to enable matrons to report concerns about standards in their clinical areas to the responsible service managers.
- Trusts need to define which members of clinical staff can take action on these concerns in the absence of the matron.
- Consideration needs to be given to the suitability of the buildings and furnishings to enable effective cleaning to take place.
- Adequate financial resources need to be made available to provide good cleaning services.
- Trusts should ensure that staff responsible for cleaning should have appropriate training especially related to principles of infection control.
- Staff responsible for cleaning should be seen as and function as essential members of the clinical team and have a designated ward area.
- Trusts should provide regular opportunities for matrons to meet with estates and facilities.
- Trusts should clarify responsibilities for ward environment budgets so that matrons and ward sisters can maximise their benefit.
- Trusts should find resources to employ ward housekeepers where they have not already done so.

9.3.2 Standards of basic care

- Matrons should be allowed to focus on their 10 key responsibilities
- Matrons should work closely with ward staff to implement systematic approaches to quality improvement such as "Essence of Care".

- Trusts should take account of messages from staff transmitted through matrons about staff numbers, skill mix and staff capabilities.
- Trusts should provide resources for staff training, education and development in order to support matrons in improving patient care.
- Matrons should have regular access to their Director of Nursing to ensure that their professional concerns about standards of basic care are noted at the highest level.

9.3.3 Patients' experience

- Matrons need to be clearly identifiable to patients through the use of appropriate badges and ward and departmental notice boards.
- Trusts should provide written information for patients on the role and responsibilities of matrons and how to contact them. Any literature should be translated into appropriate languages.
- Trusts should establish clear guidance about the respective roles of matrons and the PALS officers in addressing patient and carer concerns and complaints.

9.4 General messages from the study

9.4.1 Strategic approach to implementation

- Trusts should have a clear understanding of the matron role and an expectation of how it can fit into the nursing strategy within their organisation.
- Trusts providing mental health and learning disabilities services may wish to take into account forthcoming guidance (summer 2004) from the modern matron group at the National Institute for Mental Health.
- Where possible trusts should be prepared to allocate funding for new matron posts rather than overstretching the existing clinical leadership capacity.
- Whilst there may be advantages to allowing clinical directorates discretion in establishing matron posts to meet their own requirements, there is a danger that too much devolution and diversity might raise serious questions about equity of workload.
- Matrons should be given a realistic remit to guard against role overload and unrealistic time frames and help them address their 10 key responsibilities.
- Cross-boundary posts require careful planning, to allow for the complexity of building professional networks across different agencies, as well as for the day-to-day practicalities of maintaining high visibility and accessibility between different sites.
- Job descriptions should be based on the needs of a clinical area and should be guided by the principles set by the Department of Health.

- The clinical / managerial balance can be problematic and trusts need to give careful consideration to those responsibilities given to matrons and those given to general managers.
- Trusts should evaluate the impact of matron posts; evaluation should not be narrowly focussed on achievement of targets, but should also consider the effectiveness of the leadership component of the role taking into account the views of junior staff and patients.

9.4.2 Selection

- Selection of matrons must take into account the importance of good interpersonal skills and good communication skills.
- Techniques employed for selection should focus on the transformational leadership potential of candidates.
- Matrons should be clinically credible; what this means depends on the clinical specialism and this may or may not involve in depth specific technical knowledge.

9.4.3 Preparation for role and CPD

- Need for adequate preparation at appropriate time (i.e. early on)
- All new matrons should be given an induction course on which they meet key staff and familiarise themselves with trust systems and policies. – this especially important for matrons who are new to a trust.

9.4.4 Appropriate support

- Matrons should have the opportunity participate in regular reviews of progress with their line managers and to obtain constructive feedback on their performance.
- Matrons need proper clerical and administrative support.
- Trusts should not introduce matron roles in isolation but ensure networking, mentoring / clinical supervision and peer support opportunities are available.
- Ideally, matrons should not have to share offices, particularly when they are likely to be involved in private discussions with patients, carers, or staff.
- Matrons should be provided with IT support including personal computer and printer.

9.4.5 Developing future clinical leaders

- It is important for trusts to be seen to develop and support matron posts in such a way as to make them attractive to future recruits.

- Matrons and their managers should be encouraged to think about succession planning and ways in which staff may be helped to prepare themselves for the role in future.

9.5 Conclusion

Finally we pay tribute to the many matrons who took part in the study; their enthusiasm and commitment will be an abiding memory for the research team. In view of the fact that the matron role is still very new in many trusts and that nursing structures are still in the process of settling down to accommodate the new role; we suggest that further research into the work of matrons will benefit the incumbents of the role and the NHS as an organisation.

SECTION 10: REFERENCES

Alimo-Metcalfe, B & Alban-Metcalfe, R (2000) Heaven can wait. *Health Service Journal*, October 12 2000; 26-29

Allen I (2001) *Stress among ward sisters and charge nurses.* Policy Studies Institute, London.

Audit Commission (1991) *The Virtue of Patients: making best use of ward nursing resources.* HMSO, London.

Audit Commission (1992) *Caring Systems: a handbook for managers of nursing and project managers.* HMSO, London.

Audit Commission (2001) *Ward Staffing.* Audit Commission Publications, Wetherby.

Bass, B M (1997) *Leadership Beyond Expectations.* Free Press, New York.

Bass, M J & Avolio, B J (1994) *Improving Organisational Effectiveness through Transformational Leadership.* Sage, London.

Binley's Directory of NHS Management (Summer 2003). Beechwood House Publishing, Basildon.

Binnie, A (1987) Structural Changes. *Nursing Times,* 83 (39), 36-37.

Binnie, A & Titchen, A (1998) *Patient-Centred Nursing: an action research study of practice development in an acute medical unit* (Report No 18), RCN Institute, Oxford.

Bowles, A. & Bowles, N B (2000) A comparative study of transformational leadership in nursing development units and conventional clinical settings. *Journal of Nursing Management,* 8, 69-76

Brown, R A (1989) *Individualised Care: The Role of the Ward Sister.* Scutari Press, London.

Buchanan, A and Gibbs, G (2001) Making the most of modern matron. *Nursing Times,* 97 (35), 34.

Burns, J M (1978) *Leading Ability*. Harper & Row, New York.

Cameron-Bucceri, R & Ogier, M (1994) The USA's nurse managers and UK's ward sisters: critical roles for empowerment. *Journal of Clinical Nursing*, 3 (4), 205-212.

Cook, M J (2001) The attributes of effective clinical leaders. *Nursing Standard*, 15 (35), 33-36.

Cunningham, G & Kitson, A (2000a) An evaluation of the RCN Leadership Development Programme. Part 1. *Nursing Standard*, 15 (12), 34-37

Cunningham, G & Kitson, A (2000b) An evaluation of the RCN Leadership Development Programme, Part 2. *Nursing Standard*, 15 (13-15), 34-40.

Dawson, S. (1996) (3rd ed) *Analysing Organisations*. Palgrave, Basingstoke.

Department of Health (1999) *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to patient care*. The Stationery Office, London.

Department of Health (2001a) Health Circular HSC2001/010. *Implementing the NHS Plan: Modern Matrons*. DH, London.

Department of Health (2001b) PL CNO2001/2.*Essence of Care*. DH, London.

Department of Health (2002a) *Modern Matrons in the NHS: A Progress Report*. DH, London.

Department of Health (2002b) PL/CNO2002/3.*Ward Staffing Budgets*. DH, London.

Department of Health (2002c) PL CNO2002/5.*Implementing the NHS Plan- 10 Key Roles for Nurses*. DH, London.

Department of Health (2003) *Modern Matrons – Improving the Patient Experience.* DH, London.

Fretwell, J E (1982) *Ward Teaching and Learning: Sister and the Learning Environment.* Royal College of Nursing, London.

Gallagher, C (2003) What a difference a matron can make. *Nursing Times*, 99 (7), 36 – 37.

Glasper, A (1993) Write off sisters (Inappropriate image perpetrated by the use of ward sister/charge nurse title and role). *Nursing Standard,* 7, 24 Feb, 44-45.

Gomm, R, Hammersley, M, Foster, P (2000) Case study and generalisation. *Case study method: Key issues, key texts* (eds Gomm, R, Hammersley, M, and Foster, P), 98-115. Sage, London

Graham, I & Partlow, C / Salisbury Healthcare NHS Trust (2002) *Professional Development for Nurse Leadership. An evaluation of personal and professional development amongst directorate senior nurses.* Bournemouth: Institute of Health & Community Studies, Bournemouth University

Griffiths, R (1983) *NHS Management Inquiry.* Department of Health and Social Security, London.

Harrison, S (2001) "Policy Analysis", In (eds. Fulop, Allen, Clarke & Black) *Studying the organisation and delivery of health services: research methods.* Routledge, London. 90–106.

Healy, P (2002) Thoroughly modern matrons. *Nursing Standard,* 16 (21), 14.

Hewison, A (2001) The modern matron: reborn or recycled? *Journalof Nursing Management,* 9: 187-189.

Kemp, P & Morris, F (2003) Worthing's modern matron experience: the first year. *Nursing Management,* 10 (8), 19 -23.

Kitson, A (2000) *Leadership, Change and Learning from Experience*. (RCN Position Paper , submitted to Bristol Royal Infirmary Inquiry.), RCN, London.

Kogan, M., Cang, S., Dixon, M., Tolliday H (1971) *Working Relationships within the British Hospital Service: A First Account by Brunel Hospital Organisation Research Unit*: Bookstall Publication, London.

Kouzes, J M & Posner, B Z (1988) *The Leadership Challenge*. Jossey-Bass, San Fransisco, CA.

Kouzes, J M & Posner, B Z (1995) *The Leadership Challenge: how to keep getting extraordinary things done in organisations.* Jossey-Bass, San Francisco, CA.

Kramer, M (1990) The magnet hospitals: excellence revisited. *Journal of Nursing Administration,* 20**,** 35-44.

Levenson, R, & Vaughan, B.(1999) *Developing New Roles in Practice.* University of Sheffield School of Nursing and Midwifery/School of Health and Related Research: Sheffield

Lincoln, Y, & Guba, E. (1985) *Naturalistic Inquiry*. Sage, Beverly Hills.

Lipley, N (2001a) Ministers under fire over 'modern matron plans'. *Nursing Standard,* 15 (33), 5.

Lipley, N (2001b) London trust rules out use of 'modern matron title' *Nursing Standard,* 16 (12), 8

Manley, K (1997) A conceptual framework for advance practice: an action research project operationalising an advanced practitioner/consultant nurse role. *Journal of Clinical Nursing*, 6 (3), 179-190

McClure, M, Poulin, M, Sovie, M. & Wandekelt, M (1983) *Magnet Hospitals: Attraction-Retention of Professional Nurses*. American Academy of Nursing, Kansas City, MO:

McDonnell, A., Lloyd Jones, M, & Read, S (2000) Practical considerations in case study research: the relationship between methodology and process. *Journal of Advanced Nursing* 32 (2), 383-390.

Miles, M, & Huberman A M (1994) *Qualitative Data Analysis*. Sage, Thousand Oaks, CA.

Ministry of Health (1966) *Report of Committee on Senior Nursing Staff Structure*. Chair, Brian Salmon. HMSO, London.

Mitchell, J (2000) Case and situation analysis. *Case study method: Key issues, key texts* (eds. Gomm, R, Hammersley, M and Foster, P) Sage, London. 165-186

Moore, L., Savage, J (2002) Participant observation, informed consent and ethical approval. *Nurse Researcher,* 9 (4), 58-69.

NHS Estates (2002) *Housekeeping: A first guide to new, modern and dependable housekeeping services in the NHS.* http://www.nhsestates.co.uk/patient_environment/content/ward_housekeeping.html

Nursing and Midwifery Staffs' Negotiating Council, (Staff Side). (1988) *Guide to the Clinical Grading Structure.* Nursing and Midwifery Staffs' Negotiating Council, London.

Oughtibridge, D (2003) The modern matron. *Nursing Management*, 10 (2), 26-28.

Patton, M (1980) *Qualitative Evaluation Methods. Sage*, Newbury Park, CA.

Pembrey, S (1980) *The Ward Sister – Key to Nursing*, Royal College of Nursing, London.

Posner, B Z & Kouzes, J M (1988) Development and validation of the Leadership Practices Inventory. *Educational and Psychological Measurement*, 48 (2), 483-496.

Read, S with the ENRiP team (1999) *Exploring New Roles in Practice: Executive Summary*. Sheffield: School of Health and Related Research, University of Sheffield.

Read, S with the ENRiP team (2001) *Exploring New Roles in Practice: Full Report*. Sheffield: University of Sheffield School of Nursing and Midwifery. http://www.shef.ac.uk/snm/research/enrip/index.html

Redfern, S J (1981) *Hospital Sisters: Their job attitudes and occupational stability*. Royal College of Nursing, London.

Ritchie, J & Spencer, L (1994) "Qualitative data analysis for applied policy research" In (eds Bryman, A & Burgess, R) *Analysing Qualitative Data.* Routledge, London. 173-194.

Royal College of Midwives (2002) *Modern matrons in the maternity services. Position Statement No.2.* Midwives, 5 (12), 426.

Royal College of Nursing (1981) *A Structure for Nursing*. Royal College of Nursing, London.

Royal College of Nursing (2002) *The Concept of the Modern Matron*. RCN Internal report. Royal College of Nursing, London.

Scott, C (1998) Specialist practice: advancing the profession? *Journal of Advanced Nursing,* 28 (3), 554-562.

Scott, J G, Sochalski, J & Aiken, L (1999) Review of magnet hospital research: findings and implications for professional nursing practice. *Journal of Nursing Administration,* 29 (1), 9-19.

Secretary of State (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform.* (Cm 4818-1). The Stationery Office, London.

Sills, E (1992) Keeping a high profile (Role and skills of the ward sister). *Nursing Times* 17 June 1992, 36-37.

Single, H (2004) Personal communication. (Study being written up. All inquiries to the Clinical Leadership Programme, Royal College of Nursing, 20 Cavendish Square, London W1G ORN)

Stake, R (1994) "Case Studies." In *Handbook of Qualitative Research* (eds Denzin, N and Lincoln, Y) Sage Publications, Thousand Oaks. 236-247.

Stake, R (2000) The case study method in social inquiry. *Case study method: Key issues, key texts* (eds. Gomm, R, Hammersley, M and Foster, P) Sage, London,. 19-26.

Stapleton, MF (1983) *Ward Sisters – Another Perspective: Their Ongoing Educational Needs.* Royal College of Nursing, London.

Ward Schofield (2000) Increasing the generalisability of qualitative research. *Case study method: Key issues, key texts* (eds. Gomm, R, Hammersley, M and Foster, P) Sage, London, 69-97.

Wilmott M. (1998) The New Ward Manager: an evaluation of the changing role of the charge nurse. *Journal of Advanced Nursing, 28 (2), 419-427*

Yin R (1994) (2nd ed.) *Case Study Research: Design and Methods.* Applied Social Research Methods Series Volume 5.

Evaluation of the modern matron role in a sample of NHS trusts

Revised Report to the Department of Health

October 2004

Appendices

Appendix One

General information sheet, used to publicise the project, and sent to all participants

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

RCN Institute

Project Information

DEPARTMENT OF HEALTH POLICY RESEARCH PROGRAMME: MODERN MATRON EVALUATION PROJECT

The Department of Health has commissioned a research project to investigate the implementation of recent guidance on establishing modern matron posts. The project is being undertaken by a team of experienced researchers drawn from the University of Sheffield School of Nursing & Midwifery and the RCN Institute, London.

The researchers aim to:

- Collect information on the number of "modern matrons" (or equivalent) in post in England early in 2003.
- Identify the different ways in which trusts are implementing the guidance on the modern matron role.
- Use the experiences of a sample of modern matrons to describe how the role is being implemented in practice, and to understand more fully the challenges faced by matrons.
- Explore the impact of modern matrons on standards of patient care.
- Identify messages for trusts about how they can help matrons to make themselves accessible to patients and carers, and exert maximum influence over standards of cleanliness and other fundamentals of care, so improving patients' total experience of care.

The research project will be completed within one year (February 2003 to January 2004) and will have two strands. A postal questionnaire will be sent to Directors of Nursing in all NHS trusts in England, requesting information about the number and range of their modern matron posts. The other major strand will consist of ten case studies of NHS trusts, selected to include a range of different types (acute, mental health and primary care trusts) and different organisational structures. The case studies are intended to investigate all aspects of the modern matron role. Information will be collected in a variety of ways, including:

- Questionnaires to all modern matrons in case study sites.
- Interviews with a sub-sample of modern matrons and other relevant staff.
- Brief questionnaires to patients, to gauge their awareness/experience of the new role.
- Analysis of relevant trust documentation (eg nursing strategies; patient information literature).
- Analysis of routinely collected data (eg patient satisfaction surveys; recorded complaints; infection control data; results of audits of catering, cleaning and other support services).

The researchers are committed to protecting the interests of participants. The project has been approved by a Multi-Centre Research Ethics Committee, and permission has been sought from local Research Ethics Committees and managers at each site with respect to locality issues related to the case studies. The researchers will be seeking informed consent from potential participants at all stages, taking steps to ensure confidentiality and security of information collected. They will share their conclusions with staff in each case-study trust. At the end of the project, after appropriate reviewing, summary and full reports will be made available to all interested parties. The team will also prepare conference presentations and papers for professional journals.

Appendix Two

Letter to Directors of Nursing for the National Survey
Reminder letter to non-responding Directors of Nursing
Questionnaire for Directors of Nursing

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

RCN Institute

Department of Health Policy Research Programme:

Evaluating the role of the modern matron

Dear Director of Nursing,

We are writing to ask for your help with the above research project, which is funded by the Department of Health. Full details of the project's aims and research design are contained in the enclosed Project Information Sheet. As you can see, one of our aims is to up-date existing information about the number and types of modern matron posts being established in NHS trusts in England. This is where we would value your co-operation. We would be very grateful if you could spare the time to complete and return the attached questionnaire concerning modern matron (or equivalent) posts in your particular Trust.

Even if you feel unable to answer every question in detail, please send us whatever you can complete. We hope that filling in the questionnaire will actually be a useful exercise for you as you summarise some of the provision you have made. We realise that some of you may not have any modern matrons in post, and we have allowed for this in the questionnaire, and your responses would still be most helpful.

Your returned questionnaires will be seen and analysed by the research team alone. The information from the survey will be presented in aggregate form in the final report. We will store the questionnaires safely, and destroy them once we have coded the information and entered it on to computer. If we quote any particularly illuminating comments or opinions from individual respondents in our final report, these will be unattributed.

If you have any queries or concerns about the survey, please contact us directly. The names and contact details of the research team are on this letterhead.

Thank you for reading this letter. We hope you will decide to contribute information to our survey. (However, if you do not wish to participate, please could you return the questionnaire to us, so that we know not to send you a reminder letter).

Please return the questionnaire by 30/4/03 (or sooner if possible) in the reply paid envelope.

With kind regards from the 'modern matron' research team

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

Department of Health Policy Research Programme:

Evaluating the role of the modern matron

Dear Director of Nursing,

Early in April we wrote to ask for your help with the above research project, which is funded by the Department of Health. Full details of the project's aims and research design are contained in the enclosed Project Information Sheet. We sent you a questionnaire and a reply paid envelope. As we do not appear to have received your response we are sending another set of papers in case the first set was overlooked. If you have recently returned the questionnaire please forgive the duplication, our letters may have crossed in the post.

As you can see, one of our aims is to up-date existing information about the number and types of modern matron posts being established in NHS trusts in England. This is where we would value your involvement. We would be very grateful if you could spare the time to complete and return the attached questionnaire concerning modern matron (or equivalent) posts in your particular Trust.

Even if you feel unable to answer every question in detail, please send us whatever you can complete. We realise that some of you may not have any modern matrons in post, we have allowed for this in the questionnaire, and your responses would still be most helpful.

Your returned questionnaires will be seen and analysed by the research team alone and the information from the survey will be presented in aggregate form in the final report. We will store the questionnaires safely, and destroy them once we have coded the information and entered it on to computer. If we quote any particularly illuminating comments or opinions from individual respondents in our final report, these will be unattributed.

If you have any queries or concerns about the survey, please contact us directly. The names and contact details of the research team are on this letterhead.

Thank you for taking the time to read this letter. We hope you will decide to contribute information to our survey. (However, if you do not wish to participate, please could you return the questionnaire to us, so that we know not to send you a further reminder letter).

Please return the questionnaire as soon as possible, and by May 30th at the very latest. Thank you.

With kind regards from the 'modern matron' research team

University of Sheffield
School of Nursing and Midwifery

Department of Health Policy

Research Programme

Modern Matron Evaluation Project

Survey to all Trust Directors of Nursing in England

We hope that our project information sheet has explained the purpose of this questionnaire. If you have any further queries, please get in touch with us using the telephone numbers (or e-mail addresses) on the information sheet (these can also be found at the end of the questionnaire).

It would be very helpful if you could answer as fully as possible all the questions that are relevant to the situation in your Trust. The first questions deal with organisational details.
Please tick the relevant boxes or insert your answers in the space provided

1. **Please confirm the Name of your Trust / Organisation** (please give name and postcode)

_____

2. **Main focus of Trust activity** (please tick **one** only)

Acute ☐

Primary Care ☐

Teaching PCT ☐

Mental Health ☐

Specialist Trust ☐

Other (please specify)

_____

_____

3. Does your Trust have in-patient beds?

Yes ☐ No ☐ (if no please go to **question 4**)

If Yes, please state how many _____

If Yes, on how many sites _____

4. Total number of staff (nursing / midwifery / health visitor staff including Health Care Assistants) employed within Trust (in Whole Time Equivalents / WTEs).

Number of Staff (WTEs) _____

5. Have you appointed any "Modern Matrons" (or equivalent posts) in the Trust?

Yes ☐ No ☐

If "No" then please go to **Question 6**.
If "Yes" then please go to **Question 7**.

6. For Trusts that <u>have not</u> appointed Modern Matrons so far. Are you currently planning to introduce them?

Yes ☐

If "Yes" please give an overview of the expected timescale and number of posts and go to **Question 22.**

_____

_____

_____

No ☐

If "No" please give your reasons and go to **Question 22.**

_____

_____

_____

7. If appointments have been made how many "Modern Matrons" (or equivalent posts) do you have in the Trust?

Number of posts _____

8. What titles are being used for "Modern Matron" (or equivalent) postholders within your Trust? (please state all titles and number of posts)

Title of Post (please insert job title)	**Number of postholders** (with each title)

9. With reference to the Modern Matrons' "managerial role", could you tell us

a] Do Modern Matrons line-manage ward sisters / ward managers?

Yes ☐ No ☐

b] Do Modern Matrons line-manage any other staff

Yes ☐ No ☐

If "Yes " please give details.

_____

_____

_____

10. With reference to the Modern Matrons' "span of managerial responsibility", could you tell us

a) The smallest number of staff line managed by one Modern Matron _____

b) The largest number of staff line managed by one Modern Matron _____

11. With reference to the clinical areas covered by each Modern Matron, could you tell us:

a) The smallest number of wards/units covered by one Modern Matron _____

b) The largest number of wards/units covered by one Modern Matron _____

12. With reference to accountability of Modern Matrons.

a). To whom are they managerially accountable

_____

_____

b). To whom are they professionally accountable

_____

_____

13. On what pay band and clinical grade are the Modern Matron post holders? (please insert number of post holders on each salary band and clinical grade)

Salary band	**Number of Modern Matron's**
up to £24,999	
£25,000 - £29.999	
£30,000 - £34,999	
£35,000 - £39,999	

more than £40,000	

Clinical Grade	**Number of Modern Matrons**
F	
G	
H	
I	
Other, non clinical grade please specify	

14. How have the "Modern Matron" posts been created in your Trust?

(please identify number of posts)

How Posts were Created	Number of Posts
New posts created, both external & "in house" staff invited to apply	
New posts created, and "in house" staff only invited to apply	
Existing staff member given redefined responsibilities (i.e. role change	
Existing staff job title changed (modern matron role already considered to be within their remit (ie."rebadging")	
Others, please state	

15. Has your Trust invested extra resources in creating Modern Matron (or equivalent) posts? (please tick all that apply)

Administration support ☐

Uniforms ☐

Formal training ☐

Mentorship arrangements ☐

Action learning programmes ☐

Office facilities ☐

Other (please state)

_____

_____

_____

_____

_____

16. Were the extra resources identified in Question 15 provided by "new money"?

Yes ☐ No ☐

If "No", from which source did the funding originate?

_____

_____

_____

_____

17. Has any formal evaluation of the posts been arranged by your Trust / Organisation?

Yes ☐ No ☐

18. Please tell us how your "Modern Matron" posts were introduced? (please tick those that apply)

Were posts introduced through gradual, staged implementation? ☐

or

Did all Modern Matrons in your Trust take up their post on the same day? (i.e. a "big bang" approach) ☐

Were posts introduced as part of an overall restructuring of nursing services? **Yes** ☐ **No** ☐

Did you have any difficulties in filling the Modern Matron posts? **Yes** ☐ **No** ☐

19. a) Have you developed a core or generic job description for Modern Matrons in your trust?

Yes ☐ No ☐

b) Have you developed a list of core competencies for Modern Matrons in your trust?

Yes ☐ No ☐

If you answered "Yes", to either of the above could you please enclose copies when you return this questionnaire? Thank you.

20. With regard to the introduction of Modern Matrons please identify any <u>positive</u> outcomes that the appointment of posts has had on your nursing service and / or the wider organisation.

_____

_____

_____

_____

_____

_____

_____

_____

21. With regard to the introduction of Modern Matrons please identify any negative outcomes that the appointment of posts has had on your nursing service and / or the wider organisation.

_____

_____

_____

_____

_____

_____

_____

22. If we need further information can we contact you again?

Yes ☐ No ☐

If Yes then please give name, designation and contact details below.

_____

_____

_____

23. If there are any further comments you would like to make that are not covered in the questionnaire please add these in the space provided below.

_____

_____

_____

_____

_____

_____

Thank you for taking time to complete this questionnaire; please return it in the reply paid envelope provided before Wednesday 30th April 2003

The research team at The University of Sheffield is handling this aspect of the project.
If you have any further queries please do not hesitate to contact us:

University of Sheffield
School of Nursing & Midwifery
301 Glossop Road
Sheffield S10 2HL
Telephone: 0114 222 9734
Dr Susan Read (s.read@sheffield.ac.uk) and Mr Mick Ashman (m.ashman@sheffield.ac.uk)

Appendix Three

Letter to all matrons in case study trusts
Questionnaire for all matrons in case study trusts

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

Department of Health Policy Research Programme: evaluation of the modern matron role
Letter to all "modern matrons" in case study trusts

Dear ……..

We are approaching you to ask for your help with a Department of Health-funded project into the implementation of the modern matron role in the NHS in England. We would be grateful if you would consider completing and returning the attached questionnaire, which we are sending to all modern matrons (or equivalents) in your Trust. We hope that our Project Information Sheet will help you to understand the overall design of our research. But if you feel you would like more information, or would like to discuss your participation in more detail, please contact us. The research team names and contact numbers are on the letterhead.

The Department of Health wants feed-back on the implementation of its guidance on modern matron posts. We have been commissioned to produce a report which describes the role, responsibilities and impact of modern matrons in NHS Trusts across the country. We are collecting information from Directors of Nursing in all NHS Trusts about numbers of posts, clinical grades and models of implementation. In addition, we are undertaking case studies in ten Trusts, chosen to cover different approaches to establishing modern matron posts. *We have received formal permission from the appropriate NHS Research Ethics Committees, from your Research Governance Team and the management to undertake fieldwork in this Trust.*

As you will see from the questionnaire, we are hoping to collect a certain amount of standardised information about modern matron post-holders, including details about your professional education and experience, your selection and appointment to this post, your main day-to-day responsibilities and the sort of support the Trust is providing (or could provide) to help you achieve your objectives. We would like to emphasise that your responses will only be seen by the research team, and that the questionnaires will be stored safely and destroyed once the data is entered on computer. Your name will not be transferred to the computer. If we wish to quote directly from any general comments you make on the questionnaire, we will not reveal your identity in the report.

Thank you for reading this letter. Please refer to the Project Information Sheet as well. We hope that you will be able to find the time to complete our questionnaire. You will be making a valuable contribution to the project, which will inform our final report to the Department. It should contribute to a better understanding of the challenges, constraints and achievements of modern matrons. It may also suggest ways in which Trusts and nursing networks can provide better support to nurses in these posts in the future.

Please return the questionnaire in the envelope provided by …….

With kind regards from the modern matron research team.

University of Sheffield
School of Nursing and Midwifery

Department of Health Policy

Research Programme

RCN Institute

Modern Matron Evaluation Project

Questionnaire for all modern matrons at case-study Trusts

This questionnaire is being sent to all modern matrons (or equivalents) in this and other case-study Trusts. It should help us to improve our understanding of how the role is being implemented in different settings. Please answer as fully as possible, using extra pages if necessary. We hope you won't feel unable, or unwilling, to answer any of the questions; but if you are, please tell us, and complete the rest.

First we would like to ask you about your current post

1. **What is your job title?**
   ……..……..

2. **How long have you been in this post? …….months**

3. **On what basis are you currently employed in the post?**
   'acting' capacity / 'substantive' capacity (please circle)

4. **What clinical grade is attached to the job?** (*NB please tell us if this is a Trust- specific grade and not a nationally-recognised one)*

   grade ……

5. **Please tick the appropriate salary band:**

   £ 24, 999 or less ☐

   £25,000-29,999 ☐

   £30,000-£34,999 ☐

   £35,000 - £39,999 ☐

   More than £40,000. ☐

6. Do you have a written job description for this post? (please circle)
YES / NO

If YES, we would be very grateful if you could send us a copy of this with your completed questionnaire. We will protect your identity

If NO, please answer the next question (7)

7. If you have no written job description, please could you tell us briefly what you consider to be your major responsibilities (eg infection control; cleanliness of clinical environment services; supporting professional development etc)

……

……

……

……

Our next questions are about your selection and appointment

8. Were you already working in this Trust before your appointment?
YES / NO

9. Could you tell us which of the following procedures applied before your appointment? *(please tick all the items that apply, if more than one)*

a) Had to submit written application.

b) Had a formal interview.

c) Invited to take on new role, without any formal selection procedures

d) Other selection procedures *(please give details)*
……

……

Operational details of your role

10. When you were first appointed, were you given any specific targets to achieve?

YES / NO

If YES, please give details……

……

……

……

If NO, could you tell us:

11. Were you given the discretion to set your own targets? YES / NO

If YES, what are they?

……

……

……

……

12. Thinking back over the *previous two weeks* at work, could you give an indication of the *five* areas of activity which have taken up most of your time (*eg* dealing with individual patient concerns; formal meetings [and type]; involvement in direct patient care, *etc*)

……

……

……

……

……

The next questions are about your accessibility to patients

13. Please could you list the number and types of all the wards *and/or* departments for which you are responsible?

……

……

……

……

14. Are they all on the same geographical site? YES / NO

If NO, please give details, such as distances involved, travelling times, etc)

……

……

……

……

15. On an average day, for how many patients are you responsible? ……... patients

16. How do you try to make yourself visible/accessible to patients?

……..

……..

……

……

Our next questions are about the managerial aspects of your role.

17. How many staff from the following groups do you manage directly? *(Please state if there are none)*

Ward sisters/ charge nurses …… Qualified nurses ……

Other nursing staff (*eg* nursing auxiliaries, health care assistants)……...

……..…

Other non-nursing staff groups *(please give details)*……...……...

18. What is the title of your own line manager in the Trust?

19. Do you report directly to anyone else in the Trust for certain aspects of your job (*eg* for professional issues)? YES / NO

If YES, please give details

……

……..

……..

20. Do you have *sole* responsibility for any budgets? YES / NO

If YES, please give details

……

……

……

21. Do you *share* responsibility for any budgets YES / NO

If YES, please give details

……..

……

……

……

22. Have you been involved in negotiating Trust contracts for domestic and cleaning services with external service providers? YES / NO

If YES, please give details……

……

……

……

23. **In your opinion, is there sufficient clarity within the Trust about your own role, responsibilities and working relationships?** YES / NO

If NO, please could you describe briefly any particularly problematic areas:

……

……

……

24. Is your role being formally evaluated? YES / NO

If YES, please could you give brief details……

……

……

……

We would like to ask about preparation and on-going support for your role

25. Thinking back to the job you were doing immediately before this, are you undertaking any completely new and unfamiliar activities?

YES / NO

If YES, please give details ……

……

……

……

……

26. Did your employers provide, or fund, any education or training before your appointment to prepare you for the new role?

YES / NO

If YES, please give details ……..

……..

……..

……..

27. Since taking up your appointment, have your employers made available any continuing opportunities for professional development?

YES / NO

If YES, please give details ……..

……..

……..

……..

28. Are there any areas in which you personally would like additional formal education or professional support?

YES / NO

If YES, please give details ……..

……

……

……

29. Do you have your own office space? YES / NO

(Please add comment as appropriate) ……

……

……

……

30. Please tell us about the secretarial *and/or* administrative support you receive (If none at all, please state.)

……

……

……

31. a) What (if anything) helps you to carry out your role effectively in this Trust?

……

……

……

b) What (if anything) hinders you from carrying out your role effectively?

……

……

……

We would now like to ask you for some general reflections on the role

32. In your opinion, are any of the following factors relevant to the possible effectiveness of the modern matron role? (*Please comment as appropriate)*

a) Gender ……

b) Ethnicity ……..……

c) Formal educational qualifications……..…

d) Other (*Please identify)* ……..

……..

……..

……..

Finally we would like to ask a few questions about you and your nursing career.

33. How old are you? (*please circle the relevant age band)*

20- 29; 30- 39; 40- 49; 50- 59; 60 –65.

34. Your gender: Male / Female *(please circle)*

35. **Please list your professional and academic qualifications, with dates where possible.**

Professional…….

……

……

Academic ……

……

……

36. With regard to your career history: please list the job titles, grades and dates of the posts you held in the ten years before your current appointment, starting with the most recent.

……

……..

……

……

……

……

37. What category best describes your ethnic group?
Please circle the code that applies and write in a further description if you wish.

A. White	A1. British	A2. Irish	A3. Any other White background (please write in)	
B. Mixed	B1. White and Black Caribbean	B2. White and Black African	B3. White and Asian	B4. Any other Mixed background (please write in)
C. Asian or British Asian	C1. Indian	C2. Pakistani	C3. Bangladeshi	C4. Any other Asian background (please write in)
D. Black or Black British	D1. Caribbean	D2. African	D3. Any other Black background (please write in)	
E. Chinese or Other ethnic group	E1. Chinese	E2. Any other background (please write in)		

We are very grateful for your help with these questions. If there is anything you would like to add in connection with any of our questions - or if you would like to give us any other information about aspects of your current role – please use the extra space provided.

……

……

……

……

……

……

Please read the next section before finally returning the questionnaire.

We would like to ask your permission for two further things:

i) May we approach you for clarification *and/or* further information about the items in this questionnaire, if necessary? YES / NO *(please circle)*

ii) Would you be willing, if selected, to participate more fully in our study? This would involve at least an in-depth interview about your role and possibly - depending on your further collaboration – some further data collection exercises. YES / NO

If YES to i or ii, please could you enter your name and contact details below, and we will then give you further information about participating and ask you to sign a consent form.

……..

……..

Thank you for sparing time to fill in this questionnaire. Please return your completed questionnaire as soon as possible to the research team working in your Trust

(Midlands and North = University of Sheffield. London and South = RCN Institute)

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

Appendix Four

Letter to selected matrons in case study trusts
Consent form for selected matrons and their contacts
Interview schedule for selected matrons

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

RCN Institute

Evaluation of the Modern Matron Role in the NHS

Information for Modern Matrons invited to take part in detailed study

You are being invited to take a more detailed part in our research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish before deciding whether or not you wish to take part. Ask us if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

What is the purpose of the study?
This one-year study focuses on the modern matron role in a variety of NHS Trusts and aims to

- Understand how the new role is being implemented in different settings
- Identify what helps or hinders modern matrons in carrying out their role
- Discover patients' experience of the new role

Why have I been chosen?
You have been invited to take part in the study because you are working as a modern matron (or equivalent). The research team would like to speak to a sample of modern matrons and a range of additional staff to understand how the modern matron initiative is being implemented, and how it is being experienced within a variety of Trusts.

Do I have to take part?
You will have already been invited to complete a questionnaire, and will have returned it. Because we felt your further participation would be beneficial to the range of information gathered, we are inviting you to become more involved. It is entirely up to you to decide whether or not to take part in this more detailed study. Should you agree to do so, you will be given this information sheet to keep and be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. Deciding to withdraw at any time, or deciding against taking part in this aspect of the study, will not disadvantage you in any way.

What will happen to me if I take part?
If you agree to join this part of the study, this will involve informal discussions and a tape recorded interview of about one hour in which we would like to ask you about the nature of your role and your experience of working as a modern matron. It may also include a vignette for you to comment upon. The vignette will be a description of a hypothetical situation, chosen because it bears some similarity to common events within the NHS. If you agree, we would ask you to read and give your reactions to the scenario described in the vignette.

With your agreement and at your convenience, we might follow up this interview with informal discussions to clarify any points that remain unclear. We would also like you to keep a brief diary about your activities, or consider being "shadowed" or observed by one of the research team over the course of a shift.

What do I have to do?
If you agree to be involved in this part of the study, we will first ask you to sign the consent form. You will receive a copy of this to keep, along with the information sheet.

If you agree to keep a diary, this will entail keeping a brief record of your activities and how much time you spend on these, on a daily basis over a period of three weeks. If you agree to be "shadowed", this will involve being observed by one of the research team during your working day, where this is feasible and does not impinge on patients' privacy.

What are the possible disadvantages and risks of taking part?
There are no foreseeable disadvantages or risks associated with taking part. We might wish to quote what you say during interview or informal discussions in the final research report, but no-one will be able to identify these as your words. Whatever you tell us will be treated as confidential within the Trust setting, unless you wish otherwise. You also have the right to stop the tape recording at any point, and to have the tape wiped clean, without giving any reason. Information from diaries or "shadowing" will not be traceable to you and, where necessary, we will disguise your identity.

What are the possible benefits of taking part?
These are no immediate personal benefits to be gained from taking part in the study but your views will contribute to our understanding of the way that the modern matron role is being put into action and its possible effects for patients.

What if something goes wrong?
If you wish to complain about any issue that arises in connection with the research, you can talk to *[name and description]……,* who works within the Trust and it not involved in the study *(see contact details below)…….* Alternatively, you can speak to one of the co-investigators not directly involved in research within your Trust (see letter heading for details).

Will my taking part in this study be kept confidential?
All information collected from or about you during the course of the research will be kept strictly confidential. Any stored information will have any means of identification removed so that you cannot be recognised from it. All information from the study will be carefully stored, in compliance with the Data Protection Act.

What will happen to the results of the research study?
The results of the study will be published as a report to the Department of Health in about one year's time. This report will be available on the Department of Health website (www.doh.gov.uk) and we will also send a copy to your Trust's Director of Nursing for circulation to those who participated in the study. We also plan to present the results at a conference for NHS staff, as well as incorporate findings in teaching packages for NHS Staff, and papers for journals.

Who is organising and funding the research?
The research is funded by the Department of Health and carried out by researchers at The University of Sheffield School of Nursing and Midwifery, and the RCN Institute at the Royal College of Nursing.

Who has reviewed the study?
The Northern and Yorkshire Multi- Centre Research Ethics Committee approved the study on 10/2/03

Contact for Further Information
Name: will depend on which Trust the "matron" is within.

Thank you for considering taking part in this study

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

RCN Institute

Department of Health Policy Research Programme: evaluation of modern matrons

Consent form for interviews with selected modern matrons & other staff

Please make sure you have read the accompanying project information sheet, and do contact us immediately if you want to discuss anything before agreeing to participate in the 'modern matron' study.

Please read points 1,2 and 3 carefully and initial at end of each point to show you understand them. Then fill in complete signature at 4.

1. I confirm that I have read and understand the project information sheet (.....) for the above study and have had the opportunity to ask questions.
Initials……

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
Initials……

3. I agree that my words can be used in any report of the research findings, but understand that my identify will not be revealed.
Initials……

4. I agree to take part in the above study.

_____	_____	_____
Name of interviewee **(BLOCK CAPITALS)**	***Signature***	***Date***
_____	_____	_____
Researcher **(BLOCK CAPITALS)**	***Signature***	***Date***

Thank you. Please follow instructions about the form given in accompanying letter.

Form CC
Questions to guide in-depth interviews with selected Modern Matrons (or equivalent postholders)

This builds on information already generated through Questionnaire BB.

A) How did you come to take up the role of modern matron?

Prompts:

- Were you nominated for the post?
- What did you think of the process for recruiting modern matrons?

B) Have you felt adequately prepared for the role?

Prompts:

- Have you had any specific training to help you fulfil the role?
- Are there particular skills or abilities that you feel you need to acquire to undertake the role?

C) How do you see the role of Modern Matron?

Prompts:

- What are the main responsibilities?
    - Patient environment/cleanliness/food
    - Point of contact for patients
    - Standards of nursing care/clinical role model
    - CNO's 10 new roles/practice development
    - Strengthening clinical leadership
    - Infection control
    - Staff budgeting/skill mix
- Which of these are referred to in your job description?
- Do you have other responsibilities beyond these?

D) What is it like to work as a modern matron?

Prompts:

- Are you able to meet the responsibilities associated with your role?
- Are there responsibilities you feel you should have as a modern matron, but don't?
- In which areas do you feel that you have been able to improve standards?
- What improvements has it been easiest to make and why?
- What improvements has it been hardest to make and why?
- Do you enjoy your job?

- Is the job changing/developing in any way/are there ways in which you think it should change/develop?

E) What factors are important for the effective functioning of the modern matron role?

Prompt**:**

- Organisational issues (ward, department, directorate, Trust)
- Managerial issues (ward, department, directorate, Trust)
- Resources issues (ward, department, directorate, Trust)

F) What are the most important attributes for an effective modern matron (or equivalent)

Prompt**:**

- Authority
- Personal strengths to ensure effectiveness in role

G) The study aims to include the perspectives of staff with whom you work closely. We would be grateful if you could identify your most frequent contacts?

Prompt**:**

- Ward nursing staff {especially Sisters]
- PALS/Patient Forums
- Estates/Facilities
- External contractors (eg catering, cleaning)
- Medical
- Management [general and nursing]
- Educational staff
- Infection control personnel

H) Any additional comments?

I) Would you be able to keep a diary of your activities?

J) How would you feel about one of the research team "shadowing" you for a day or half a day?

Appendix Five

Letter to selected matrons' key contacts in case studies
Interview schedule for matrons' key contacts

University of Sheffield
School of Nursing and Midwifery

The University of Sheffield
School of Nursing and Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

Department of Health Policy Research Programme: evaluating the role of the modern matron (EEEE)

We are asking you for help with our research study. We hope that this information sheet will help you to decide if you want to take part. If you would like more information about the study, we would be happy to talk to you about it (see names and contact numbers of the research team above). We have already obtained permission for our field work from the appropriate NHS Research Ethics Committees and from the Trust.

What is the research about?
The Department of Health recently issued guidance on the establishment of 'modern matron' posts in all NHS Trusts with in-patient beds. The Department now wants to know how this policy is being implemented across the country, and has commissioned a team of experienced researchers to undertake an evaluation. A major part of work will be to undertake in-depth case studies in this and nine other NHS Trusts. We aim to collect detailed information from modern matrons (or their equivalents) about their roles and responsibilities. We will also be talking to other key members of staff whose work brings them into contact with modern matrons; and we will seek the views of patients and/or carers about this new nursing role.

Why have I been approached?
We have asked the matrons we've talked to in this Trust to identify post-holders with whom they have important working relationships, and who can give us useful and relevant information about the impact of these new nursing roles. (In this particular hospital, modern matrons are known as Clinical Nurse Managers.).

Do I have to take part? No
Your participation should be voluntary.

What will happen if I agree to participate?
If you join the study, this would involve an interview, focused on pre-selected topics (see below). This would take about 30 minutes, and would be arranged at your convenience. We might ask for your permission to tape record what you have to say; otherwise, the interviewer will just take notes. Alternatively we might ask you to fill in a questionnaire.

What will I be asked about?
We shall invite all our interviewees to discuss the same broad topics in relation to modern matrons. For example, we would like to understand how you view the role and functions of these nurses.(or therapists!) You may have some practical experience of working collaboratively with a modern matron to improve patients' total experience of care. Alternatively, you may be able to identify organisational or other obstacles which prevent modern matrons from working as effectively as they might. Your views will contribute to the DoH's understanding of the way that this new nursing role is being put into action, and its possible effects for patients and other healthcare staff.

Will my information be treated in complete confidence? Yes
We might wish to quote what you have said during the interview in the final research report, but no-one will be able to identify these as your words. Whatever you say during the interview will be treated as confidential within the Trust setting, unless you wish otherwise. If are recording it, you have the right to stop the tape recording at any point, and to have the tape wiped clean. All information from the study will be carefully stored, in compliance with the Data Protection Act.

What do I have to do if I want to take part?
If you do agree to be involved, please will you keep the attached consent form ready to sign at interview, We will give you a copy of the signed form to keep along with this information sheet. Please contact the researcher who sent this letter, to arrange a meeting. Please note that, even after signing, you would still be free to withdraw at any time and without giving a reason.

Thank you for reading this. We hope you will consider contributing to our research.

EE **Questions to inform discussions with 'other staff' in case study Trusts**

(Staff from a variety of disciplines and departments will be involved, therefore questions/prompts will be tailored as necessary)

A) Background information

Prompts:

- Job title/clinical grade
- How long in post
- General responsibilities
- Rewards and challenges associated with own role

B) Understanding of the modern matron role

Prompts:

- What are the main responsibilities of modern matron in your area
- What are the most important aspects of the role
- What attributes does the role demand?

C) Contact with modern matron

Prompts:

- How (eg face to face, phone) and how frequently
- Over what sorts of issues
- Is working relationship predominantly formal or informal?
- Any examples of successful outcomes of collaborative working with modern matrons?

D) Formal relationship

Prompts

- Are respective roles and functions clearly understood and documented (if so, what are they), or are they still being negotiated?

E) Experience of the role

Prompts:

- How has the modern matron contributed to the care or health care experience of patients within your clinical area?
- In your experience, what have the main benefits of the introduction of this role?
- In your experience, what are the main problems associated with the introduction of this role?

  Prompt:

  - Role boundaries
  - Clarity of responsibilities
  - Authority

Any other comments you would like to make?

Appendix Six

Letter to patients asking them to fill in questionnaire
Patient questionnaire (also translated into other languages)

University of Sheffield

University of Sheffield
School of Nursing & Midwifery
301 Glossop Road
Sheffield S10 2HL

Dr Susan Read and
Mr Mick Ashman
0114 222 9734
s.read@sheffield.ac.uk
m.ashman@sheffield.ac.uk

Royal College of Nursing
of the United Kingdom
20 Cavendish Square
London W1G 0RN

Dr Jan Savage and
Mrs Cherill Scott
0207647 3833
cherill.scott@rcn.org.uk
jan.savage@rcn.org.uk

RCN Institute

Evaluation of the Modern Matron Role in a sample of Trusts

Information for patients and carers

We are approaching you to ask for your help in answering a short list of questions. Before you look at the list, we would like you to read this sheet. It gives you information about the research, which we hope will help you to decide if you want to take part. Please take time to read it carefully and discuss it with others if you wish. If the details are not clear, or you would like more information about the study, we will be happy to talk to you about it. The researchers are based at the University of Sheffield School of Nursing and Midwifery, and the Royal College of Nursing Institute and their names and contact numbers are at the top of this sheet.

What am I being asked about?

In response to public demand for more senior nurses in hospitals and other health services with the authority to improve standards of patient care, the NHS has started to employ a new group of nurses called 'modern matrons' (or a similar title). The Department of Health has now asked the researchers to find out how this idea is being acted on and how modern matrons are helping to improve patient care.

Why have I been chosen?

You have been invited to take part in the study because you (or a member of your family or someone you care for) are being treated in a hospital or NHS department that has already appointed 'modern matrons'. In this particular hospital the 'modern matrons' are known as ..... We would like to find out whether you have met one of these nurses during your stay in hospital, or health service visit. You may even have asked for some help or advice from her (or him) and we would like to know how easy this was for you.

What do I have to do if I choose to take part?

Please answer as many of the questions on the sheet you have been given as you can, even if it's just to say 'don't know' or 'not sure.' We will make arrangements either to collect the questionnaire from you, or supply you with a stamped addressed envelope.

Do I have to take part? - No

It is entirely up to you to decide whether or not to take part in this study. If you do, your views will give the Department of Health some idea about how easy it is for patients and their families to make contact with the new 'modern matrons'. If you choose not to take part, it will not affect your care in any way.

Will my information be kept confidential? - Yes

We do not ask you to fill in your name or any other personal details on our form. The questionnaire will only be seen by the research team and we will not pass it on to anyone else. Your answers will be completely private.

Does the hospital or NHS organisation know about this research? - Yes

We have given them full details of our research, and we have permission to approach staff members and patients for their help. The study has been approved by the appropriate research ethics committees. One member of the staff is acting as a link with our team, and you may contact her/him if you have any anxieties about the study. Their contact details are: .....

....

Can I find out about the results of the research? - Yes

We expect both brief and full reports to be available in the spring of 2004; you may ask any of the research team about that by contacting us at the addresses at the top of this letter. We also expect that your local NHS newsletter (if there is one published) may contain an article from us during the course of 2004.

We are very grateful for your help in filling in the questionnaire.

Patient survey: questions about the "Modern Matron" role

Thank you for answering this questionnaire. Please circle the most appropriate answer for each question.

1. Are you:

(a) a patient **(b) a carer or family member of a patient?**

2. How long have you (or the patient) been in this ward/unit (Please circle one of the three answers below)

(a) between 1-5 days (b) between 6-10 days (c) 11+ days

3. Have you stayed on this ward/visited this unit before over the past 12 months?

Yes No

4. Have you heard that there is a 'modern matron' covering this ward/unit?

Yes No Not sure

5. Do you know who works as a 'modern matron' in this ward/unit?

Yes *No* *Not sure*

6. Have you met the 'modern matron' that covers your ward/clinical area?

Yes No Not sure

7. Do you know how to contact the modern matron that covers your area?

Yes No Not sure

[Please turn over page]

8. Please look at the list below and tell us if you think the 'modern matron' does any of these things (Please circle all your answers)

Ensures good food for patients	Yes / No / Not sure
Helps ward nurses to manage their budgets	Yes / No / Not sure
Helps prevent infection	Yes / No / Not sure
Helps patients and families with problems /questions	Yes / No / Not sure
Ensures clean wards and clinical areas	Yes / No / Not sure
Ensures discipline among staff	Yes / No / Not sure
Ensures good patient care	Yes / No / Not sure
Ensures the right staff are employed to provide good care	Yes / No / Not sure

9a. Have you asked your modern matron for any help or information about any of these issues?

Yes No

9b. If so, what sort of help did you ask for:

Help with getting better food	Yes / No
Help with questions about your treatment	Yes / No
Help with ensuring a clean ward or clinical area	Yes / No
Help to ensure your comfort	Yes / No
Help to ensure good nursing care	Yes / No
Something else	Yes / No

9c. Was your modern matron able to help?

Yes, a little Yes, a lot No

10a. Have you asked anyone else for help about these issues? (Please tick all that apply)

your ward sister	☐	your named nurse	☐
another member of staff	☐	your doctor	☐
your ward housekeeper	☐		

10b. Did you ask this person as well as asking your modern matron about these issues? (please circle)

Yes **No**

Thank you for your help. Please return this form to ……..