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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 a research team from the RCN Institute and the University of Sheffield to investigate: a) how NHS trusts were establishing 'modern matron' posts; b) the experiences of nurses in these posts; and c) 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 trusts 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. The survey revealed that 113 different job titles were in use.

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 (eg 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 (cited by 77% of respondents); provision of staff support and liaison for wards (cited by 49%); and delivery of direct patient care (cited by 44%).

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 managers.
- 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 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 overstressing 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 to 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.