Does leadership style of modern matrons contribute to safer and more effective clinical services?

Background

The NHS Plan (Department of Health (DH) 2000) outlined the targets and changes required to improve and modernise the NHS over the subsequent ten years. Following its publication, there was much concern from the public and the NHS workforce about the lack of visible clinical leadership at ward level. To address this, modern matrons were introduced, as accountable, accessible professionals who could manage groups of wards, and improve patients’ experiences and care.

The NHS Plan (DH 2000) proposed that every hospital should appoint matrons to carry out two important, ward-level functions: strengthen clinical leadership and increase public confidence by addressing concerns (Smith 2008). However, even before implementation of the role, there were concerns about what modern matrons would require in terms of preparation, scope of practice, personality and experience, since immense pressure would be placed on them (Wildman and Hewison 2009).

Cole (2002) agreed that modern matrons would be under tremendous pressure but believed they would be empowered in their new roles and that success would depend on the style of leadership they adopted.

NHS reform has involved seemingly endless relabelling of managers and leaders and retitling of professionals, and at that time it was argued that the modern matron role was no more than a political stunt to persuade the public that ‘traditional matrons’ could change the NHS back to how it had been at its inception (Hewison 2001).

Health service managers and leaders are under constant pressure, with nursing and medical directors trying their best to improve services through initiatives such as harm-free care, compliance audits, patient-experience feedback, user groups and other local and national initiatives (Royal College of Nursing (RCN) 2013). There are various motivators for these initiatives, including patients’ right to choose a care provider, scoring care providers for services and patient experiences, and compliance with Care Quality Commission regulations and inspections.

In clinical practice, the evolution of the NHS has affected the already challenging and demanding roles of matrons and requires them to be quick-thinking managers who can resolve issues at the bedside.

In 2003, the then chief nursing officer (CNO) for England extended the role of matrons in emergency departments, for example, by giving them budgets of £10,000 to improve patients’ experiences of urgent care (DH 2003). The CNO said it was becoming clear that the range of functions matrons perform, and how they could improve patients’ experiences, was ‘even greater than originally foreseen’ (Mullally 2003).
Historical nursing management

In the 1960s, the Salmon Review advocated the abolition of traditional matrons and the creation of senior nurses who would be separate from the wards and bedside patient care (Brown 2013). The role of senior nurses and matrons changed significantly, but by the 1980s nurse managers were perceived as detached from clinical practice and separated from ward-level nursing staff (Brown 2013) and it was suggested that they had poor insight into the performance of clinical staff and a poor understanding of the challenges they faced (King’s Fund 2011).

At that time, nurse managers were accountable to non-nurses such as NHS graduates, administrative and clerical managers (King’s Fund 2011), which may have been difficult due to a lack of understanding of each other’s roles and goals (Bach and Ellis 2011).

This change in the nursing hierarchy was significant, and it continues today. Not only were senior nurses answerable to their governing body, at that time the UK Central Council (UKCC) for Nursing, Midwifery and Health Visiting, they were also accountable to administrative managers, who focused more on business than on clinical priorities.

The UKCC, the predecessor of the Nursing and Midwifery Council as nursing’s governing body, managed professional misconduct and complaints, maintained a record of registrants, had a code of professional conduct, and influenced and guided nurses’ decision-making processes. It identified and promoted professional leadership as opposed to the ‘management duties’ of administrative managers, who had less appreciation of the value of clinical leadership.

Challenges faced by matrons

To ensure recognition of the modern matron role at ward and senior management level, nurse postholders must be credible (Brown 2013). Therefore, the challenges they face begin at interview, as the ‘right people’ must be selected and need to possess expertise, knowledge, confidence and respect for colleagues (NHS England 2013).

Another challenge is the expectation that matrons lead on evidence-based practice and high standards, while providing clinical cover when wards are short staffed. This could be perceived as good, visible leadership, and gain them respect from multidisciplinary colleagues. However, the time spent on clinical cover could be used to fulfil the ‘management’ expectations of the role, such as audits, patient experience surveys, harm-free care reports, recruitment and selection processes, rosters and agency bookings (Smith 2008).

Stanley (2006) states that credible and competent registered nurses placed in managerial posts are burdened by the expectation that they retain clinical responsibilities, resulting in conflict, confusion, ineffective leadership and management, dysfunctional clinical areas and poor care. Many nurses are excellent leaders but there is an assumption that they are also skilled in managing staff and services, and that the two concepts are interchangeable. However, leaders do not necessarily make good managers, as the role and skills required are different.

Management or leadership?

It could be argued that matrons should be leaders and managers and, while the relationship between leadership and management continues to be debated, there is a need for both (Marquis and Huston 2009). Edmonstone (2008) suggests there is a misunderstanding about the relationship between leadership and management in healthcare settings. Some authors regard leadership as one of a manager’s tasks while others say the skills required for leadership are more complicated than those needed for management (Cook 2004, Hughes et al 2006, Bach and Ellis 2011). Some of the distinctions between managers and leaders are listed in Box 1.

Nursing management and nursing leadership overlap significantly, and the terms are sometimes used interchangeably (Cook 2004). But what determines matrons’ influence and credibility, whether the role is management or leadership, is the behaviour they display (Hughes et al 2006, Edmonstone 2008). Target-driven, short-term and goal-driven management pressures in healthcare organisations cause conflict, potentially leading to hostility between managers and senior nurses (Edmonstone 2008).

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**BOX 1. Distinction between managers and leaders**

<table>
<thead>
<tr>
<th>Managers</th>
<th>Leaders</th>
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<tbody>
<tr>
<td>› Administer</td>
<td>› Innovate</td>
</tr>
<tr>
<td>› Maintain</td>
<td>› Develop</td>
</tr>
<tr>
<td>› Control</td>
<td>› Inspire</td>
</tr>
<tr>
<td>› Have short-term views</td>
<td>› Long-term views</td>
</tr>
<tr>
<td>› Ask how and when</td>
<td>› Ask what and why</td>
</tr>
<tr>
<td>› Accept status quo</td>
<td>› Challenge status quo</td>
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(Hughes et al 2006)
Yet clinical leadership roles are fundamental to delivering good patient care and creative
working environments (Stanley 2006).
Murphy et al (2009) support this, saying
clinical leadership encourages patient safety,
professional accountability and delivery of
best practice. To recognise and develop nurses’
leadership skills, and to equip them with the
skills required to become modern matrons,
they must have access to courses such as the
RCN leadership programme (RCN 2009)
(Figure 1).
It could be argued that every manager
should be a leader, while leadership without
management can result in chaos and failure
for organisations and post holders (Marquis
suggests that leaders are the inspiration for
actions as well as the directors of actions, and
use a combination of personality and skills
in a way that makes others want to follow.
These ideas lead to the question: are matrons
managers or leaders?
There are many links between managers and
leaders, and both roles are needed to influence
and guide others. In clinical practice, managers
must be able to react to multiple situations,
which can result in a sense of firefighting
and crisis control. Mullins (2010) suggests
that managers strive for productivity, trying
to create faster services and reduce spending
while following policies and procedures, while
Stonehouse (2013) thinks that leaders do
not have the same anxieties and restraints as
managers, so have more time to be proactive
and innovative. This is why leaders are often
viewed as role models, as they are visible
and available rather than absent because of
meetings or desk duties.
Bennis and Nanus (2004) state that
‘managers are people who do things right,
and leaders are people who do the right thing’,
which suggests that managers do what needs to
be done at the time, while leaders have a wider
vision, possibly with fewer time constraints.
When I worked as a modern matron I
adopted leadership and management personas
in practice by doing what needed to be done,
but first considering the long-term effects of
the action and whether it was right for patients
and staff. This might be because the healthcare
provider for which I worked encouraged
matrons to display and carry out both roles.
Additionally, my own perspectives, culture,
clinical experience and leadership style affected
whether I was regarded as a manager or a
leader by my colleagues.

Leadership styles
Matrons’ leadership styles greatly influence
work environments and staff behaviour,
negatively or positively. For many years,

Figure 1. Elements of the Royal College of Nursing leadership programme
hospital leaders have displayed a dominant leadership style (Barr and Dowding 2013), but current thinking suggests that leaders move dynamically between different styles when reacting to different situations (Politis 2001). Two distinct leadership styles have long been discussed in the literature: transactional and transformational.

Transactional leadership
This traditional style of leadership focuses on transactions (Bach and Ellis 2011). For example, team members will do what is requested in exchange for a reward. Transactional leaders state what needs to be done, allocate the task and expect it to be completed. This reflects a ‘get the job done’ attitude rather than selecting who should be involved to ensure the task is carried out effectively. This style can be effective in emergency situations or when confronting deadlines, but it is outdated, was more relevant when healthcare was task-orientated and non-holistic, and does not fit well with NHS values (Nicolson et al 2011).

Transformational leadership
Burns (1978) describes transformational leadership as a ‘process in which leaders and followers help each other to advance to a higher level of morale and motivation’. Transformational leadership is based on how things could or should be done and effectively communicating this ‘vision’ to others. Transformational leaders are passionate about what they do and about involving the right people to bring about change, and usually gain ‘followers’ who respect them, share their vision and feel energised, valued and enthusiastic.

The NHS benefits from transactional leadership during periods of stability (Nash and Govier 2009), and past leaders and their staff were satisfied with transactional relationships because they knew what was expected of them (Govier and Nash 2009). However, in response to the vast changes in the NHS over recent decades, a more transformational leadership style that is more

Dock 2. Four leadership styles and four levels of staff maturity in situational leadership

Leadership styles
- Telling. Directing and taking charge.
- Selling. Encouraging the desired performance from staff.
- Participating. Improving working relationships.
- Delegating. Encouraging employees to work to their strengths and full potential.

Staff maturity levels
- Staff who lack knowledge, skills and willingness.
- Willing and enthusiastic staff who lack ability.
- Capable and skilled staff who are unwilling to take on responsibilities.
- Highly skilled and willing staff.

(Hersey and Blanchard 1969)

References

encourages flexibility, creativity and the involvement of patients and staff has evolved.

Leadership has to work in the context and culture of an organisation, and I would argue that at times both styles are required. For example, the Francis report (2013) highlights the failure of senior nurses to manage clinical areas safely at Mid Staffordshire NHS Foundation Trust. Neither transactional nor transformational styles of leadership alone could have rectified the situation there, but perhaps a mix of both had been required. ‘Enabling’ others through transformational role modelling has its place, but using a transactional style to manage staff who require structured, descriptive direction, for example junior or new nurses, or those who do not conform to policies, may also have been beneficial. This mix of styles is encapsulated in situational leadership theory.

Situational Leadership

Situational leadership theory (Reddin 1967, Hersey and Blanchard 1969) suggests that individuals use a variety of leadership behaviours and skills depending on their teams’ level of experience, knowledge, competency, willingness and ability. The approach is based on a combination of four leadership styles and four levels of staff ‘maturity’ (Hersey and Blanchard 1969) (Box 2).

An autocratic, transactional style of leadership can work with junior staff who lack experience, knowledge and skills, while a democratic and transformational style can work with more experienced, competent and willing teams (McCleskey 2014). Situational leadership allows a flexible and adaptable style of leading and supporting staff at novice or expert level, and recognises, not only the importance of the task, but also the people in the team. It enables leaders to direct junior or novice staff to complete tasks, and to develop senior and experienced colleagues.

This style of leadership is relevant in today’s evolving NHS. Leading teams, particularly in specialist teaching hospitals, requires working with new staff and changing team dynamics constantly. Modern matrons need to be able to adapt their styles to specific situations.

Conclusion

This article examined the skills required by modern matrons to enable them to provide effective leadership of clinical services. Matrons must be able to innovate and develop team members, inspire colleagues by role modelling, create vision, explore long-term ideas to improve clinical services and remain visible to improve patients’ experiences. They must be clinically and academically credible, professionally accountable and able to implement best practice. These attributes and abilities are best described in a situational leadership style, which encompasses transactional and transformational approaches.