Modern matrons: reviewing the role

In the first of two articles, Alison Smith reports on a survey of modern matrons that has resulted in a complete review of their role, from recruitment to continuing professional development.

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Modern Matrons were introduced in the NHS as part of The NHS Plan (Department of Health (DH) 2000) to improve patient care and the patient experience.

A key aspect of health service reform is to allow senior nurses to lead quality improvement, and several policies explicitly link the modern matron role with clinical governance and the government’s health service modernisation agenda (DH 2000, 2001).

Savage (2004) suggests that, in the context of these policies, modern matrons and ward staff in directorates at middle management level should ensure that appropriate services are in place by working across organisational boundaries in their trusts.

This suggestion is supported by former chief nursing officer for England Dame Sarah Mullally (2001), who said: ‘Matrons were introduced to provide strong clinical leadership on wards and to be highly visible and accessible to patients. They were there to lead by example in driving up standards of clinical care and empowering nurses to take on a range of clinical tasks to help improve patient care.’

Many authors argue that, as policy guidance and the modern matron role evolve, trusts must decide whether their modern matrons focus on the responsibilities of corporate management or on providing credible professional leadership (Hewison 2004, Mullally 2001).

Paton (1995) thinks that this dilemma is rooted in the polarisation of NHS management, whereby clinical managers focus on professional workloads and responsibilities while general managers concentrate on operational and strategic issues.

Owens and Petch (1995) suggest that this polarisation causes friction between healthcare professionals and general managers, whose objectives have traditionally been different. For example, general managers may attempt to subject clinicians to a corporate rather than professional agenda (Hunter 1994).

In 2005, the newly appointed director of nursing at South Tees Hospitals NHS Trust requested a review of its nursing roles and structures.

It was discovered that matrons in the trust used the title ‘clinical matron’ (CM) because they thought that it described the purpose of their role, namely to enhance clinical care, better than the title ‘modern matron’.

The trust’s director of nursing decided therefore that the CM role required further review as part of the trust’s governance agenda. A CM project review group (PRG) was formed with the following aims:

■ To establish how CMs function in the trust.
■ To make recommendations to the trust’s nursing and midwifery governance committee (NMGC) on the best model of practice for matrons in the organisation.
■ To provide a generic job description and ‘person specification’ for all CMs in the organisation.
■ To develop an induction, training and development programme for newly appointed and existing CMs.
■ To establish the impact of the role on the trust.

As part of its evaluation of the modern matron role, the PRG undertook a study to explore the views of CMs and their divisional managers.

Role evolution

The modern matron initiative has its roots in a public consultation about the NHS undertaken on behalf of the government shortly after Labour came to power, in 1997 (Savage 2004). This consultation found that many patients and their relatives were concerned that nurses lacked sufficient authority at ward level to address shortcomings in services.

The matron role was developed to address nurses’ apparent powerlessness when faced with such concerns and the three main strands of the role were clarified in Implementing the NHS Plan: Modern matrons (DH 2001). This document identifies the following priorities for modern matrons:

■ To provide leadership to professional and direct care staff, ensuring the availability of appropriate administrative support services in their ward groups.
■ To provide a visible, accessible and authoritative presence on wards, to whom patients and their families can turn for assistance, advice and support.
The DH further defined the role by publishing a set of ‘ten key responsibilities’ for matrons (Box 1). The DH commissioned an evaluation of the modern matron role in a sample of NHS trusts (RCN Institute and University of Sheffield 2004), and the resultant report argues that matrons strengthen clinical governance by developing protocols and achieving greater compliance with them.

It also finds that matrons can increase skill mix and staff retention rates by improving nursing teamwork in and across clinical areas, including infection control, and by identifying and meeting staff development needs.

The report notes however that there is enormous variation in title, role and pay rates among modern matrons, and urges trusts to bolster modern matron posts or see them ‘squandered’. It states that ‘unless trusts take an effective, “whole systems” approach to quality improvement, and understanding of the role of modern matrons within this strategy, the potential of this new role may become diluted, making it indistinguishable from recent, comparatively limited middle management roles’ (RCN Institute and University of Sheffield 2004).

The same report proposes that trusts take a strategic approach to:
- Establish roles.
- Select staff and prepare them for roles.
- Continue professional development.
- Provide appropriate support.
- Develop future clinical leaders.

It also states that matrons should be ‘clinically credible’, although how this is interpreted depends on matrons’ clinical specialties. It does not necessarily imply that they require in-depth and specific technical knowledge.

A study by Hill (2005), which examined the effect of the modern matron role on healthcare-associated infection (HCAI) and cleanliness, found that, although matrons do not have day-to-day management responsibilities for the prevention of HCAIs, they are responsible for leading clinical teams in these areas.

Hill (2005) proposes that in addition to this responsibility, matrons should oversee infection control practice on their wards and in their departments before developing systems to improve it.

Judging by these two studies (Hill 2005, RCN Institute and University of Sheffield 2004), the difference between the modern matron role and those of other senior managers, such as nurse directors, is difficult to discern.

There is a suggestion that, in some trusts, matrons have replaced directors of nursing as the visible public face of the nursing profession, and that directors of nursing see matrons as people who collaborate with them by sharing some of their workloads (Agnew 2005).

Nurse directors have also acknowledged that the matron role, in some circumstances, has caused problems with staff who think that matrons encroach on ‘their’ territory. For example, the report for the DH (RCN Institute and University of Sheffield 2004) notes that many ward sisters were uncomfortable because their autonomy had been suddenly undermined by the appointment of modern matrons.

One director of nursing suggests that, after trust managers made clear that the emphasis of the role had been shifted from clinical input to leadership across specific services, initial tensions between modern matrons and other staff appeared to be resolve (Agnew 2005), which suggests that key staff should be involved in defining and developing the matron role before it is introduced.

Study
The study for the DH (RCN Institute and University of Sheffield 2004) provided the PRG at South Tees Hospitals NHS Trust with background information relating to:
- Models of matron roles in NHS trusts.
- The impact of the matron role.
- The need for strategies to establish matron posts.
- Key themes and messages about the matron role.
- Recommendations for developing clinical leaders.

The group of 11 permanent members comprised a CM from each of the seven clinical divisions, one member of the infection prevention and control team, the assistant director of nursing and head of risk management.

Box 1. Matrons’ ten key responsibilities
- Leading by example
- Making sure patients receive good quality care
- Ensuring that staff levels are appropriate to patient needs
- Empowering nurses to take on wider ranges of clinical tasks
- Improving hospital cleanliness
- Ensuring that patients’ nutritional needs are met
- Improving wards for patients
- Making sure patients are treated with respect
- Preventing hospital-acquired infections
- Resolving problems for patients and their relatives by building closer relationships with them
applied leadership

Table 1. Information requested in the questionnaires

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<thead>
<tr>
<th>Question areas for divisional managers</th>
<th>Question areas for clinical matrons</th>
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<tr>
<td>Number of inpatient beds</td>
<td>Previous experience</td>
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<td>Number of nursing staff in division</td>
<td>Academic level</td>
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<tr>
<td>Number of divisional matrons</td>
<td>Salary</td>
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<tr>
<td>Line management responsibilities</td>
<td>Roles and responsibilities</td>
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<td>Budget responsibilities</td>
<td>Selection and recruitment of staff</td>
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<td>Professional accountability</td>
<td>Strategic responsibilities</td>
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<td>Recruitment to the role</td>
<td>Patient involvement</td>
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<tr>
<td>Role remit and areas of responsibility</td>
<td>Review of previous two weeks' diaries to identify key tasks undertaken.</td>
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<tr>
<td>Development in the role</td>
<td>Line management responsibilities</td>
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<tr>
<td>Achievements</td>
<td>Budget responsibilities</td>
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<tr>
<td>Strategic responsibilities</td>
<td>Support for and impact of the role</td>
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<tr>
<td>Difficulties</td>
<td>Difficulties</td>
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<td>Personal and professional development</td>
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The appointment of matrons presented senior sisters with a new career development opportunity.

All matrons in the study used the word ‘matron’ in their titles, although not all were called CMs.

Most appointments were substantive posts, with only 12 per cent working in an ‘acting’ capacity only.

Four per cent of matrons were given no job description on appointment.

Fifty per cent were given specific targets to achieve, while 41 per cent could set their own targets.

Twenty nine per cent of matrons operate on the trust’s two hospital sites, while the remainder have responsibility on one site only.

Remit, clarity of role and working relationships

The number of staff line-managed by a matron ranged from six to 222 full-time equivalents, but two matrons had no line management responsibility at all.

Matrons who line-managed staff were responsible for various people across the organisation including audit team members, charge nurses, healthcare assistants, medical secretaries, nurse practitioners, porters, specialist nurses, ward clerks and ward sisters.

They had roles and responsibilities that are more associated with senior nurse operational managers in clinical directorates and divisions.

Some divisional managers said that matrons had been appointed to reflect divisional or directorate needs rather than to allow matrons to focus on the role defined by DH guidance.

Eight per cent of matrons thought they were ‘unsupported’, 38 per cent thought that they were ‘adequately supported’, and 54 per cent thought that they were ‘very supported’.

Some matrons had no responsibility for patients while one had responsibility for 300 patients in any one day. Most had responsibility for between 50 and 80 patients daily.

Administrative support varied; a few matrons had dedicated secretaries, while some had no clerical support at all.

Experience of the ten key responsibilities

The matrons thought they provided a visible senior nursing presence on wards and in departments.

They focused on delivering DH Essence of Care and quality standards.

They described themselves as senior nurses in the divisional structure who provided a focus for resolving nursing problems.

Management, one hospital bed management sister and one ward manager representative. Members held monthly meetings to which the ward manager of one of the surgical wards was invited to represent ward managers’ views on, and requirements of, the matron role.

To establish the role of matrons in the trust, the PRG drafted two separate questionnaires, one for divisional managers and one for matrons, to collect the information described in Table 1.

Ethical approval was not required for this process because the questionnaires were part of service evaluation. They were not piloted due to lack of time.

Seven questionnaires were sent to divisional managers and 24 were distributed to matrons.

Results

Five divisional manager and 23 matron questionnaires were completed and returned, and key themes were identified from these using Burnard’s (1991) thematic analysis. Some of the findings are listed below.

Preparation for the CM role, and the selection and recruitment of CMs

All seven clinical divisions had at least one matron, while some had appointed up to ten, although one division had one matron to cover the whole of her clinical division, giving her a large remit.
They thought that they provided clinical leadership and were involved in the development of robust protocols across the directorate.

Involvement in clinical activity varied. One matron reported having had no time in clinical activity over the previous two weeks, two spent over 70 per cent of their time in clinical activity, while most spent between 20 and 40 per cent of their time in clinical activity.

Impact of the role
The matrons reported that they liked being able to use the title when dealing with complaints. They said that the public appreciated the role and they assumed that this was because the title, ‘matron’, was ‘reassuring’.

They also reported that the title of matron gave them access to corporate groups and to directors of nursing through their CM forum.

Some thought that they raised the profile of the operating theatres across the trust and had helped standardise practice across them.

Participants noted that divisional matron meetings resulted in a generic review of matrons’ performance, and how they collaborate with, and support, other healthcare professionals.

Forty one per cent of matron participants reported that they had little, if any, contact with patients.

Other results
Matrons’ pay, the amount of time matrons were involved in patient care and their most frequent activities are shown in Tables 2 and 3 and Box 2.

Several matrons commented that there was no clear difference between their role and that of senior nurses with operational management responsibility. Such comments were not made by all matrons in the trust however, and only some thought that there was conflict between their responsibilities and those of the senior nurses.

Since starting the CM review, the director of nursing has clarified the specific operational and corporate management responsibilities of each role.

The study’s findings highlight the enormous variation in how the matron role has been implemented at South Tees Hospitals NHS Trust.

Due to lack of time, the effect of the matron role has not been evaluated, but responses to the survey from matrons and divisional managers suggest that matrons are improving standards of nursing care, skill mix and staff retention, staff morale and the patient environment. They are also improving cleaning contracts, developing and supporting new nursing roles, encouraging staff development and reducing the number of complaints.

The responses to the survey at South Tees Hospitals NHS Trust also highlighted areas of concern that could limit the success of the role. These include:

- Role conflict.
- A lack of clarity in, and understanding of, the role.
- The fragile authority inherent in the role.
- Role overload.
- A blurred interface with other roles.
- Inequitable grading and responsibilities.
- Inadequate administrative support.
- Competing priorities.

Some of these problems can be addressed by reviewing and restructuring the role. Findings from the report for the DH (RCN Institute and University of Sheffield 2004) meanwhile suggest that, if posts are planned

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<th>Table 2. Matrons’ pay</th>
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<tr>
<td>Salary scale</td>
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<tr>
<td>Senior manager pay</td>
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<td>Trust grade 14</td>
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<td>Trust grade 13</td>
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<td>Trust grade 12</td>
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<td>Trust grade 11</td>
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<th>Table 3. Time spent caring for patients</th>
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<td>Percentage of time spent involved in patient care or clinical work over the previous two weeks</td>
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<tr>
<td>70 and above</td>
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<tr>
<td>Between 40 and 60</td>
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<td>No involvement</td>
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<th>Box 2. Most frequently reported activities over the previous two weeks, in descending order of frequency</th>
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<tr>
<td>1. Attending meetings</td>
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<td>2. Dealing with staffing issues</td>
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<td>3. Arranging ward cover due to staff sickness</td>
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<td>4. Dealing with personnel issues</td>
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<td>5. Dealing with patients’ or carers’ issues or complaints, and patient advice and liaison services enquiries</td>
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<td>6. Being involved with patient care</td>
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Carefully and matrons are given the appropriate organisational support, these problems can be avoided.

This study highlights three models for the matron role, similar to those identified by the RCN Institute and University of Sheffield (2004). These are the:

- **Clinical matron role**, which is concerned with leading operational clinical care, quality and standards, and includes occasional hands-on clinical activity.
- **Managerial matron**, which is similar to the role of senior nurses with operational management responsibility, which is concerned with the operational management agenda away from clinical areas.
- **Mixed model**, in which clinical and managerial responsibilities are combined.

The trust PRG agreed that the CM model is the most appropriate model for matrons to adopt to meet their ten key responsibilities. The trust’s matrons will continue therefore to use the title ‘clinical matron’.

A core job description, person specification and organisational structure that identifies where matrons fit in each division, based on the NHS Knowledge and Skills Framework and the ten key responsibilities, have therefore been drafted.

The job description is based on the DH job match for matrons at band 8a, and core and specific specifications for all matrons have been agreed and examples of necessary evidence added to the outline.

An induction and training programme, again based on the ten key responsibilities, has been developed for new and existing matrons, as appropriate, with leadership, infection prevention and control, and risk management being training priorities for existing matrons.

Discussions have taken place with the local Improvement Alliance, which works with clinical teams to provide strategic guidance for service improvements, to aid the development of a specific clinical leadership programme for CMs.

As part of this programme, CMs will provide annual reports to the director of nursing, trust board and the NMGC to highlight their progress in meeting the ten key responsibilities and how healthcare services have developed in their areas and across the organisation.

Finally, the trust PRG has recommended further evaluation of how matrons affect the trust by obtaining the views of all staff levels, patients and carers, nursing students, support staff and senior management team members.

In the next article about modern matrons, due to appear in the September issue of Nursing Management, the authors will discuss staff experiences of matrons.

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**References**


