

**Modern matrons in an acute setting:
a qualitative case study**

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Although there is one name on the cover of this submission, I have many people to thank who have supported me to complete this doctorate. My doctoral supervisors, Professor Fiona Brooks and Dr Patricia Wilson, thank you.

To my family. I have been absent every Saturday for eight years and more recently for increasing amounts of time - thank you for your patience.

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'Matron Jones', via her diaries, was an historical participant of this study and it is important to formally acknowledge her contribution here. It was unlikely that Matron Jones would have thought, whilst she was keeping her records, that a 21st century nurse researcher would have been interested in what she had written. Matron Jones's contributions have helped to provide a realistic insight (albeit on a small scale) into a traditional matron's role in a rural fever hospital supported by key literature. The role complexities, challenges and location as a nurse leader demonstrated a continuity with her modern colleagues. Matron Jones was located within a similar predicament due to being subordinate to the medical officer and the hospital administrator and she may have recognised the situation that the modern matron body encountered as a familiar one: this aspect of nurse leadership has demonstrated the connectivity between the traditional and modern matron roles.

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To my fellow students. It has been a long, rocky and arid road. I would not have reached the end without your supportive words and good humour, thank you.

Finally, to my daughter Grace. This is for you. You can reach for the stars; never let anyone tell you that you can't. All is possible.

Modern matrons in an acute setting: a qualitative case study

Abstract

The arrival of the modern matron into the NHS acute setting in 2001 was in response to increased public and political concern regarding standards of nursing care and the quality of patient care. As a politically motivated initiative, the modern matron role and its relationship with the concept of the traditional matron has been extensively debated. The aims of this study were to explore:

1. How far the modern matron represents continuity between the traditional matrons of the mid 20th century and the present day.
2. What socio-political forces led to the development and establishment of the modern matron?
3. From the perspective of health professionals, what impact has the modern matron had on the quality of patient care?

Adopting a case study design underpinned by realistic evaluation, the study involved interviewing patients and a carer, a focus group and interviews with staff and national policy leads. Documentary analysis was undertaken on a set of traditional matron archives.

A number of key themes emerged from the research, including: the importance of uniform and visibility, patient expectations, the impact of policy processes and the political rationale for national policy change. Conflict between ensuring nursing quality and operational demands, which acts as a barrier to the modern matron role, was also found. Long-held assumptions about the functions and the positioning of the traditional matron are explored, with continuity and divergence between the traditional and modern matron roles revealed.

Using a realistic evaluation approach, the findings were framed whilst considering the structural and generative elements, which resulted in social interplay or visible phenomena and provided an explanation for the predicament of the modern matron.

The key conclusions were that national policy decisions appeared to be diluted once locally implemented. Modern matrons in part did positively impact on care quality. The introduction of modern matrons and the quality agenda may have been the start of a national discussion about how to continually improve patient care in an arena where intermittent care quality challenges which give concern. The effect of previous national policies that impacted on senior nurses may have diverted them away from their core purpose – patient care. The modern matron guidance may have been limited before publication by the inference within it about limiting the authority of the new post-holders. There was limited evidence of the modern matrons' visibility to patients and this was reflected by the traditional matron's accounts. The expectation of modern matrons' physical presence may have been drawn from assumptions embedded in nostalgia and media portrayal of the traditional matron. The thesis concludes with implications for strategic nurse leaders and national policy leads to consider how the organisational arrangements for secondary care can best support and secure the ultimate aim of consistent provision of good quality nursing care.

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¹ At the time when modern matrons were introduced, the terminology was 'hospital acquired infection'. However, as the nature and transmission of infections were further understood the terminology was amended to reflect the broad nature of transmission, which was beyond the confines of hospital: hence, 'healthcare acquired infection' is the current term.

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Chapter One

Introduction

1.0 Setting the scene

This thesis examines the role of the modern matron and its impact upon the quality of nursing care and in doing so has sought the views of modern matrons, senior sisters, national policy leads, patients and a carer. The study has a historical dimension by way of archival diaries and other evidence regarding what could be broadly termed as 'traditional matrons'. In this submission, the term 'traditional matron' has been broadly applied to differentiate between the modern matrons. Therefore, traditional matrons were those diverse group of matrons working in various settings from the 19th century until their demise in the 1960s. The purpose of this chapter is to outline the aims of the research. The layout of this thesis is also detailed.

1.1 Discontent with nursing performance in the context of an imminent general election

Towards the end of the 1990s the Labour Government had promised to 'save the NHS' (Labour Party Manifesto 1997). The Government had provided considerable financial investment to new systems and processes to address concerns regarding the waiting times for procedures and operations; despite the increased investment, it was reported that the public were apparently discontented with the perceived provision of poor quality nursing care across England at that time (Allison 2001; BBC 2001b).

Following public and staff consultations, the Department of Health developed the NHS Plan (2000) – a ten-year plan which outlined the targets and changes required to improve and modernise the NHS. The Plan contained an initial outline to amend nursing leadership in order to secure the delivery of good quality nursing care by way of a strong and visible leader: a modern matron. The modern matron had ten prescribed tasks and overall was defined as:

a strong clinical leader with clear authority at ward level, easily identifiable, visible and accessible to patients and their families and able to influence standards and be clinically credible.

(Department of Health 2001b)

The modern matron guidance (Department of Health 2001a) was expected to be implemented by all English NHS Trusts: not all of the trusts complied, but many did (Lipley 2001). The revival of a matron role was an unexpected development within nursing leadership and for the wider nursing profession. The media harked back to images of traditional matrons and the familiar depiction of a traditional matron from Carry On films (Thomas 1972).

In contrast, a traditional matron of 1948 onwards is broadly defined as a female senior nurse, in a general hospital, in charge of all female staff, nursing and non-nursing. A post which during and after the inception of the National Health Service held an imprecise portfolio and a tenuous managerial position who was not afforded unilateral authority (White 1985). The two definitions begin to outline a tension for the modern matron. The modern matron was, from the definition outlined above, required and expected to have full authority. The traditional matron did not possess unilateral powers and lacked the benefit of national definition. The possible gaps in understanding the daily reality of the traditional matron may have been unwittingly designed into the modern matron role. The traditional matrons had undefined and imprecise job roles and were not always able to make unilateral decisions. They matrons also occupied a different location in relation to where they worked: traditional matrons in large metropolitan hospitals, generally in large towns and cities, considered themselves to occupy a higher status when compared with their colleagues in provincial hospitals with a small bed base, sometimes fifty beds or fewer (White 1985). This left the traditional matron at that time with a wide definition of responsibilities and scope and with a variety of localised requirements that encompassed each role.

The Salmon Review (Salmon 1966) recommended the eradication of the traditional matron and the formation of senior nurses, who were encouraged to be distant from the wards and direct patient care. Traditional matrons metamorphosed into senior nurses, whose work roles and revised career structures were formulated as a result of the Review.

During the 1980s the requirement for improved performance of the NHS was given new attention in policy and practice with the recommended solution being increased performance management and managerialism (Strong and Robinson 1990; Rivett 1997). Whilst it was thought that these reforms had little direct impact upon nursing, the managerial ideals were loosely adopted by some senior nurses. One result of this was that nurse managers were seen a more distant from nursing practice and distinct from the uniformed nursing staff (Owens and Glennerster 1990). In addition, senior nurses were formally accountable to non-nurses. The direct nurse-to-nurse accountability that Salmon had designed was eradicated and senior nurses were accountable to general managers, who may not have been nurses (Salmon 1966; Strong and Robinson 1990). Nursing during the 1980s had also seen the drive for increased recognition of nurses and the acquisition of a wider range of skills and knowledge. Nurse leadership's distance from patients and focus on self development (Davies 1995; Keogh 1997) may have contributed to nursing leadership's reduced attention to the quality of nursing care.

The Department of Health's concern during 2000 and 2001 with regard to the quality of nursing care in English hospitals was a recurring theme, with rising infection rates at that time and reports of indifferent nursing staff and apparent lack of attention to the fundamental elements of nursing care: dignity, eating and drinking, complaints responses etc (Foxton 2000; Allison 2001; Healthcare Commission 2007). Healthcare is an emotive subject and is a service that has probably impacted upon most of the electorate in some shape or form during their lives (Pressman and Wildavsky 1973) and it is known to be unfavourable for governments to have a discontented public prior to a general election (Kingdon 1995). There were some nationally

reported poor experiences of nursing care and the wider health system failing patients and one case of an elderly woman who died alone in an accident and emergency department, unbeknown to the staff (Pollard 2002). The implementation of the modern matron role was perceived to be a politicised manoeuvre that was possibly designed to contribute to a returned Labour Government (Hewison 2001).

1.2 The nature of the ‘problem’ and research aims

One of the first major national studies to research modern matrons was commissioned by the Department of Health to ascertain how implementation of the new roles had progressed (Read, Ashman et al. 2004). The study was conducted soon after the roles were implemented and so some of the responses were aspirational as opposed to actual occurrences. The nationwide study provided a substantial overview of the new modern matrons but was unable, because of the study’s breadth, to focus on the detail as presented within this thesis.

The aims of this study are to determine:

- what ignited the thought of a matron in the minds of the national policy leaders?
- why did the Department of Health bring back the matron role?
- what are the differences, similarities and continuities between the traditional and modern matron?
- what impact has the modern matron role had on care quality?

1.3 Organisation of this thesis

The literature review, findings, discussion and conclusion chapters will be structured in line with the aims of this study in three consistent parts: Part I Socio-political influences on nurse

leadership's development; Part II Continuities between the traditional and modern matrons; Part III The impact of the modern matron on care quality.

The next chapter charts the changes within nurse leadership from Florence Nightingale's initial conceptualisation and the subsequent widespread appointment of traditional matrons until their demise during the late 1960s. The progression of nurse leadership is resumed during the 1980s and moves forward to the implementation of the modern matron.

Chapter Three describes the study's methods. This study has drawn from a qualitative case study methodology approach and realist philosophical underpinning and utilises individual interviews, a focus group and archival analysis. The chapter includes an account of my own location as a registered nurse, researcher and former modern matron.

Chapter Four presents the findings and intertwines the modern contributions with historical perspectives of traditional matrons.

Chapter Five discusses the findings and explores whether the predicament of the modern matron with the mandate to improve the quality of nursing care is juxtaposed with a context of corporacy and local interpretation of the modern matron policy. Theoretical frameworks are drawn upon to illuminate the impact of the modern matron on care quality, the influence of nostalgia on policy and the position of the modern matron.

The thesis concludes in Chapter Six with implications for nurse leaders at national and local levels. Policy leads are cautioned to resist further politically motivated amendments to nurse leadership, but instead to consider amendments to organisational infrastructures supporting modern matrons, which may enable them to deliver and sustain good quality nursing care.

Chapter Two

Literature review

Her spirit will be seen through the whole establishment; and just in proportion as she performs her duties intelligently and thoroughly, so will her domestics follow in her path. (Beeton 1861)

pp 1

2.1 Introduction

Using the study aims as the structure, this chapter is a critical appraisal and evaluation of the literature regarding the rise, demise and revival of the matron role in the English National Health Service (NHS). The systematic review of the literature explores the evolution of nurse leadership as a concept and the impact of managerialism and nursing, the creation of new nursing roles and the impact of organisational change on nursing work. The progression of nurse leaders from traditional matrons to senior nurses and modern matrons will be examined in this chapter.

The literature regarding the response to the modern matron will be explored. Drawing on academic sources, the chapter will identify significant legislation and policy changes which have impacted upon and led to changes to nurse leadership.

This chapter will include an appraisal of the location of women and will briefly touch upon post-modern feminist thought to consider the gendered division of labour and the resulting ambivalent position that nurse leadership continues to occupy.

Finally, the chapter will critically evaluate the return of the modern matron to the English NHS and will illustrate the context of the Service in relation to concerns about the quality of nursing care at that time. As the chapter concludes it will focus on literature relating to modern matrons,

which will aid the identification of gaps augmented by literature mapping (Evidence for Policy and Practice 2010) in current nursing knowledge.

2.2 A mapping approach to the literature review

The principles of literature mapping have been applied to this review as an approach to enable the identification of gaps in the current research and to help define the direction of this study (Evidence for Policy and Practice 2010). A literature mapping approach was applied in the areas of traditional and modern matrons, nurse leadership and political decision making surrounding nursing care during the later 1990s onwards.

2.2.1 Inclusion criteria

The mapping process included all types of primary studies that addressed modern and traditional matrons. A paucity of primary studies for modern matrons was identified. The mapping also included grey literature and unpublished masters' degree dissertations. In addition, discussion papers were included as these provided the contextual sense and commentary of what was occurring within nursing at the time of the modern matrons' arrival; the mapping process was also extended to journal papers from the nursing trade press which focussed on the thoughts of nurses and others during the traditional matron era. All studies were UK based and in the English language as the traditional matron concept and progression of that role did not appear to be similarly applied in international settings.

Leaving limitless parameters for the dates returned eight peer reviewed papers by nurse historians who had explored the influence of Florence Nightingale and had traced the path of nursing leadership. Some papers were found in popular nursing journals during the 1960s and provided a contemporary view of the traditional matron at the time which helped to contextualise the role further.

2.2.2 Search strategy for identification of studies

The search for English language primary, commentary and grey literature was accessed using the following databases: Pub Med, CINAHL, EBSCO, Department of Health, the British Nursing Index and Google Scholar. Publisher sites were also search and those included, Science Direct, Wiley and Blackwell for peer reviewed nursing and healthcare journals (Potter 2006). The original searches began in 2009 and acknowledged new publications until 2013. New publications were automatically notified via ZETOC, which is an alert system for new papers; this facility has enabled the body of literature previously sourced to remain current (Eason and Ashby 2002). The search for papers and books related to traditional matrons was not date restricted and most were sought from the Royal College of Nursing archives from journals that had ceased publication. A small number of authors were contacted for papers that proved difficult to locate on line.

In addition to electronic searching, hand searching of some journals was also conducted and this was on occasion found to be productive; at the time of the literature review began, not all journals were available on line and so this method led to the location of additional papers that were not electronically listed. The reference lists of all books and papers were searched to locate further relevant primary sources.

The date range for the modern matron literature was from 1998 until 2012. An abundance of literature was sourced in from 2000 – 2002, as it was during this period that the modern matron role emerged and began to be implemented across England. Approximately 85 books and papers were sourced using various methods as outlined above. Search terms included: ‘matron’, ‘modern matron’, ‘modern matron and infection’, ‘nursing leadership’. The following section will discuss and critically appraise the traditional matron role and the prevailing legacy of historical influences.

Part I Socio-political influences on nurse leadership's development

2.3 The traditional matron – rise and demise

Generally, if people who are outside of the realms of nursing were asked to describe a matron, they would possibly articulate an image of a mature stern female in control of all nursing and nurses, typically characterised by the late Hattie Jacques in the 1970s (Thomas 1972). However, a critical appraisal of the literature suggests that this highly gendered popularised image of traditional matrons is the one that prevails (Hallam 2000). Rosemary White's work on the effects of the NHS on the nursing from 1948-1961 details the impact of the changes leading up to and afterwards specifically on all staff groups and including the matrons (White 1985). This work will be extensively used and supported by other sources to enable an expansion of the timeframe that White used as it was the only study found that provided sufficient detail and illustrated the impact of the policy change on matrons at that time.

Further exploration of the traditional role as enacted during the 19th and 20th centuries may provide a way of evaluating how much of the discourse surrounding the modern matron the actual work and role of the traditional matron as opposed to the stereotypical view.

The word 'matron' is derived from the Latin for 'mother' (*māter*) and is associated with nurse leadership (The Chambers English Dictionary 2011). The matron was derived in part from nursing structures established by Florence Nightingale and her contemporaries in other hospitals, which were based on domestic service arrangements (Lorentzon 1997). Florence Nightingale's work and achievements in the Crimea and London are well documented (Strachey 1918; Holliday and Parker 1997; Lorentzon 2003; Bostridge 2008). As a Government mandated leader of nurses, Florence Nightingale was installed as the nurse leader for the Scutari Hospital. Florence Nightingale's self installation into the hospital hierarchy helped to solidify and provide a template for the matron as a third-party partner of the hospital's governing body, between the

medical officer and the administrator (Bostridge 2008). The tripartite organisational structure for nurse leadership became integral to the curriculum at St Thomas's Hospital where middle class Victorian women, the lady pupils, were trained to become matrons (Carpenter 1977); at this time, some of the matrons were nurses and some were not. This model of nurse leadership and nursing was replicated and adopted across England's provincial hospitals (Lorentzon 2003). The traditional matron was seen by some as the pinnacle of the nursing hierarchy within the general hospital setting (Salmon 1966; White 1985) and was seen as a female senior nurse, in a general hospital, in charge of all female staff, nursing and non-nursing, occupying a post which during and after the inception of the National Health Service held an imprecise portfolio and a tenuous managerial position.

The ideal characteristics for a traditional matron were suggested to be good health, good education and manners and self reliance, whilst exercising sound judgement and a sense of proportion (Castledine 2007). It seems that the traditional matron was expected to have good leadership skills and maintain a level of vocational commitment: embodying what was considered to be a 'good woman' (White 2002). It is maintained that traditional matrons were predominately caring and considerate women, with high moral standards, who cared for patients and staff and thrived on order and routine (Ardern 2002).

The traditional matrons' personal power and the ability to create order from chaos has been periodically depicted in fictional television dramas, but was infamously characterised as a sexualised comedic hyperbole of a traditional matron (Thomas 1972; Hallam 2000; Bufton 2005). Recent interpretations of the traditional matron have been increasingly factual and have been drawn from verified records (Brozel 2009). First-hand accounts of the traditional matron are understandably limited and as the years progress memories either become diluted or are at risk of embellishment.

The traditional matron did appear or have been reported to have held a tenuous managerial position and there was apparent variance, according to the literature, unilateral authority (White

1985; Ardern 2002) The possible gaps in understanding the daily reality of the traditional matron may have been unwittingly designed into the modern matron role.

‘Matron’ is a word, that exudes an expectation of a role with power and authority (White 1985). Although the matron title conjures the idea of a standardised role, there was quite a range of modes in which the traditional matron operated, which were largely related to the size and structure of the hospitals where they worked (White 1985). Matrons led nurses, nursing and housekeeping services in a range of small and large hospitals; some hospitals provided teaching for medical and nursing staff. The traditional matron was the head of the nursing service and in effect was the head housekeeper, managed the nurse training school and was in charge of all female staff outside of nursing (Baly 1995; Ardern 2002). Therefore, the traditional matron can be said to have enjoyed a wide sphere of influence and control (Savage 1985). Other hospitals were financially supported by charities (cottage hospitals and metropolitan teaching hospitals) or by local authorities for the provision of statutory care (county and fever) hospitals (White 1985; Emrys-Roberts 1991; Currie 2005).

A matron was the central coordinator for nurse education and she established defined standards and expectations for the delivery of nursing care. Matrons were reported to have tight systems and process for the delivery of that care which rarely allowed for practice deviation (White 1985).

There is a prevailing perception commonly depicted (Thomas 1972) that the traditional matron was in sole charge of the hospital and made unilateral decisions. In reality, the traditional matron worked in a partially triangulated manner with the medical officer but was subordinate to the hospital administrator, but nevertheless was part of the hospital’s management team (White 1985; Ardern 2002). The traditional matron may not have been granted access to all hospital management meetings (Wildman and Hewison 2009) and so her sphere of influence was sometimes limited.

Traditional matron roles developed across England without a standardised template prior to the arrival of the NHS (Central Health Services Council 1954) and would often be supported by a team of deputy and assistant matrons, night sisters and home sisters (White 1985).

There was a hierarchy between traditional matrons which was dependent upon the size and prestige of the hospital that the matron was employed, whereby traditional matrons who worked at large teaching hospitals held self-termed 'elite' status (White 1985).

2.3.1 Elite and other matrons – who were they?

The matrons in metropolitan and charity-funded hospitals generally had large hospitals to manage and had direct access to the hospital board and these were self-termed and since referred to as the 'matron elite' (Hallam 1998). Other traditional matrons who worked in provincial or local authority and fever hospitals tended to manage smaller establishments, sometimes with a bed complement of no more than thirty (Carpenter 1977; White 1985).

2.3.2 Elite matrons

The matron role was developed from the nursing model as established by Florence Nightingale; many of her pupils later became matrons in various hospitals across the UK (Lorentzon 2003).

The matron "elite" were matrons who were in charge of nursing services for large metropolitan, charitably funded teaching hospitals such as St Bartholomew's, The Royal London or St Thomas'. These hospitals often had hundreds of beds. The Royal London in 1910 had over 800 beds (McGann 1992). These matrons mostly had direct access to the hospital board and so had the opportunity to influence decision making. Some elite matrons were also influencing the direction and development of modern nursing both via their training programmes and nationally

(White 1985; McGann 1992); Mrs Bedford Fenwick who was the matron at St Bartholomew's Hospital during the late 19th century led the campaign for the registration of nurses and thereby gained national recognition.

In 1890 a House of Lords Select Committee wanted to examine the management of metropolitan hospitals. The matron at the London Hospital, Eve Lũckes was perceived by some hospital staff to have too much power (McGann 1992) leading to tensions between staff and their matron managers. Former nurses of the London Hospital were called to the Committee as witnesses and they reported poor working conditions which were later unsubstantiated; this may have been a deliberate discredit of the matron from witnesses or a description of the scenario from their perspective, their truth. Matron Lũckes responded that she visited the wards every three weeks; the frequency was deemed unsatisfactory by the Committee who expected her to visit each ward daily. Daily visits may not have been required by her personally, because she was supported by four assistant matrons who most probably reported to her as required (McGann 1992).

2.3.3 Other matrons

A nursing editorial drew attention to the overworked, underpaid and sleep deprived matrons in cottage hospitals (Bedford Fenwick 1909). Cottage or voluntary hospitals were small establishments, with often no more than 10 beds principally supported by charitable funds to serve the needs of the town (Emrys-Roberts 1991). The editorial described the working lives of some matrons in small cottage hospitals as all encompassing, enduring and intolerable: managing accounts, ensuring the provision of clean and repaired linen, general cleanliness and catering in addition to caring for patients. These tasks were all conducted by the matron with minimal staff, possibly two staff and no other nurses apart from herself; a probationer may have worked with the matron but this would have added an additional burden of teaching (Bedford Fenwick 1909). The plight of these matrons was raised by Mrs Bedford Fenwick a prominent elite matron from London who was also campaigning for the registration of nurses. It is notable that Mrs Bedford

Fenwick was able to appreciate the wide spectrum of the matron community beyond her elite sphere (White 1985). The editorial illustrated the exhaustion, long and never ending hours, some matrons worked days and nights merely because there was no one else available to nurse the patients. The ultimate purpose of the editorial was to warn nurses not to apply for matron posts in small and under funded hospitals (Bedford Fenwick 1909). The editorial (Bedford Fenwick 1909) contributes to dispel some commonly held beliefs that all matrons were powerful and in control. The matron in a cottage hospital or may not have had access to the board and so was less able to influence decisions about the operationalisation of the hospital or indeed some nursing matters.

The working lives of some traditional matrons outlines a complex job role which was not solely ward based. Similarly, it is not generally known that traditional matrons in smaller and precariously funded hospitals were required to be frequently 'hands on' for all nursing and ancillary functions.

Mrs Bedford Fenwick and her colleagues were part of the elite matron group. Elite matrons led nursing in large metropolitan prestigious teaching hospitals such as The Royal London or Guys (White 1985). These matrons had minimal patient contact, merely because of the large number of patients and the nursing infrastructure which supported her.

The traditional matron role is difficult to succinctly conceptualise. The traditional matron was a leader of nursing and housekeeping services to varying degrees across the general hospital population at that time. It seems from the literature that matrons defined and strove to maintain high standards of care. Some matrons were well paid, and had a supportive infrastructure from which to operate and a few were nationally recognised and actively influenced the national nursing agenda. The levels of power varied greatly from the matron elite having direct access to the hospital board and others having less influence and possibly far removed from decision making. In summary, some traditional matrons were powerful and others were not. However,

the perception that all traditional matrons were powerful continues to be perpetuated, despite the myriad of change that nurse leadership has experienced.

The architecture of nurse leadership as described above prevailed in most provincial hospitals for almost eighty years (Butler 2001). The inception of the NHS in 1948 heralded the arrival of significant periodic change for all healthcare staff and in particular, the traditional matrons (White 1985).

2.4 Reform and disharmony

The new NHS took responsibility for over 2700 hospitals and 390,000 beds (Central Health Services Council 1954) and from that strived to create streamlined and coherent organisational systems and structures to enable the provision and progression of modern health care. The myriad of traditional matron structures and roles that had developed across England did not reconcile itself well with the Ministry of Health's vision of nationally recognised, defined processes and structures. The complexity of nurse management at that time was considered to be obsolete and cumbersome for the new service (White 1985; Baly 1995). The NHS had implemented a local structure of hospital groupings, with small hospitals being co-located to comprise one group for the purposes of administration. The revised arrangement led to the physical loss of a traditional matron for each hospital, which was not welcomed by the traditional matron body and became the focus of the traditional matrons' protests. Unfortunately the matrons had not recognised and seized the opportunity to lobby Government before the NHS Act was passed and so they were unable to effect change upon the new architecture, which in turn negatively impacted on their roles (White 1985).

Some aspects of the traditional matron's role were passed to lay administrators, which in turn restricted her sphere of influence (White 1985). The triangulated arrangement of the traditional matron, the medical officer and the administrator was eventually discarded in favour of hospital

management committees, which largely comprised of lay administrators. The committees were often supported by sub-committees which were accountable for hospital departments, such as catering and linen, and were previously the domains of the traditional matron, as most of the job roles within those departments were held by women. There were also committees for nursing, but very few committees had nurses as part of their membership (White 1985). The change in approach to the management of nursing suggested to others outside of nursing that the profession could be managed by non-nurses and that a matron's contribution at those meetings would have been superfluous. The management of nurses by non-nurses may have been the genesis for the management of nursing in hospitals today.

The marginalised position experienced by some traditional matrons and therefore nursing (White 1985) initiated discord between the new administration and traditional matrons; this tension became increasingly apparent to the Government at that time. A review of the new structures was commissioned by the Government, the Bradbeer Committee (Central Health Services Council 1954). The Committee was charged with redefining the boundaries and responsibilities of nursing and administrative staff. The Report acknowledged that the NHS was in its infancy and new relationships with defined responsibilities would provide role clarity in a dynamic and evolving provision. The Bradbeer Committee seemed intent on relieving the traditional matron of unnecessary administration as the expansion and complexity of the Service and increasing specialisation of care developed. The Bradbeer Committee found that some new hospital administration committees had failed to acknowledge or appreciate the knowledge and value of traditional matrons. The Committee had found in some cases that deputy matrons had been appointed by hospital committees or other key decisions regarding nursing were discussed and agreed without the knowledge or input from the traditional matron herself. The Report recommended that all traditional matrons should be recognised as equal partners with the hospital administrator and the medical officer. Because the Report *recommended* this change and did not mandate it, local interpretation meant that often the traditional matron remained

excluded from managerial decision making (White 1985). In summary, the Bradbeer Report recommended the following for the traditional matron:

- the matron would remain as the head of the nurse training school;
- the matron should be seen as the head of nursing services and professional lead and the administrating supervisor for non-nursing departments;
- the matron must be fully consulted at all times on matters that affect patients, i.e. catering or laundry;
- matrons would establish hospital-based nursing advisory committees, equitable in status to the previously established medical advisory committees. The committees would be chaired by a matron and the chair would be expected to attend the hospital committee meeting as the nursing representative.

The creation of a nursing committee was an attempt to channel a collective nursing voice on equal terms with the medical advisory committee, to influence the hospital management committee in an advisory capacity (White 1985). The recommendation also stated that the traditional matron would be consulted on certain matters, but left to local interpretation, this could also be used to exclude the traditional matron from the heart of decision-making.

A succession of policy changes and Government reviews of Health Service structures (Wildman and Hewison 2009), which impacted upon nursing administration and traditional matrons, eventually contributed to the elimination of the traditional matron from the NHS during the 1960s. Table 2a provides a summary of the significant changes that impacted on traditional matrons over a thirty-year period. The revised organisational framework, whereby a traditional matron's sphere of influence was reduced and the Government drive to 'reduce the burden' on them (Central Health Services Council 1954) could be perceived as gender laden – traditional matrons unable to manage, unable to delegate and unable to manage budgets.

As NHS structures and practices developed, a second review focussed solely on nursing staff structures; the Salmon Report (1966) was commissioned by the Government. The Report was tasked with re-defining nursing structures from ward to regional levels and to differentiate between those nurses who were engaged in policy development and those who enacted the policy. By the 1960s new hospital builds were in progress with capacity for up to 400 or more in-patients (Rivett 1997) – difficult for one traditional matron to oversee. The operationalisation of healthcare had increased in pace and complexity and the new structures recommended by Salmon were developed to support those changes.

Table 2.1 Legislature and reviews which have impacted upon matrons and senior nurses from 1948 – 1966

Publication	Purpose	Impact on matrons
NHS Act 1946 enacted 1948 REF	To establish the new infrastructure for the NHS	<ul style="list-style-type: none"> • The legislation failed to specify where and how matrons would be included in the revised management structures. • The introduction of lay administrators meant that many matrons became answerable to various committees and their membership (White 1985). • Matrons in some cases were removed from direct management decision-making (White 1985). • Matrons' role portfolio was diminished, which negatively impacted on their sphere of influence (White 1985).
Report of the Committee on the Internal Administration of Hospitals 1954 'Bradbeer Report'	To provide clarity to nursing, medical and administrative roles and the appropriate division of administrative duties.	<ul style="list-style-type: none"> • The report suggested that the inclusion of matrons in management decision-making would be preferable. • Some hospital administrations decided to include matrons and others did not, as the recommendation was not mandatory. • Some matrons remained in advisory capacities and removed from management decision-making. • The report specified that the revised responsibilities should avoid over burdening the matron.
Senior Nursing Staff Structure Report (1966) 'Salmon Report'	To provide a clear structure for nursing administration from ward to regional levels.	<ul style="list-style-type: none"> • A gender-neutral title - 'nursing officer' - was recommended, but it was advised that female staff retain the 'matron' title. • Nurses were managed by nurses • Nurses had clearly defined roles and a career pathway from hospital to national levels. • The nursing officer post was designed to be a mix of administrative and clinical work. Most former matrons had lost or never had specialist nursing skills and were not clinically equipped to work in their new specialities. Therefore, nursing officers roles became predominantly administrative (Clerk 1995).
Griffiths Report (1984)	To implement managerialism.	<ul style="list-style-type: none"> • The report does not mention nurses, but the recommendations did impact on senior nurses. • Senior nurses became managerially accountable by default to non-nurses or general managers. • Senior nurses no longer had budgetary control, which meant that nurses had little control of the environment in which nursing was conducted.

The Salmon Report (Salmon 1966) provided standardised job descriptions, introduced to ensure role uniformity alongside supervisory and managerial training for ward sisters upwards. Salmon criticised the traditional matron model that had been previously advocated by Bradbeer (Salmon 1966) and felt that senior nurses had interfered clinically and were a source of annoyance for the ward sister:

senior nurses tend to interfere in ward matters more than they ought to and however laudable it may seem for the administrative nurse to 'roll up her sleeves' in the wards, it is often really a satisfying of her own needs and not a service to patients or ward sisters.

(Salmon 1966) pp 7

Salmon's message was clear for the new senior nurses – let the ward sister get on with her job and step away from the ward.

The new job titles were gender neutral; at the level of the traditional matron, the title became 'nursing officer'. The grading title was matron, and the Committee advised that female staff should retain the matron title:

... a long honoured tradition, profound significance for the general public.

(Salmon 1966) pp 6

Male staff were permitted to use the 'nursing officer' title, and this was possibly a pivotal point in the progression of men in general nursing, as it opened up more career opportunities for them. Previously male nurses were predominately limited to the realms of mental health (White 1985).

The 1980s saw a review of hospital management, a revision of structures and new emphasis to increase the performance of hospitals. The changes were not expected to impact upon nurse leaders, but we now know the changes had far-reaching implications for nursing. Further health service reforms have subsequently continued to impact on nurse leaders.

2.5 The impact of managerialism on senior nurses

The Health Service reforms of 1984 were in part initiated because of widespread industrial action by staff due to their dissatisfaction with their pay and conditions (Rivett 1997). The Department of Health and Social Security (DHSS) at that time was concerned about mismanaged and diminishing resource and wanted to see a new approach to enable the NHS to perform more effectively and increase financial stability (Rivett 1997). Sir Roy Griffiths, an executive manager from a commercial background was invited by the Secretary of State for Health and Social Services to lead a review of Health Service management. Sir Roy Griffiths managed a chain of supermarkets that had improved its profitability and performance. The review provided recommendations to implement managerial approaches which were proven in commercial settings to improve service performance by the employment of professional general managers who were placed at regional, district and hospital levels to be solely accountable for the management of resources (Strong and Robinson 1990). The resources to be managed were financial and human and so the general managers direct line reports included senior nurses and consultant staff.

The Griffiths' recommendations were accepted by the Secretary of State for Health and Social Services and rapid implementation commenced (Rivett 1997). Layers of professional general managers became singularly accountable for various levels of the Service. The new managers received performance related pay as an incentive to deliver change and improve service outcomes (Traynor 1999).

Prior to the Griffiths recommendations being implemented, the Health Service had been managed and led by doctors and nurses via a consensus approach, whereby staff worked in a collegiate manner underpinned by a level of mutual trust and respect (Hunter 1984). The matron or nursing officer was in charge of nurses and nursing; the most senior doctor was in charge of all medical matters and all doctors, supported by a hospital administrator. This approach fostered by nurses and doctors encouraged a parochial decision making process whereby the parties would ensure that their own interests were promoted and or protected which sometimes led to a lack of acknowledgement of the wider needs of the Service. The consensus approach was identified by Griffiths as the root of the Service's problems – no one person in charge and accountable to make executive and sometimes difficult decisions and no singular person to view the service as a whole (Strong and Robinson 1990). The new approach was viewed as a system ground in distrust as opposed to the trust based consensus style (Hunter 1984).

The recommendations sought to remove senior nurses from direct decision making and reduced their status from managerial to advisory. The Griffiths recommendations made little mention of nurses and nursing. The seemingly scant regard of senior nurses within the revised management structures was viewed by some nursing leaders as a dismissal of the professions which led to a degree of animosity from nurses towards the new structures (Strong and Robinson 1990; Rivett 1997).

The Salmon recommendations had created a nursing career structure and hierarchy from ward to national level whereby nurses were managed by nurses (Salmon 1966), but the Griffiths proposals interrupted this approach to management and instead enabled unilateral decisions to be taken by a general manager with clinical staff being able only to advise. Senior nurses and ward sisters no longer had unlimited access to resources as they were required to seek permission via a general manager; in that way total control of ward sisters and senior nurses clinical areas was dissolved (Salvage 1985).

Senior nurses and nursing officers at hospital and regional levels were regarded by the new general managers as minimally educated with insufficient skills to manage the service and to then advance the service to a place of efficiency (Strong and Robinson 1990).

2.5.1 Nursing leadership from the perspective of new general managers

The ethnographic approach undertaken by Strong and Robinson (1990) used interviews and observation of key personnel within a district health authority following the implementation of the Griffiths reforms to illicit participants' thoughts and perceptions on the changes. Strong and Robinson's work (1990) illuminated the perceptions of other staff regarding the contributions and limitations of senior nurses in the management of services prior to and immediately following the reforms; the reported responses about senior nurses were partly responsible for the ineffective way in which resources had been managed. It was reported that nursing structures had become over inflated whereby seniority was gained by longevity in the profession and seemingly bore no relationship to knowledge attainment. According to respondents some senior nurses were reported to be weak in influence, feeble and overly patient focussed which prevented them from appreciating a wider view of health service provision. It was suggested that some senior nurses maintained control of their subordinates by denying access to professional development, thereby the senior nurses maintained their own position at the top of the hierarchy. Medical colleagues were similarly criticised, but the nursing professions additional deficit when compared with doctors was the lack of a scientific basis for decision making (Strong and Robinson 1990).

Despite many changes in the provision of the Health Service, the Griffiths reforms within contemporary hospital settings largely remain (Kings Fund 2011). Today, a director of nursing is the professional lead for nurses and is the nursing and corporate voice at board

level but may not directly manage the nursing service. General managers continue in some hospitals to be prevalent and some manage whole services which includes clinical staff (NHS Careers 2012).

The nursing profession now has an improved scientific underpinning which became increasingly evident in the 1990s onwards. Entrants to the profession are education in universities and many registered nurses are graduates and are encouraged to engage with post graduate study (Longley, Shaw et al. 2007; Nursing and Midwifery Council 2010). It could be suggested that the profession 'came of age' and has addressed the deficits levelled at it by Griffiths during the 1980s with its senior nurses fully equipped to work equitably alongside general managers and medical colleagues. However the mandate to ensure that all new entrants to nursing are graduates is a debated issue (Nursing and Midwifery Council 2010). The necessity for graduate knowledge is not immediately evident at the bedside and the recognition that nurses in their daily practise are required to assimilate complex data to provide care for increasingly ill patients is not always appreciated. The juxtaposition of educated nurses and the delivery of fundamental care remains a difficult position. Despite the nursing profession grounding itself in evidence there remains a debate and concern that graduate nurses are not focussed on delivering the fundamentals of care (Moore 2005; Castledine 2009; Glasper 2009).

Although the Griffiths reforms were not directly aimed at nursing leadership, their implementation did significantly impact upon nurse leaders. Senior nurses appeared to be exposed by the reforms as an impediment to the progression of an effectively managed Health Service (Strong and Robinson 1990). Nurse leaders via their respective unions protested about the lack of power and loss of position because of the new structures. It is thought that their argument was diminished because their sole consideration was for their

own loss of power and position and not about the wider impact of the reforms (Salvage and Smith 2000). The protests gradually waned as health unions were advised that pay and conditions would be specifically reviewed for nurses (Rivett 1997).

On reflection of these events, the Griffiths reforms demonstrate the vulnerability that the nursing profession has experienced due to politically initiated change. This was evident when the NHS was formed in 1948 and the subsequent impact on traditional matrons (White 1985). Again, there were protests, but the remonstrations were too late in the policy process and so could not be taken into account. It is perhaps the subservient position of nursing, coupled with minimal education levels that led to scenarios whereby policy changes were imposed upon nurses, because nursing was at that time possibly unable to impose or propose wide scale informed change for itself.

The nursing chain of command from the ward to the top of the nursing hierarchy established and popularised by Florence Nightingale and reaffirmed by the Salmon recommendations had been swept away during the Griffiths reforms (Salmon 1966; Lorentzon 2003). The process of nurses being managed by other nurses and also being in control of resources for their patients was eliminated in favour of general management driven to improve performance. Possibly due to the criticism, nursing appeared to diminish in presence as general management became the focus and locus of control for the Health Service at that time. Nursing had been criticised for its limited knowledge and narrow patient focus; this criticism may have contributed to the impetus for nursing to broaden its horizons and to adopt a more scientific approach by embracing continual professional development, thereby ensuring that the profession as a whole became more credible and robust.

The literature has shown that since the 1940s there has been perpetual change for senior nursing roles primarily due to politically initiated reforms which have either directly or indirectly affected this group of staff. When the Salmon recommendations were

introduced, the ward sister was seen as the pinnacle of the ward – a role that should be permitted to practice without interference from the senior nurse or nursing officer (Salmon 1966).

The adoption of managerialism may have contributed to the oscillation of senior nurses and ward sisters level of engagement with clinical practice, particularly as managerialism in the shape of the Griffiths reforms were focussed on process and productivity (Salvage 1985). Ward sisters metamorphosed into ward managers to accommodate and acknowledge the managerialist philosophy and accommodate their newly acquired budgets and workforce establishments whilst senior nurses maintained their distance from clinical practice.

In essence the perpetual changes at senior nurse and ward sister levels with regard to role emphasis and contextual drivers and influencers may have contributed to changes between how the two job roles interrelate and work with each other to deliver care. Post Salmon, it seems that the ward sister managed the ward with minimal senior nurse involvement and changed during the post Griffiths phase to adopt managerialist tendencies. After the arrival of the modern matron, the ward sister could expect regular clinical practice engagement from that role and support which again may have led to a lack of role clarity and a variance of expectations between those two post holders.

Recent reviews have asked for role clarity for the ward sister role and earlier reports and reviews vow to strengthen nurse leadership via courses, development and supporting mechanisms, but it could be that the bids to strengthen nurse leadership may be in vain because of the continual change and lack of clarity between the roles (Department of Health 1999; Royal College of Nursing 2009). Lack of clarity and the position of nursing and nurses in leadership roles continue to be debated and continues to be influenced by gender (Davies 1995; Witz and Annandale 2006).

2.6 Gendered division of labour and its prevailing impact on nursing

Nursing is predominately a feminised profession, which is positioned in settings whereby the leadership for patient care is directed and prescribed by the medical profession. The medical profession emanates from a gendered and masculine perspective (Witz 1992; Witz and Annandale 2006). The working relationship between nursing and medical staff has been likened to traditional husband and wife roles which emulated the organisation of Victorian middle class domestic life (Beeton 1861; Cordea 2011). To appreciate the location of nursing leadership, it is prudent to consider the gendered division of labour which has shaped the organisation and structure of healthcare and has influenced the position of nurse leadership (Code 1991). To help illustrate the position of nursing sociological theories of the medical division of labour, post-modern feminist thought will be drawn upon.

Lorraine Code (1991) documented the relevance of the knowledge of the knower whereby the gender of the knower and their knowledge appear to carry different weight. Code's tenet was that the gender of the knower impacts on our lives without conscious understanding and she uses nursing to help illustrate her theory that female knowledge is valued differently when compared with male knowledge. Female knowledge is diminished to the level of experience whilst male knowledge retains its elevated position and those of the knower. The nurse's knowledge does not empower her (Code 1991). The value of female knowing coupled with the continued invisibility of women, and therefore nursing, ensures that nursing at times remains invisible and often inconsequential; this line of thinking begins to illustrate the possible underlying socially constructed ambivalence of nursing and nurse leadership.

Davies' work (1995) on the gendered predicament of nursing explained the position in which nursing found itself. Nursing has been restricted by the position it maintains in relation to medicine and other traditionally male roles. Davies described how Florence

Nightingale readily adopted the roles and tasks that medicine did not wish to engage with (Davies 1995) such as cleaning, nurturing and caring (Carpenter 1977; Porter 1992), or as has been described, death, dirt and domestic work. The tasks of comforting, cleaning and household duties would, at that time, have been naturally associated (essentialist) with women's work in the domestic setting (Beeton 1861; Owens and Glennerster 1990). Lorraine Code (1991) describes female essentialism as an inherent female trait which is displayed in the gentle and sensitive approach.

With the arrival of more formalised nursing care, the medical profession began to offload some tasks to nursing, and these tasks were the traditional domain of women and the socially constructed gender arrangement which was reconstructed in the workplace (Witz 1992). This task offload has been a continual feature from medicine to nursing under the auspices of expanding nursing practice and giving nurses increased levels of responsibility (Daly 2003).

Stein's seminal work (Stein 1967) on the occupational games which are played out between nursing and medicine carefully portrayed how domestic relationships of husband and wife have been conveyed in and were evident in modern healthcare settings, whereby the nurse assumes a deferential demeanour. Communication within this relationship adopts a subtle and subservient manner from the nurse towards the doctor. Stein (op cit) acknowledged that the power within the relationship rested with the doctor, as the nurse was nearly always required to defer to the doctor for a final decision or change of treatment. Stein (1967) suggested that nurses acted as mediators between doctors and patients. Nurses are symbolic wives of doctors (Davies 1995) whereby nurses continue to work in support of the doctor. The doctor (husband) adopts a commanding and visible stance and his position is sustained because of the support provided to him by the nurse (wife), which has contributed to the maintenance of the medical profession's prestige and the subservient position of nursing (Zelek and Phillips 2003).

It has been suggested that dichotomous positions of labour division are obsolete in contemporary healthcare (Witz and Annandale 2006). Contributions in this field asserted that the division of medical labour was no longer predominately gender driven but that contemporary division of labour was fragmented and principally based on economics and competence (Witz and Annandale 2006), but gender still influences how the nursing and medical professions interact with each other (Porter 1992).

Despite the myriad of structural change and the eventual demise of the traditional matron, it was a matron-like figure that was called upon to improve care standards in a modern Health Service. The rationale for returning to this obsolete role was not evident, but may have been triggered by prevailing images of a traditional matron and a sense that the quality of nursing care was somehow better than what was currently being experienced. The most tangible and visible change to nurse leadership was the Department of Health's insistence that the modern matron return to clinical attire which was symbolically an indicator of continuity between traditional and modern matrons.

Part II Continuities between the traditional and modern matrons

2.7 The return of the uniform

A key component of the modern matron concept was to ensure that the person in that role was visible to patients, staff and relatives, and modern matrons were advised to wear distinctive uniforms (Department of Health 2001a), a suggestion which reignited what appeared to be frequent dialogue about nursing attire both within and without the profession (Hallam 1998; Richardson 1999; Pearson, Baker et al. 2001). The Department of Health had not been prescriptive about nursing uniforms since the 1950s (Central Health Services Council 1954) and so intervention at that time was unusual. Many senior nurses had not worn a uniform since the arrival of the Griffiths reforms whereby commercial practices, behaviours and masculine ideals of organisational control were

paramount; to follow in that trend, senior nurses adopted business suits and discarded their uniforms (Savage 1985; Owens and Glennerster 1990). The change in attire at that time during the 1980s was congruent with wider social changes of women challenging men in the workplace and the fashion industry responded with 'power dressing' (Frankell 2009). The image of the nurse in uniform to some symbolised power and status and provided an expectation of a good role model, in addition to being an image of reassurance for patients (Savage 1985; Richardson 1999; Hallam 2000; Jones 2001; Pearson, Baker et al. 2001). To others, the uniform symbolised oppression and subservience (Pinard 2006).

Some NHS trusts welcomed the change from managerial dress into clinical uniform for their modern matrons and fully embraced the traditional image of the role, donning 'traditional' nurses' dresses, belts and cuffs, attire which had not been seen in the Health Service since the 1970s (Elliott 2003). Modern matrons were enveloping themselves in historical regalia (Savage 1985; Hallam 2000), which may have been an intentional conduit to find a connection between themselves as modern matrons and their traditional predecessors in order to enact the role. However, the addition of a new uniform to the nursing ranks in some instances became lost in the existing array of uniforms, making the new modern matron in some cases unrecognisable to patients (Read, Ashman et al. 2004; Bufton 2005), but also a signal of continuity between the traditional and modern matron roles.

2.8 Reaction to the modern matron role

The return of the matron to the Health Service provoked responses from within the nursing profession and the general public. Within nursing there was a sense of ambivalence and slight disbelief that a role that was considered to be obsolete within the NHS was to be revived. The juxtaposition of a health service striving for modernisation

with the reinstatement of an old-fashioned figurehead did not appear to be congruent and was a source of concern and debate (Hewison 2001; Carlowe 2002). The combination of an old-fashioned styled nurse who was thought to have battle-axe tendencies appeared to be at odds with the modern leadership approach within the health service (Fox 2000; Matthews 2000; Stephens 2002; Maddams 2005). It was suggested that the return to a matron figure gave a sense that nursing wallowing in nostalgia and harking back to a golden age (Keeley, Goodman et al. 2005) and that instead the Department of Health should have facilitated heightened visibility to those nurses who were already in leadership positions (Matthews 2000). There was concern that the weight of expectation on the modern matron role was considerable, unachievable and unreasonable (Close 2001; Jones 2001). The complexity and range of tasks that the modern matrons would be expected to deliver explicit improvements against was acknowledged to be difficult without the support of other departments such as estates or catering.

The public responded with a sense of apparent relief and slight concern upon the announcement that a matron would return to the wards with a defined remit to improve the quality of nursing care and lead on the reduction of hospital acquired infections (Butler 2001; Butler 2001; Wilkes 2002). The concern came from patients who could recall a traditional matron 'who ran wards like an Army camp' (Wilkes 2002). It was suggested that patients were happier since the arrival of modern matrons because of the improved quality of care that they had implemented, such as increased dignity in emergency departments (Elliott 2003). There was concern that the new role was a political manoeuvre to gain votes and was designed to appeal to 'middle England' voters (Butler 2001). The notion that the traditional matrons 'ruled with a rod of iron' was misplaced and romanticised (op cit).

The Department of Health advised that the new modern matron would be 'authoritative and have influence'; this approach resonated with the Briggs Report (Central Health Services Council 1954) which had similar expectations of the traditional matron. The

expected authoritarian nature of the modern matron role was not predicted to reconcile itself well with the predominant management culture and style in the Health Service of leadership and empowerment (Department of Health 2001a; Oughtibridge 2003). However, within the general media, it was noted that the traditional matron's authoritarian and unilateral approach to hospital management was unfounded (Butler 2001).

Although the words 'power' and 'powerful' had been frequently mentioned within the guidance for the modern matron role, it was noted that the role would have a level of influence for services such as catering and cleaning that would lie outside the managerial accountability of the role (Jones 2001; Department of Health 2001a). Therefore, the level of power and influence that the role would be actually afforded was questionable. Indeed, a significant study found that the 'power' element of the modern matron role was largely based on personal power of the post holder, rather than the post (Keeley, Goodman et al. 2005). The articulation of power and influence related to the role raised concern among some nurse commentators that the role could have potential to encroach upon and undermine the director of nursing and/or the ward sister or charge nurse (Agnew 2005); similar concerns were raised by the Salmon Report (Salmon 1966).

Department of Health guidance advised that the new cadre of modern matrons could be drawn from existing senior nurse cohorts. Some senior male nurses were concerned that they would inherit the modern matron title and many refused on the grounds of sexism because the title 'matron' referred to women only (Rowden 2001; Duffin 2002), as documented by the Oxford English Dictionary:

the woman in charge of the nursing in a hospital
(Soanes 2002)

There was an example of a male matron in the Department of Health literature, maybe to emphasise the point that men could be modern matrons (Department of Health 2002a). The NHS Plan not only identified modern matrons as a new role but also nurse consultants and this to some degree had an impact on the existing nursing structures at the time (Department of Health 2000).

2.9 New nursing roles and their impact on existing nursing structures

As part of the Department of Health's modernisation of the Service new nursing roles were designed as an attempt to retain the knowledge and skills of senior nurses close to the patient (Department of Health 2001c). The job roles were constructed to lead and implement changes to provide modernised and patient focussed care. For the purposes of this submission, the focus is the modern matron, but it was the nurse consultant role which was initially announced (Department of Health 1998; Department of Health 1999). The nurse consultant role will be considered here as it formed part of a revised career pathway for senior nurses, which included the modern matron role. This section will also consider what the new roles meant for nursing and existing nursing structures.

2.9.1 Nurse consultants

The Prime Minister announced in 1998 his intention to require the Department of Health establish nurse consultant posts to hold equal status to medical consultants (Department of Health 1998). It was hoped that the nurse consultant role would attract senior nurses who wanted to retain a nursing role, whilst being able to utilise the full range of their knowledge and expertise to enable tangible changes to nursing practice and patient care. The consultant role was offered as an alternative to senior nurses' progression into management (Department of Health 1999) and was designed around four key tenets or functions:

- expert practice
- professional leadership and consultancy
- education, training and development
- practice, service development, research and evaluation

Fifty percent of a nurse consultants' time was expected to be close to practice to enable streamlining and leadership of that practice based on the best available evidence (Department of Health 1999). Candidates were expected to hold a masters degree or preferably a doctorate to enable the ability of the consultants to draw on and apply advanced knowledge, equitable to that of medical consultants.

The Department of Health (Department of Health 1999) acknowledged that responsibility for managerial and corporate tasks would be a distraction from the nurse consultant role, whereas the modern matron role was expected to undertake managerial and corporate functions. The nurse consultant role was provided with guidelines about the amount of clinical activity that was expected to be undertaken, whereas there was an absence of similar parameters provided for the modern matron (Department of Health 1999; Department of Health 2001b).

It seemed from the guidance (Department of Health 1999) that the consultant roles were afforded a veneer of protection and autonomy as it was stated that the roles should not be 'undermined' and should be given access to resources in order to discharge the duties of the posts. The selection for the posts was carefully monitored and that process was required to gain approval for each appointee from regional health authorities (Department of Health 1999).

Since the implementation of the roles it became apparent that the aspirations of the Department of Health for the role in relation to qualifications were probably beyond some senior nurses who were still close to practice in the profession at that time; candidates

with a masters or a doctoral degree were difficult to source (Guest, Peccei et al. 2004). The appointment panels reported that personal qualities and experience outweighed the requirement for post graduate qualifications; some nurse consultants were found not be graduates (Guest, Peccei et al. 2004; Mullen, Gavin-Daley et al. 2011). This was an unfortunate outcome which suggests that level of academic and status equity that the Department of Health wanted to for nurse consultants to be on a par with medical consultants was being eroded from within the nursing profession itself who (Guest, Peccei et al. 2004), downgraded the necessity for the nurse consultants to hold appropriate qualifications and knowledge.

Despite clear guidance from the Department of Health (Department of Health 1999) that the nurse consultant should not be required to engage with line or corporate management responsibilities, some nurse consultants found that managerial responsibilities began to encroach upon their job roles (Mullen, Gavin-Daley et al. 2011).

2.9.2 Nurse consultants and modern matrons – what did the new roles mean for the profession?

The Griffiths reforms had put the concept of general management and therefore general managers as the key to improvement in the health service (Strong and Robinson 1990) and in doing so magnified the deficiencies in nursing with regard to a lack of academic rigour, deficient managerial competencies and minimal or lack engagement with a defined body of knowledge. The modern matron and nurse consultant roles helped to elevate nursing at that time as a viable profession that had important knowledge to share from an evidence base and so addressed the deficiencies that were criticised by general managers during the 1980s (Strong and Robinson 1990). It could be considered that the new nursing roles were a signal to other professional groups and managers that nursing had ‘come of age’ and were seen to be instrumental to help modernise the health service (Department of Health 2001c).

The roles provided two distinct pathways for senior nurses. The modern matron role was more aligned with the existing senior nurse roles at that time, but with increased specification with regard to the roles focus (Department of Health 2001b). The modern matron roles required expert and knowledgeable nurses, but the Department of Health did not specify the educational requirements for these roles (Department of Health 2001b) whereas there were specific educational requirements for the nurse consultant. In fact the position of the modern matron role within existing organisational structures was not specified by the Department of Health and the roles could have been implemented at senior sister or ward level or alternatively overseeing a group of wards at senior nurse level (Department of Health 2001b).

The nurse consultant role possibly helped to advance the concept that nurses had a wealth of evidence based knowledge and could effect significant change to aid the modernisation aspirations of the Health Service. However, the modern matron role merely by its title was seen by some as a retrograde step for the profession (Matthews 2000). It could be argued that the nurse consultant and the modern matron roles were at odds with each other but also had a shared purpose to improve the care received by patients. Outlined below is a comparative table which helps to identify some of the differences between the two roles.

Table 2.2 Nurse consultant and modern matron roles in comparison

	nurse consultant	modern matron
Academic requirement	masters or doctoral degree	sister or charge nurse level or senior nurse level. Experienced and knowledgeable nurses. No identification of academic attainment was specified
Recruitment	Carefully monitored by the health authority	No regional monitoring
Targets	No national target set	National target was set which was monitored by the health authority and then nationally

Access to resources	Nurse consultants should have access to the resources required to discharge that role	Modern matrons had access to environment funding. Other managers were advised not to be threatened by the modern matron role.
Engagement with corporate and line management	No involvement with line and corporate management required as this was seen as a barrier to the success of the role	The role had line management functions.
Clinical time	50% of the role should be clinically focussed	No specification
Organisational position	Equal status to medical consultants	Variable depending on organisational structure
Attire	not specified	clinical uniform

Both nursing roles and the accompanying press statements and literature at that time sought to locate nursing at the centre of modernisation agenda and a key stakeholder and implementer of change (Department of Health 1998; Department of Health 1999; Department of Health 2001a; Department of Health 2001b; Department of Health 2001c; Department of Health 2002b). Nursing had possibly become diminished in the surge of general management and during the subsequent years the profession worked to redress the criticisms levelled at it by general managers (Strong and Robinson 1990). The roles also may have sought to extend the aspirations and possibilities for senior nurses who had worked to gain academic recognition and highlight to them that their knowledge and skills could be fully utilised in a clinical setting in the role of nurse consultant. However, the same level of academic attainment was not deemed necessary for the modern matron. Principally, the modern matron was designed to improve the quality of patient care and the next section will consider the literature related to that aspect of the role.

Part III The impact of the modern matron on care quality

2.10 Matrons' return

The Labour Party's manifesto (Labour Party 1997) promised to safeguard the basic principles of the NHS. During the Party's first term of office in Government it had heavily invested in addressing long waits for surgery. However, media reports regarding

poor nursing care and accounts from patients and relatives of uncaring nurses continued to prevail. The public apparently continued to experience and report prolonged waits for surgery and interventions in some areas in England (Martin 2009) and when care was available it was sometimes delivered in what were reported to be unclean wards (Baggott 2004; Healthcare Commission 2007). However, media reports have since been analysed and found that the reports of ‘dirty hospitals’ and the direct link that was made between hospital cleanliness and increases in infections was unfounded and perpetuated an incorrect belief or perhaps an exaggeration of the facts in public and government arenas alike (Chan, Dipper et al. 2010). Table 2.2 identifies some media reports of unfavourable care around the time that the modern matron concept became evident.

Table 2.3 Popular and public influences

Date and source	Headline
Daily Mail 2001	<i>Woman 93 waited 30 hours for hospital bed</i>
Daily Mail 2002	<i>Hospital defends waiting times</i>
BBC 2001b	<i>Patient dies after 9 hour wait</i>
BBC 2001c	<i>£30M to improve 'dirty' hospitals</i>

Possibly due to the prevailing concerns of the public and the Government at that time, the Department of Health commissioned a listening exercise with the general public about patient care; the forums generated a wealth of ideas and solutions to help develop all services in the NHS for the next ten years. The recommendations following the consultations formed the basis of the NHS Plan (Department of Health 2000). The Plan was an unprecedented document and it set out the aspirations of the NHS and key deliverables for the years ahead. The recommendations set out in the Plan also focussed on nursing leadership. Two key career pathways were identified for nurses at a senior level, enabling these nurses to stay within the clinical area: nurse consultant roles to expedite patient care and streamline care pathways and modern matrons to improve the quality of nursing care. It had been interpreted from the consultations that the public wanted a responsive nursing service which also addressed the environment in which patients were being nursed (Department of Health 2000). The Health Service Circular

for 4 April 2001 (Department of Health 2001a) described the public facing rationale for the necessity of modern matrons' inclusion into NHS nursing leadership hierarchies.

The modern matron guidance (Department of Health 2001a) was expected to be implemented by all English NHS Trusts. Not all of the trusts complied, but many did (Lipley 2001); the number of trusts that did not comply is publicly unknown. The revival of a matron role was an unexpected development within nursing leadership and for the wider nursing profession. The media recalled to images of traditional matrons and the familiar depiction of a traditional matron from *Carry On* films (Thomas 1972).

The modern matrons were defined as:

... visible, accessible and authorities figures to whom patients and their families can turn for assistance, advice and support and upon whom they can rely to ensure that the fundamentals of care are right.

(Department of Health 2001b)

pp 2

The Department of Health had suggested in its guidance that the modern matron should see this aspect of her role as a mechanism to improve care standards. The modern matron concept was described in more detail in a press release (Department of Health 2001a) and in guidance for NHS organisations (Department of Health 2001a). The guidance stated that the new modern matron would provide assurance to patients and relatives by being ultimately responsible for nursing care, would have adequate authority to correct and improve care quality and would be a strong and visible leader. The role comprised three main strands:

- secure and assure the high standards of clinical care by the provision of leadership to the professional and direct care staff within the groups of wards for which they are accountable;
- ensure that administrative support services are designed and delivered to achieve the high standards of care for which they are accountable;
- provide a visible, accessible and authoritative presence in ward settings to whom patients and their families can turn for assistance, advice and support.

More specifically, the modern matron's quality mandate was set out in ten key roles (Department of Health 2002a):

1. lead by example;
2. make sure patients get quality care;
3. make sure wards are clean;
4. ensure patients' nutritional needs are met;
5. prevent hospital acquired infection;
6. improve the ward for patients;
7. empower nurses;
8. make sure patients are treated with respect;
9. resolve problems for patients and their relatives;
10. ensure staffing is appropriate to patient need.

The Health Service guidance (Department of Health 2001a), was in places ambiguous; the document attempted to describe two modes of implementation for the new role:

1. rename ward based senior sisters and senior charge nurses as matrons, or
2. give the matron title to existing senior nurses in the organisational structure, whereby the new matrons would have responsibility for a group of wards and thus provide support to senior sisters and senior charge nurses.

Although the guidance provided conflicting advice, it did allow a certain amount of freedom for trusts to implement the modern matron concept into their existing organisational structures (Hewison 2001). Conversely, the positioning of the role was not

clarified, because of the two levels of the hierarchy at which the matron role could be applied – senior sister or senior nurse levels.

The Department of Health detailed requirements for an initial target of five hundred modern matrons in England by 2004 (Department of Health 2002a). To ensure that modern matrons were able to deliver on the ten key roles, they were to be provided with further education in leadership, articulated at the time as ‘principles of matron-ship’ (Department of Health 2001a).

Housekeepers were later appointed to ensure that wards were cleaned and patients’ food choices were met. The words ‘matron’ and ‘housekeeper’ had a suggestion of nostalgia from a Victorian hospital setting or domestic staffing structures (Beeton 1861). The terminology did not appear congruent with the Department of Health’s modernisation agenda at that time.

The guidance stated that modern matrons were to be afforded greater powers to withhold payments from cleaning and catering contractors if their provision for patients was judged to be unsatisfactory. However, the Department Health advised (Department of Health 2001b) pp 5 that modern matrons:

should not be seen as a threat to the responsibilities of middle and non-clinical managers. Rather, it is an opportunity for them to better attune their work to the needs of patients by working more closely with the frontline clinical staff who co-ordinate and direct care.

This statement was possibly detrimental to the positioning and scope of the modern matron role prior to its implementation. It would be less likely that managerial colleagues of the modern matron would respond to their requests, particularly as the limit to the modern matron’s ‘power’ was influence.

The Matron's Charter was a more extensive document that aimed to set out what modern matrons could do to improve the quality of patient care (Department of Health 2002a). The Charter focussed on the importance of leadership from modern matrons and the importance of modern matrons to engage all nursing staff and housekeepers on the wards to ensure that cleanliness was improved and infection control standards were met. Modern matrons were particularly tasked with establishing a cleanliness culture and monitoring of standards, possibly because infection control had been a continuing theme of public concern and adverse media attention.

Improvements in infection control had been achieved, but improvements in practice (Department of Health 2002a) were not solely the concern of the modern matron, but of other colleagues too, such as microbiologists and pharmacists (Shuttleworth 2004; Goddard 2006; Weston 2010; Dougherty 2011; Flynn and Zombolis 2011). During 2007 the Prime Minister, Gordon Brown, ordered English NHS trusts to increase the numbers of modern matrons to five thousand, principally to reduce healthcare-acquired infections (Department of Health 2007). The Department of Health advised that the additional matrons would:

...devote a substantial amount of time to the delivery of a safe and clean environment for patient care.

(Department of Health 2007)

2.11 The aims for this study

The literature has demonstrated that there is a lack of understanding and appreciation of how the policy decision making resulted in the reincarnation of an obsolete nursing role. The popular journals offered supposition and critique about the role, but there is to date

no knowledge available which illustrates the process which led to the modern matron as there has not been any discussion with policy decision makers involved.

The literature brings together the development and changes to nurse leaders and has explored the origins and challenges of some traditional matrons. The modern matron appears to have been created in part, as a modern facsimile of the traditional role. The current literature available does make broad comparisons between the modern and traditional roles, but the deeper understanding of the traditional matron role and modern day parallel have yet to be achieved.

The modern matron role was created according to the literature to improve the quality of care for patients and to raise and maintain nursing standards. The literature has demonstrated that there had been some improvements in practice soon after the modern matron role had been implemented, there has not been enquiry into the role on this aspect once the role had been embedded. Taking these points into consideration, the aims of this study are:

- what ignited the thought of a matron in the minds of the national policy leaders?
- why did the Department of Health bring back the matron role?
- what are the differences, similarities and continuities between the traditional and modern matron?
- what impact has the modern matron role had on care quality?

For succinctness and clarity the aims above fall into three distant categories:

1. Socio-political influences on nurse leadership's development
2. Continuities between the traditional and modern matrons
3. The impact of the modern matron on care quality

2.11.1 Socio-political influences on nurse leadership's development

Whilst there had been a wealth of commentary regarding modern matrons, there had been minimal research that has considered the origins of the modern matron. Research that has been undertaken has been more concerned with the modern matrons' role in relation to infection control and cleanliness (Crawford and Brown 2008). Shortly after modern matrons were introduced, the Department of Health commissioned an evaluation to determine how the roles had been operationalised in various hospitals (Read, Ashman et al. 2004) that had surveyed modern matrons and directors of nursing and included patients and carers. The research identified a range of operational interpretations of the modern matron, and various challenges and successes. The ward sisters who were surveyed identified that the modern matrons were caught in a dichotomy of operational management and clinical work. The study found that broadly, there were three types of modern matron in respect of their portfolios: completely clinical, administrative or a hybrid model between the two. The modern matron body reported that they lacked authority to make substantial changes and this constraint restricted their ability to further improve the quality of nursing care. The study was helpful to provide the Department of Health and NHS Trusts with a status summary and an opportunity to consider how the roles had been implemented. The study was one of the first pieces of research on the progress of the role (Read, Ashman et al. 2004). The Department of Health commissioned evaluation was in-depth and wide ranging, but the study was unable to include the opportunity to consider the socio-political forces that led to the introduction of the modern matron (Read, Ashman et al. 2004). A later study may have presented a different perspective once the new job roles had been embedded. The study did elicit the views of patients, but the feedback was thought to be of poor quality and therefore attracted minimal weighting.

Whilst the level of commentary regarding the modern matron role had been abundant, research on this subject had been sparse. Dealey's (Dealey, Moss et al. 2007) audit was

informative and provided a perspective on the implementation of the matron role, but the study was self-limited in its scope to fully consider the modern matron guidance and policy amendments which had impacted on the traditional matron and the modern matron (Salmon 1966; Department of Health 2001a). However, the audit did provide a valuable and immediate review of the role within that trust.

No study was found which sought to explain the policy decision making process at national level which resulted in an old concept being revived. Addressing this gap via this study will help to towards gaining a greater understanding for nurse leaders and ensure in future that they are fully engaged at an early stage of policy development.

2.11.2 Continuities between the traditional and modern matrons

The Department of Health study (Read, Ashman et al. 2004) although the study was broad in nature, but was possibly limited because of its inability to undertake a deep and focussed review of one organisation). The research briefly acknowledged the review of nursing structures (Salmon 1966) but did not extend to the continuum of nurse leadership from the pre-Salmon era through to the arrival of the modern matron and the subsequent location of that role within a modern healthcare arena. The research very briefly touched upon the impact of managerialism, but a more extensive acknowledgement of Griffiths and other significant changes that have impacted upon nurse leadership may have provided an illustration of context which was under consideration through that research (Read, Ashman et al. 2004). Read, Ashman et al's study (2004) acknowledged the difficulties of obtaining feedback from patients and carers, as not many of those participants in that study had recognised that they had seen a modern matron.

2.11.3 The impact of the modern matron on care quality

An audit of the modern matron was conducted to assess the impact of the new role (Dealey, Moss et al. 2007). The audit surveyed managers and clinical staff and asked for their views regarding how the role was perceived across the organisation. The audit site did not use the modern matron title, but instead retained the senior nurse badge and implemented the modern matron concept. The audit demonstrated that the senior nurses had contributed towards the reduction of patient safety incidents and noted that the role was hindered from fully addressing the ten key roles of the modern matron because of operational demands, but concluded that the roles were essential in improving care quality.

An exploratory case study sought to determine the impact that the modern matron had had on improving the safety of care (Keeley, Goodman et al. 2005). The study found that the modern matron was a significant contributor to improving patient safety by monitoring practice and surveillance of care. The modern matrons in this study achieved safer care by influencing the culture of care and by having a strategic approach to the application of safer systems.

2.12 Conclusion

The modern matron was constructed in response to a combination of public request and political motivation to address the need to improve the quality of nursing care; further research would benefit from asking patients and their carers for their views on the modern matron. Current research was unable to illuminate the socio-political thinking and decision-making that led to the modern matron role.

Although existing research focuses on the modern matron, it is important to understand the context and location of the traditional matron from which the modern matron role is

derived, coupled with the impact of the gendered location of nursing. It is possible that once there is more understanding of the traditional matron role, the modern matron role could then be further understood.

The next chapter will discuss the methodological approach and methods used to respond to the research questions.

Chapter Three

Methodology

3.1 Introduction

This chapter is divided into two sections. The first section is focussed on the methodology and theoretical framework underpinning the study. The second section will explore the range of methods used for data collection. The process of recruitment, interviewing and gaining access to policy leads will be explored. The consideration and application of ethical requirements are discussed along with assurances of rigour and trustworthiness. In addition, the experience of working with archive data will be explained. The chapter will also outline my location as a researcher. To provide context for this chapter, an explanation of the focus for this study is presented below.

3.2 The focus for this study

As identified in the Literature Review, there has been minimal research on the return of the modern matron. I feel it is important to gain a more expansive and balanced understanding of the traditional matron role to enable an appreciation of the impact of the modern matron. In this way a full appreciation of the connectivity with previous iterations of nurse leadership (Salmon 1966; Strong and Robinson 1990) and historic assumptions about the traditional matron can possibly be illuminated. There has been considerable time between the implementation of the modern matron role and the start of this research; therefore it is hoped that the modern matrons will have been sufficiently embedded into their job roles and will have the ability to reflect on the impact and challenges that they have faced whilst trying to improve the quality of nursing care.

To enable a realistic evaluation and impact of policies, Pawson and Tilley (1997) provide the architecture for a stratified view of the social world. The modern matron guidance was in effect a social programme (Department of Health 2001b). The intention of the modern matron guidance was to alter the behaviours of senior nurses at that time. Therefore the addition of a realist approach as the theoretical underpinning for this research would be helpful, as it should help to illuminate which elements of the modern matron guidance were effective, and if they were not, to articulate why that was so. The next section will expand upon realistic evaluation and its application to this study.

3.2.1 What is realistic evaluation?

A realist approach seeks to expand the understanding of what occurred following a programme or policy intervention and to identify the underlying causes of subsequent outcomes (Wainwright 1997; O'Brien and Ackroyd 2011). Realistic evaluation positions itself as a model of explanation that avoids the traditional epistemological poles of positivism and constructivism (Pawson and Tilley 1997). Realism's key feature is its emphasis on the methods of explanation and the resultant progressive learning, advancement of knowledge and the ability to view the social world from a stratified reality (Pawson and Tilley 1997).

Realistic evaluation has been primarily developed by Pawson and Tilley (1997) and is now applied more frequently to social science research (Byng, Norman et al. 2005; Tolson, McIntosh et al. 2007; Marchal, Belle van et al. 2012) possibly because the approach is designed to enable the illumination of complex issues. Because of its relatively recent emergence, there remains much debate about the application and interpretation of realistic evaluation; however, its utilisation within nursing enquiry is apparent (Wainwright 1997; Byng, Norman et al. 2005; Tolson, McIntosh et al. 2007; Wand, White et al. 2010; Marchal, Belle van et al. 2012).

Pawson and Tilley (1997) advocate that realistic evaluation supports the knowledge extension of policy makers and practitioners, which suggests congruence with this study.

Realistic evaluation has its philosophical base in ontology and stratified reality (Pawson and Tilley 1997) whereby the social, cultural, individual, group and organisational responses to a new policy or social programme are explored and considered. In the context of realistic evaluation, a social programme is a new policy or guidance which is intended to induce change (Pawson and Tilley 1997; Exworthy, Berney et al. 2002; Byng, Norman et al. 2005). Pawson and Tilley (1997) advocate that all social interactions and social programmes experience interplay between individuals, institutions, structure and agency. The social aspect refers to cohorts of people or individual to which the policy applies to enable an alteration in the behaviour of those individuals within a social system (op cit). Pawson and Tilley (1997) consider that structures exist independently of the research participants; the participants are affected by their surrounding structure, organisation or culture in which they operate. Because people are involved, this level of interplay may result in disagreements, subversion or adaptation of the social programme that has been applied to them.

Realism's ontology posits that structures which create the world cannot be directly observed (Wainwright 1997) and boasts the ability to increase ontological depth by locating and understanding behaviours and outputs which may be unobservable whilst acknowledging physical and social realities (Pawson and Tilley 1997; Wainwright 1997). Realistic evaluation examines the mechanisms and context to enable the evaluation of change induced by a social programme by seeking to understand what lies beneath the immediately observed as opposed to acceptance of what is directly seen (Pawson and Tilley 1997; Exworthy 2003; Byng, Norman et al. 2005).

It is advocated that the language surrounding realistic evaluation should be clear and meaningful and not shrouded in complex scientific vocabulary, as this would reduce the

opportunity of realist evaluation to be applied to a real world issue (Pawson and Tilley 1997).

Realistic evaluation can be employed as a whole methodology (Byng, Norman et al. 2005; Blamey and Mackenzie 2007; Tolson, McIntosh et al. 2007) whereby the research is theory based and the questions emanate from an initial conjectured position, but can also be used as an approach to a study whereby elements of it are employed (O'Brien and Ackroyd 2011).

Realistic evaluation acknowledges the status of open systems whereby research is conducted in a natural environment and outside the control of the researcher (Pawson and Tilley 1997). Open systems are permeable to unexpected change because of the social world that we occupy. Realistic evaluation creates an opportunity to understand what worked well with a policy and appreciate how the outcomes of it may have been affected by other intrusive influencers, i.e. organisation, culture, existing structures, people and their behaviours (op cit). This approach, according to Pawson and Tilley (1997), illuminates policy makers' understanding about successful and unsuccessful elements of a particular policy; subsequently, realistic evaluation helps policy makers to identify what amendments need to occur to achieve the intended outcomes of a policy. Realistic evaluation has been viewed as a process by which disappointing policy outcomes could be reduced and the learning that emanates from this methodology may discourage the implementation of large-scale homogenous policy application without full consideration of the receiving context (op cit).

Policy outcomes, according to realists, are induced by forces that emanate from social, individual or attitudinal influences that have the potential to impact upon the success or failure of a policy. Generative causation is a complex regard of the influences which impact upon how programmes or policies go beyond simple x y causation (Pawson and

Tilley 1997). Pawson and Tilley (1997) posit that causation should be viewed via the formula of:

$$\text{mechanism} + \text{context} = \text{outcome}$$

It is advocated that this formula forms the central principle of realist evaluation (Pawson and Tilley 1997). The significance of this formula is explained more fully in the next three sections.

3.2.2 Mechanisms

Mechanisms are the key towards the development of detailed explanations and are usually hidden, sensitive to contextual variations and generate outcomes (Astbury and Leeuw 2010). Within the social world, mechanisms relate to individuals' choices and actions, which in turn make a programme work. For example, an electronic reminder could be seen as a mechanism to enable timely renewal of library books. The understanding of why something works or does not helps to define and determines the success or failure of a social programme (Pawson and Tilley 1997).

3.2.3 Context

From a realistic evaluation perspective, context refers to social groups, organisational culture and group norms. For example, nursing has its own group norms and behaviours: the process of handover, the rituals of night duty (Walsh and Ford 1989). As social policies require optimum conditions to be successful, this may focus on the organisational influences which impact upon the modern matron. Existing contexts can be subject to the residual influence of historical events and this will be illuminated with the addition of a historical component of this study.

3.2.4 Outcomes

Outcomes are the result of the interplay between context and mechanisms. Outcomes can vary and are dependent upon the context and the individuals involved. Programmes result in many different or unexpected ones (Pawson and Tilley 1997). Outcomes can differ depending on the context into which a programme is intended. The evaluative approach towards the review of the outcomes enable policy leads to determine whether to continue, amend or discard a programme (Pawson and Tilley 1997).

3.2.5 Context, mechanism and outcome configurations

Context mechanism and outcome (CMO) configurations is the culmination of the three key elements of a social programme's progress and are compared and explored by using a tabular layout (Byng, Norman et al. 2005). The CMO configuration will enable the findings of this study to be further illuminated and move beyond what was said, but instead to understand how the various participants, group norms and organisational culture may have impacted upon the operationalisation of the modern matron guidance (Department of Health 2001b) and the modern matrons themselves.

It is contested that an outcome may have been the result of several mechanisms and the simplified modelling advocated by Pawson and Tilley (1997) is not always fully representative (Astbury and Leeuw 2010). An example of a context mechanism and outcome is illustrated below in Figure 3.1 (Pawson and Tilley 1997). Educationalists may implement a policy to encourage parents to read to their primary school children for fifteen minutes each day to enable an increase in reading competency amongst primary school children. The context, mechanism and outcome that the policy is intended to achieve are outlined below:

Table 3.1 Context mechanism and outcome example 1

mechanism	+	policy intended context	=	outcome
national policy to encourage parents to read to their primary school children for fifteen minutes each day.		committed and focussed parents who will prioritise their children's education.		children's reading ability is elevated above expected standards.

Following implementation of this fictitious policy, the educationalists' intended outcomes were as a result of the interplay between the mechanism and the individual behaviours of parents. The educationalists could not control the home environment, which was an open system and was subject to other influencers, such as the motivation of the parent and creating the time to read. The response to the mechanism from the parents was also unexpected and outside of the control of the policy makers. Displayed in a context, mechanism and outcome configuration, the educationalists found:

Table 3.2 Context mechanism and outcome example 2

mechanism	+	policy intended context	=	outcome
policy to encourage parents to read to their primary school children for fifteen minutes each day		some parents state they do not have the time to spare.		primary age children's reading ability remains below expected standards.

The next section will describe how realistic evaluation will be employed as the lens for this study.

3.2.6 Realistic evaluation – the lens for this study

The purpose of drawing from realistic evaluation for this study is to provide additional illumination to the findings and enable the interplay between causation, context and

mechanisms to be explored. A realistic lens should encourage the elucidation of why the modern matron guidance may have produced unanticipated outcomes (Department of Health 2001b).

The research site, a general hospital, is, from a realistic evaluation perspective, an open system (Pawson and Tilley 1997). The site and more specifically the modern matrons are vulnerable to a range of influences which cannot be controlled by the researcher and therefore is a naturalistic environment and an open system (Stake 1995; Pawson and Tilley 1997; Yin 2009). Realism's stratified approach should produce a stratified response to the research questions and may enable policy makers to appreciate the complexities of large-scale policy implementation.

Case studies are thought to be derived from social constructivism, which also acknowledges that there are a range of perspectives and this approach should enhance and contribute to the realist ontology of a stratified reality (Pawson and Tilley 1997; Yin 2009).

The modern matron guidance (Department of Health 2001b) could be viewed from a realist perspective as a social programme for the induction of change for the senior nurses at that time. The context for the purposes of this study will be the environments and the local arrangements in which the modern matrons worked. The outcomes are yet to be seen, but will be considered in the Discussion Chapter via the lens of realistic evaluation. The context, mechanism and outcome configurations will be arranged in 'context, mechanism and outcome' formation towards the end of that chapter, which will enable an evaluative conclusion to this study (Pawson and Tilley 1997; Tolson, McIntosh et al. 2007).

3.3 Methodological rationale

Prolonged consideration occurred with regard to which methodology would be the most appropriate framework to respond to the embryonic research questions (Salmon 2012). The research methodology would need to gather data collected from a range of participants, including historical and contemporary contributions. The three research questions are trying to gain an understanding and explore whether there is connectivity between the modern and traditional matron roles (Creswell 2007). In order to respond to the questions, the data would need to be from a qualitative paradigm.

Ethnography or phenomenology may have been appropriate methodologies. The central tenet of ethnography is observation (Fetterman 1989; Skeggs 1994). A conscious decision was made to veer away from the observation of modern matrons. Whilst ethnography would have been ideal for gathering data on the interactions of modern matrons and the culture in which they operate, this may not have entirely responded to the research questions. Having worked previously as a modern matron, there was personal concern that as an observer, I might have looked but I may not have seen what the modern matron was engaged with because the nature of their work would have been familiar to me; aside from these concerns, an ethnographic study (Fetterman 1989) may be more appropriate once this research has provided further knowledge in relation to the historical derivation of the matron roles and the political decision-making which led to those changes in nurse leadership and the subsequent impacts.

The research could also have adopted a phenomenological approach (Creswell 2007; Salmon 2012) by gathering and analysing the essence and meaning of what it is to be a modern matron, their experiences and behaviours (Salmon 2012). However, the research questions are more grounded in the establishment of the modern matron role and resultant outcomes. The gap in current knowledge that I have identified was not concerned with eliciting the lived experience of matrons. Learning more about the lived experience would

be a valuable piece of research, but again possibly after more is known about the traditional and modern matron roles and the contributions they have made to date.

The methodology that was repeatedly considered was the qualitative case study. The case study (Stake 1995; Yin 2009) acknowledged the contribution that could be made to the research by historical sources. The process of bounding the case provided a discipline in respect of what and who to study. The 'how' and 'why' nature of the research questions appeared to be consistent with the characteristics of a case study. Therefore the qualitative case study was selected as an appropriate methodological framework to draw from to guide the initial phases of the research: initial design, methods, case boundary and included in the convergence of data towards the end of the study with realistic evaluation.

3.4 Qualitative case study

The methodological approach for this research was drawn from the theorising and practice of case studies predominately from Robert Stake (Stake 1995) and Robert Yin (Yin 2003; Yin 2009). Case studies can be quantitative, qualitative or use mixed methods (Yin 2009) and could be described both as a process and as a product of enquiry (Denzin and Lincoln 2000). Some researchers use case studies as a method within a larger study and sometimes it is used as the main methodology, as it will be for this study (Yin 2009). Yin defines case study research a methodology that allows the ability to understand a real-life phenomenon in depth. Stake suggested that case study is the study of the particularity and complexity of a single case (Stake 1995).

Case studies are designed to study holistic real life events, organisations or individuals (Stake 1995; Yin 2009) and should focus on a particular group of people, profession or issue of public interest (Stake 1995; Yin 2009). Stake (1995) and Yin (2009) both acknowledged that case studies are a flexible methodology, which provides an

opportunity for questions to emerge and change as the study progresses. Case study research has been increasingly used within social sciences and nursing (Bergen and While 2000; Bryar 2000; Ekman, Skott et al. 2001; Green, Segrott et al. 2006; Luck, Jackson et al. 2006; Yin 2009).

Stake (1995) appreciated that for a researcher to undertake meaningful study, he or she does need to be personally drawn to the research subject in order to be motivated to conduct the study; Stake refers to this as intrinsic research, research that has been borne out of personal or professional interest.

Creswell (2007) suggested that case studies are derived from the social constructivist paradigm, hence there are a range of realities and perspectives - there is no one truth or viewpoint. Case studies are designed to capture these multiple realities by employing a range of research methods. One characteristic of a case study is to be able utilise a range of methods: interviews, focus groups, observation and archival data. These multiple evidence sources will then converge to formulate the findings. It is not a requirement for all of the methods to be used simultaneously, but it is perceived to be valuable to use more than one (Yin 2009).

Yin (2009) and Stake (1995) both agree that minimal researcher interference is favourable. Case studies strive to be naturalistic whereby the researcher cannot control the events, whether they are contemporary or historical (Stake 1995).

Case studies can be single or multiple (Yin 2009). An individual, a single organisation or a particular event can be the subject of a single case study. Multiple case studies provide the opportunity for comparison between individuals, organisations or events. Single and multiple case studies are of equal value and the choice is dependent upon the research questions to be answered and the level of resources available to conduct multiple studies

(Yin 2009). The value of single case studies is advocated by Stake (1995) to capture the complexity and depth of that case.

3.4.1 Generalisation and particularisation

The primary obligation of the researcher is to study the one special complex case, typical or unique (Stake 1995). Although a case may be unique, it is envisaged that there will be findings that can be generalised and any learning or new approaches to be either wholly or partially considered in relation to other similar settings. Stake (1995) was not striving to achieve generalisation but particularisation and the privilege of being able to thoroughly understand one case, in order to capture the multiple realities and interpretations, and this is the approach that this research will be taking. The importance of focussing on the particular and having the time to go into depth enables the detail of the single case to emerge (Stake 1995; Tellis 1997; Pegram 2000).

Stake advised that he drew from a range of qualitative paradigms and is explicit regarding his arbitrary and less structured approach towards the methodology, which provides the researcher with freedom to design studies around the question whilst ensuring an appropriate fit with the style and epistemological location of the researcher. The early development of questions as a formalised process within case study research will be discussed in the following section.

3.4.2 Propositions and question development

Another key characteristic feature of case study methodology is the formalised stage before the research questions are solidified. Yin (2009) refers to this stage as 'propositions', whereas Stake (1995) defines a similar concept but calls these 'issues'. Essentially, issues and propositions² are the same. According to Yin (2009):

² For clarity in this study, the term 'propositions' will be used.

each proposition directs attention to something that should be examined within the scope of the study (p. 28)

Whether it is due to limited editorial space or a lack of appreciation of the components of case study methodology, the proposition phase has a tendency to be overlooked in most published case study research (Tellis 1997; Bryar 2000; McDonnell, Lloyd Jones et al. 2000; Pegram 2000; Zucker 2001; Jones and Lyons 2004; Luck, Jackson et al. 2006; Baxter and Jack 2008). This phase of the methodology provided this study with early formalised direction towards the finalisation of the research questions.

Most qualitative methodologies allow a degree of flexibility (Creswell 2007) and case study methodology is no exception. Stake's (1995) approach was based on ensuring that the methods chosen were congruent with the questions and the researcher's own approach to conducting the study.

3.4.3 Bounding the case

The concept of 'bounding the case' is a characteristic of case study design (Yam and Rossiter 2000; Yin 2003; Yin 2009) and is not always fully explained. Case studies can be bound by time, or geography, although organisation is a key mechanism to help maintain the focus for a study. Stake (1995) emphasised the importance of the boundedness of a case study, whereby it should be contained within a system; for example, it might be difficult to study the work of a school teacher who was unemployed, but a school teacher who was employed at a school and is bounded by that system would be an accepted research focus for a case study.

This section has explored the characteristics and opportunities that case study research can provide. The next section explains how qualitative case study methodology will be applied to this study.

3.4.4 How this study is guided by case study methodology

This study has drawn from case study methodology and has adopted some of the characteristics and applied them to this research (Stake 1995; Yin 2009). The study will also employ realistic evaluation (Pawson and Tilley 1997) as outlined earlier to illuminate the study's findings.

Case studies are characterised by multiple methods (Yin 2009) to enable the extraction of data, and for this study, three methods of data collection will be employed: interviews, a focus group and a review of archive data. It has not been specified (Stake 1995; Yin 2009) what an optimum sample size should be for a qualitative case study; however, the nature of the propositions and the questions suggest that more than one participant should be involved in the study (Stake 1995). Sixteen participants (or units of analysis) were included, or seventeen if the diaries of the traditional matron are included. Further detail of the participants is outlined in table 3.6.

3.4.5 Propositions and question development

Following consideration of the literature as laid out in Chapter Two, the propositions were formulated:

- What are the differences and similarities between the traditional and modern matron?
- Why did the Department of Health bring back the matron role?
- What difference has the modern matron role had on the quality of nursing care?

- What ignited the thought of a matron in the minds of the national policy leads?

Over time, these propositions were then developed into research questions:

How has the 19th century concept of the matron contribution to restoring public confidence about the quality of healthcare in an acute NHS trust?

1. How far does the modern matron represent continuity with the traditional matrons of the mid 20th century to the present day?
2. What socio-political forces led to the development and establishment of the modern matron?
3. From the perspective of health professionals, what impact has the modern matron had on the quality of patient care?

3.4.6 The nature of this study

This study has many features: it is single sited, embedded, explanatory and intrinsic (Stake 1995; Yin 2009). The research site was one NHS trust in the south of England. The participants or units of analysis (Yin 2009) were integral to the organisation and so were embedded into the site, as illustrated in Figure 3a. The national policy leads were located inside the research boundary, as they had influenced the work of the modern matrons via the modern matron guidance. Alternatively, the national policy leads could have been placed outside the site and the diagram modified to show that their influence affected the trust, but either option would equally reflect the scenario. The intrinsic nature of the research relates to my personal and professional interest in nurse leadership, historical and contemporary.

This research study is bound by time, geography and organisation, whereby the units of analysis (participants) and the research site are contained within a specified area as

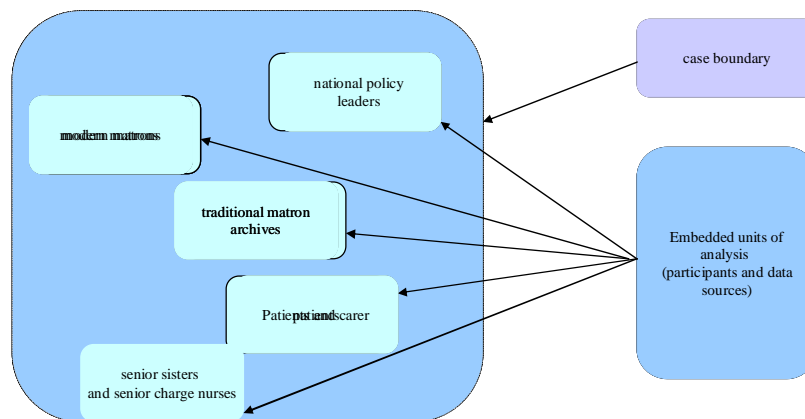
defined during the research design. The case was selected primarily because of the archive access and so this led to conducting the research within the NHS trust where the archives were stored. The traditional matron archives spanned from 1945 – 1966 and so this time frame for the understanding of the traditional matron is also bound for this study by those dates. The case is also bound by time: the data collection is centred on the immediate pre-NHS phase until the demise of the traditional matron and re-focuses on the re-emergence of the modern matron role in 2001 until 2010. Although the time frames between the traditional matron and the modern matron span over sixty years, the connectivity of recognisable place names contained within the archives because of the geographical co-location of the research site and its bounded nature contribute to this study's uniqueness.

The bounding of the case with regard to geographical location has enabled the study to maintain its focus on the research site as opposed to creating a reliance on easily accessible archive data from nearby cities, when it is known that the traditional matrons from metropolitan hospitals regarded themselves differently and probably were a little different when compared to their provincial colleagues (White 1985).

3.4.7 The research site

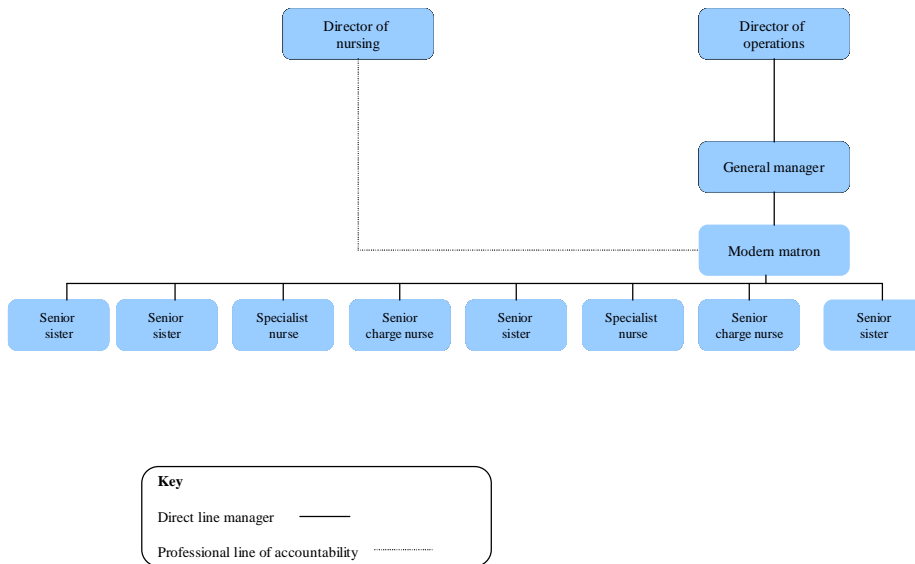
The research site was an acute NHS trust in the south of England and had approximately six hundred in-patient beds. The trust served a community of mixed financial and educational affluence. The trust had a director of nursing on the board, who was an executive voting member.

Figure 3.3 Illustrating the case



The work of the trust was divided into directorates relating to medical diagnosis, i.e. emergency medicine, women and children and surgery. The modern matrons were part of the management team for each directorate and there was more than one modern matron per directorate, sometimes four or five. The modern matrons were line-managed by a general manager and this hierarchy is a remnant of the Griffiths era (Owens and Glennerster 1990). The general manager was line-managed by the director of operations. The modern matrons were remunerated at different levels, some at Agenda for Change grade 8a and others at 8c (Royal College of Nursing 2012). The modern matrons at grade 8c sometimes managed the modern matrons at 8a and this arrangement was dependent upon directorate size and complexity. Figure 3.4 shows the more typical arrangement of a structure without a matron at grade 8c. The modern matrons' line managed senior sisters and senior charge nurses. The modern matrons had a professional line of accountability to the director of nursing, but the director of nursing did not line manage the modern matrons; modern matrons were managed by general managers.

Figure 3.4 Typical trust structure from trust board to directorate level



3.5 Access and research ethics

This section addresses the formalities of gaining access and applying for ethical and research governance approval, but will also explain additional and necessary ethical considerations of confidentiality and anonymity and will afford particular attention to this in relation to the focus group. The dilemma of whether to reimburse participants will be raised.

3.5.1 Gaining access to the research site

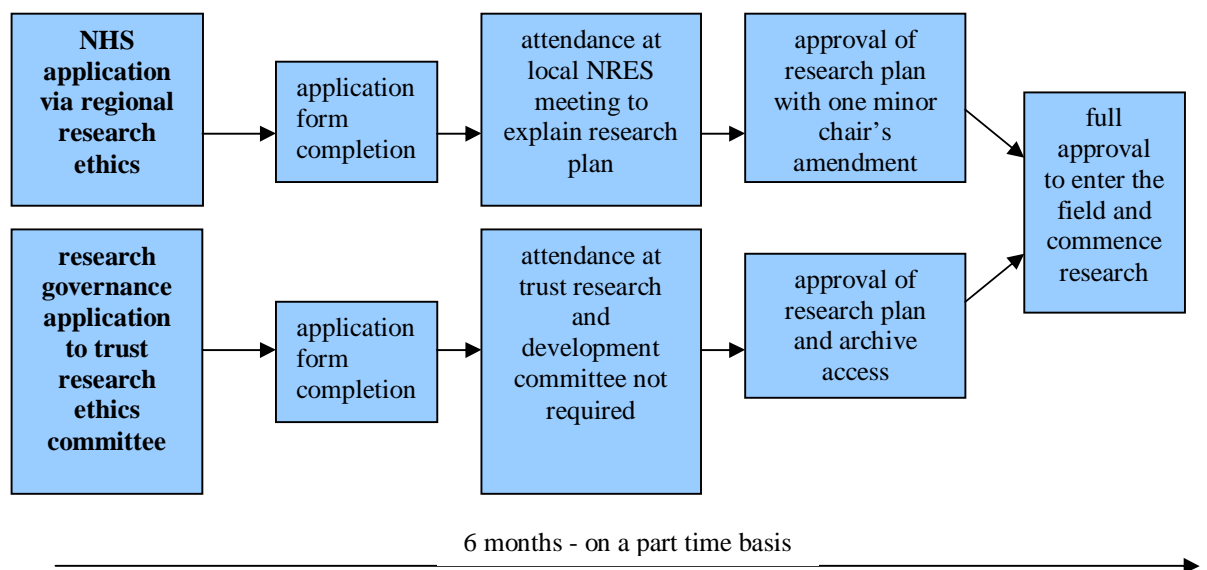
Gaining access is an essential component of most research programmes involving people (Woods and Roberts 2003). General texts have a tendency to ignore the challenge of gaining and maintaining access to the research site. Two key texts provided me with guidance on the development of my approach to access (Burgess 1984; Feldman, Bell et al. 2003). I identified the director of nursing as the key gatekeeper to the research site in relation to nursing (Burgess 1984; Woods 2003). Following an enquiry letter and a successful one-to-one meeting, the director was wholly supportive of the research;

unfortunately, that director left the organisation and another was appointed. The process of explaining the rationale for the research and the implications for their staff was repeated with the new appointee. The new incumbent was supportive of the research (appendix 1) and this agreement gave permission to progress the application to the National Research Ethics Service (NRES) and trust based research and governance approvals processes.

3.5.2 NHS ethics and governance approvals

As the research was to be conducted in an NHS setting, there was a stipulation that the research be approved via this route, which was a prolonged process and is pictorially described in figure 3.5:

Figure 3.5 NRES and trust research ethics processes



Although the research ethics and governance processes have been criticised (Byrne, Morgan et al. 2005), I found the process helpful, as the detail that was required for the eventual approval enabled me as a new researcher to ensure that I had fully considered every aspect of the research study and the anticipated impact on individuals (Flick 2010) (appendix 2).

3.5.3 Gaining participants' consent

All participants were provided with full information about the rationale for the research as required by NRES (appendices 3a, 3b, 3c, 3d, 9). None of the participants stated any concerns about the research, which suggests that the information was clearly articulated. To ensure correct application of mandatory confidentiality and anonymity, both aspects required consideration.

3.5.4 Confidentiality, anonymity and data protection

Confidentiality and anonymity are terms that are sometimes used interchangeably, but the two concepts are inextricably linked and equally distinct:

confidentiality definition: *intended to be kept secret*

anonymity definition: *not identified by name*

(Soanes 2002)

Due to the requirements of the research regulators (NRES), all participants were assured of anonymity. Confidentiality describes the process whereby the transfer of certain information is not permitted (Mander 1995). However, confidentiality could not be completely guaranteed for the focus group participants, as any of the participants might have breached that confidence, which was outside of my control (Greenbaum 1998): all focus group participants were advised about this risk before the group began. Being assured of these two vital elements may have contributed to the participants feeling that they would be able to speak with a certain amount of ease.

Anonymity means that nothing should be attributable and therefore identifiable to a named person. Assurances of anonymity may also have helped with recruiting

participants, although this is difficult to measure, as all credible studies must assure participants of these fundamental elements of research governance (Mander 1995).

3.5.5 Nurse as researcher, researcher as nurse

Having dual roles as a registered nurse and a researcher has been a point of consideration within the nursing profession (Wilkes and Beale 2005; Houghton, Casey et al. 2010). Using a reflexive process (Finlay and Gough 2003), I was confident that I would be able to navigate myself through most ethical eventualities. Most of the modern matrons' offices were located adjacent to ward areas; had a patient or anyone become ill in my vicinity, I would be professionally obligated (Wilkes and Beale 2005; Nursing and Midwifery Council 2008) to respond in a reasonable manner and within my scope of knowledge.

The director of nursing agreed that if I had witnessed or heard of significant poor practice whilst in the field then I would speak to the nurse concerned as a fellow registrant at that time. If the concerns were serious then I would advise the sister or modern matron for that area of my concerns (Nursing and Midwifery Council 2008). As an additional precaution, I was also prepared to document any serious concerns in a confidential contemporaneous notebook to be accessed if my evidence was required at a later date – no such concerns were encountered.

3.6 Minimising the participant researcher gap

I was keen to ensure that the research participants were appropriately supported and valued during the research process. Although some would dispute that striving for a level of egalitarianism within the researcher and participant relationship would not be entirely possible (Cotterill 1992; Skeggs 1994), recognising the potential gaps between the researcher and participants, I believe, is the first step towards minimising the gap by

being open and warm and ensuring that all participants and their contributions were equally valued. I worked hard during the interviews and focus group to value the time that people had taken outside of their busy routines to help me and contribute to the research. I did not want to do a 'smash and grab' exercise. I treated all the participants hospitably and all the participants received a letter and a small gift as a sign of my appreciation.

3.7 Public involvement

I was keen to test the material that I had developed for the research by gaining the opinions of members of the public. I convened a small lay reference group and they were tasked with ensuring that template letters and advertising material were clear, meaningful and understandable. The feedback from this group was particularly helpful in designing the research material and ensuring that what I had written would be meaningful.

Research is required to adhere to guiding principles that demonstrate good practice has been applied and that readers can gain assurance about a study's trustworthiness as outlined below.

3.8 Rigour and trustworthiness as applied to this study

The approaches for determining the rigour and trustworthiness of qualitative research has been a debated issue (Lincoln and Guba 1985; Sandelowski 1986; Sandelowski 1993; Tobin and Begley 2004; Rolfe 2006; Houghton, Casey et al. 2012). The papers cited all use a mele of different terminology to describe rigour and trustworthiness and establishing a common approach for the assessment of rigour within qualitative research has remained illusive (Tobin and Begley 2004).

Within case study research a framework for ensuring validity and rigour are offered primarily to ensure that study findings are equally regarded to other qualitative methodologies (Yin 2009). More broadly it is expected of all research studies to ensure that quality, transparency and overall trustworthiness of enquiry and encompassing processes have been appropriately addressed and acknowledged. As this research has drawn from the guiding principles of case study methodology (Yin 2009), Yin offers a framework to assess the quality of research. However, he relies on others (Kidder and Judd (Yin 2009) pp 44) to guide this process. Therefore, I have turned to Lincoln and Guba (Lincoln and Guba 1985) for a framework which should provide clarity on evidence of rigour and trustworthiness of this study.

However, it is suggested that the artistic nature of qualitative methodology is somehow stifled by the requirement to demonstrate that rigorous and trustworthy study has been conducted which in turn violates the uniqueness of the qualitative research process (Sandelowski 1986; Sandelowski 1993). According to Sandelowski (1993) the most appropriate response to ensuring quality in research is to ensure meaningful and true portraits of life. Sandelowski continues to advise that research should be singularly assessed rather than be subjected to a plethora of constraining and confusing processes (Sandelowski 1993). Nevertheless, there is an expectation that rigor and trustworthiness must be addressed as all research studies should be open to scrutiny to assess the robustness of the process and subsequent findings (Long and Johnson 2000).

Lincoln and Guba (1985) conceptualise trustworthiness as the mechanism of persuading readers of the research that the process and subsequent findings of enquiry are worthy of attention with criteria to be addressed: credibility, dependability, confirmability and transferability, with strategies underneath as outlined in table 3.3 I will also draw on the more recently recognised need within naturalistic enquiry to appreciate the influence of the researcher and the benefits that reflective approach can provide (Finlay and Gough 2003; Jasper 2005).

Table 3. Strategies to determine trustworthiness

Approaches to rigour	Strategies
credibility	prolonged engagement and observation triangulation peer debriefing member checking
dependability	audit trail reflexivity
confirmability	audit trail reflexivity
transferability	thick descriptions

3.8.1 Credibility – prolonged engagement and observation

It was suggested that sufficient engagement and consistent investment with regard to time in the case study site is an important component to the rigour and trustworthiness of the research process and findings (Lincoln and Guba 1985). Prolonged engagement with the site allows for the researcher to understand and appreciate the culture of the research setting whereby particular behaviours and relationships between key participant groups for example can be observed; moreover, correct interpretations of particular interactions can be made. In addition, researcher engagement within the site can also ensure that prospective participants become familiar with the researcher which may increase the researchers credibility (Lincoln and Guba 1985).

Taking this into account, I attended meetings with the modern matrons to promote the research and invite them to join the study. Whilst there, I was able to appreciate some of the cultural features within the staff group; for example, the language and parlance used, their current organisational challenges and an apparent informal hierarchy whereby some modern matrons appeared to have a greater influence compared to some of their peers, with regard to their longevity in the role and personal knowledge.

3.8.2 Credibility – triangulation

Triangulation is the process whereby several methods are employed to illicit a range of data. It is a characteristic of case study methodology to have multiple data sources (Yin 2009) but triangulation is referred to as data convergence. Triangulation ensures that there is increased credibility and strength to the final findings (Lincoln and Guba 1985). This study will aim to use a focus group, individual interviews with a range of participants and use the data provided by the archive diaries from the traditional matron. The various approaches and sources to illicit data should provide an in-depth understanding of the modern matron role within the case study site and maximise the triangulation or convergence of data to provide a complete case study (Lincoln and Guba 1985; Yin 2009). However, following literature review there was limited availability of evidence to demonstrate the societal understanding of the matron role, therefore, some media sources have been utilised to help illustrate the societal view.

3.8.3 Credibility – peer debriefing

Peer debriefing is advocated as a necessary strategy to ensure rigour and trustworthiness in research whereby the researcher invites a known expert in qualitative research to provide guidance on identifying significant codes within the data (Lincoln and Guba 1985). Guidance was sought from the research supervisors who initially suggested how the coding might develop, but all subsequent work was conducted independently by the researcher (Holloway and Wheeler 1996). Peer debriefing can also be achieved by presenting the methodology and findings to fellow researchers in order to invite critical exploration. During the doctoral programme, I presented my ongoing work to peers whereby they asked questions which contributed to the development of the study.

3.8.4 Credibility – member checking

Member checking provides participants with the opportunity to review and amend their contribution to a study (Lincoln and Guba 1985). It is suggested that this process, reduces the risk of the researcher unwittingly biasing or providing a misleading or unfair representation of the data. Therefore, member checking ensures that the data remains 'true' or trustworthy. Conversely, it has been recommended that member checks would be more useful if they were conducted by a third party as the participants may feel more able to raise a query regarding the transcripts (Long and Johnson 2000). Sandelowski (1993) argues that achieving trustworthiness can be threatened by member checks. Sandelowski stated that the focus of participants differs to that of the researcher as participants focus on their own contribution, whereby researchers are striving to present a multiplicity of realities; this view is rather narrow as adoption of this approach could lead to a paucity of qualitative research.

In this study, member checking was conducted after the transcription phase. Transcription was conducted by the researcher (see section 3.19). The individual transcripts were then sent to each participant with a covering letter. One participant advised that the word 'porters' had not been mentioned during the interview which was curious as the transcriptions had been diligently conducted. Nevertheless, the word was amended at the participant's request; the amendment did not alter the shape or meaning of the transcript. Sharing the transcripts with the participants provided me with assurance that the participants would gain confidence having been involved in a transparent and open process.

3.8.5 Dependability and confirmability – audit trail

Rigour and trustworthiness can be assured by the transparency of decision making during the research process and the final study findings (Lincoln and Guba 1985). Yin explains the importance of researchers maintaining a case study database whereby all written and electronic information is diligently stored in a recognised order to increase the reliability

of the study (Yin 2009). Yin refers to this as the 'chain of evidence' (Yin 2009) (pp 119). The chain of evidence or audit trail should be significantly strong to allow another researcher to follow the decision trail and be able to conduct a similar study and arrive at similar conclusions (Lincoln and Guba 1985).

All data will be securely stored for the duration of the study including the interview tapes, written transcripts and electronic and hard copy, but hard copy and electronic data will be destroyed in accordance with Data Protection legislation (1998). All supervisory notes and agendas have been and will continue to be retained as a record of the development of the study and also of my self development. All versions of the chapters will be retained as a record of how the final work develops. If required, it would be possible to describe using the documents how the research started, progressed and was finalised, with all the decision making processes clearly identified and recognisable.

3.8.6 Dependability and confirmability – reflexivity

Reflexivity is not a concept which is mentioned by Lincoln and Guba (1985), but it is increasingly noted as a valuable addition to assuring others about the rigour and trustworthiness of qualitative research. The development of qualitative research has acknowledged the personal contributions of the researcher and the impact the researcher may have upon the final findings is now recognised and that research should not devoid of personal contribution (Jasper 2005). Reflexivity should be seen as a critical view of oneself in order to challenge researcher practice (Finlay and Gough 2003) and offers techniques to allow clarity of thought and self discovery (Jasper 2005). It is now accepted that the researcher is central to qualitative enquiry and is instrumental in the design and subsequent study findings (Koch 1994; Jasper 2005). A daily diary is suggested to capture reflective thoughts and to challenge ideas and create new perspectives (Koch 1994). However a daily ritual of diary keeping may not be practical.

Reflection can also occur within oneself without committing those thoughts to paper (Finlay and Gough 2003).

Diary entries were maintained and proved to be particularly useful when deciding which research methodology should be employed. Following interviews, I would also speak into the microphone and my immediate thoughts, concerns and fears would be captured. I felt able to record my perceptions about how I had performed during the interaction. Reflexivity was a process which was instrumental in enabling me to identify my location as a nurse and a researcher via the musings in my reflective diary a process which challenged my thinking and enabled me to review myself afresh.

3.9 Situating myself

The influence of self on the conduct of the research and my interpretation of the findings has been addressed in the previous section (Marshall 1994; Finlay and Gough 2003; Letherby 2003) and I will explain below how the process reflexivity and conclusions influenced my approach to the research.

The intrinsic nature of this research stems from my nursing background and the time I spent working as a modern matron in an acute hospital. Whilst working as a modern matron for nearly three years, the experience initiated my consideration of the traditional matron role. I have used feminist literature from the United Kingdom and the United States of America to afford me the opportunity to examine who I am from the perspective of a nurse researcher. Once I have understood these elements, the approach in which I conduct the study can be applied.

The literature review acknowledged the contribution of post-modern feminist thought as a minor component of the theoretical framework to help explain the position and progression of nurse leadership within National Health Service (NHS) organisational

structures (Code 1991; Oakley 1991; Acker and Van Houten 1992; Davis 1995; Letherby 2003). Whilst exploring this body of literature, it became apparent to me that there was an additional layer of feminist thought - black feminism. This aspect of feminist work had been largely silent in mainstream text and also to me (Oakley and Mitchell 1986; Code 1991; Letherby 2003). This body of knowledge (Marshall 1994; Mirza 1997) initiated my critical analysis of the prevailing socially constructed feminist image of the white middle class woman. I explored black feminist texts, some of which helped me to deconstruct and then reconstruct my position as a black female nurse researcher (Mirza 1997). Other literature emotively articulated the position of black women in society (hooks 1982; hooks 1989)³ but this body of literature was not congruent with my own experience and was at times unpalatable.

Marshall (1994) suggested that I should expect my skin colour to be a barrier to gaining access to participants during the research process, which until I read her text I had not appreciated as potentially problematic (Finlay and Gough 2003). Marshall (1994) suggested that being a black female researcher was a 'subversion of the norm' in relation to a 'conventional' Caucasian image of a researcher, but I was unable align myself to Marshall's warnings and I was unwilling to share the burden of inferiority that she had experienced, as again these concerns were not in parallel with my worldview (which some might call naïve, or at least the issue is retained at the back of my mind).

My experience of being black is my only experience: I have no experience of being another colour. However, my experience, like most women's, has been unique to me. I was brought up in a Fenland market town, the only black person in that town and one of eight black people in the county. My experiences have often been defined by being the 'first' or the 'only'. I was the first black female prefect in my school; the first black person to win a prize at my school and the only black nursing sister in a north London hospital. I think the diversity of black women is as broad as being a woman – each

³ bell hooks presents her name in all lower case characters and this is replicated here.

woman has their own unique experience and perspective on life. Whilst Marshall (op cit) warned about the uneasy reception I should expect to receive from research participants, this was not a concern that was foremost for me. I would be in denial if I said that I did not experience periodic covert racism - I do, but I did not expect my skin colour to affect my research. I met many participants, all of whom were welcoming and none of whom appeared to be aghast or uncomfortable that a black woman should be conducting research.

In particular, I was interested to draw from aspects of Oakley's experience of minimisation of the researcher and participant gap. I drew from Code's (1991) contributions and her insight into the position of nursing and her observations of how female knowledge is perceived as lower in value compared to male knowledge; Code's tenet would help to consider the position of nursing leadership.

Celia Davis's (1995) work on the perpetual changes within the profession and nursing's gendered position bear relation to this study. It is possible that this study, in a small way, may be a development beyond Davis's work. Together, aspects of these theorists' work have contributed to my approach as a researcher leading this study. Whilst these theorists may not share my skin colour, I have concluded that all women have varied life experiences and perspectives, all of which are valuable, few of which are entirely shared or homogeneously experienced. This process of self positioning and brief period of introspection has helped me to augment a clear approach towards my interaction with the research methods and the participants and has helped me to recognise how my experiences may have impacted on the study.

3.10 Transferability and thick description

The transferability of a study's findings can be determined by the manner in which the data is included in within the research report or submission (Lincoln and Guba 1985).

Thick description allows for full accounts of the case study context, the use of research methods and examples of raw data within the final report to enable readers to consider how they might apply or replicate a similar study (Dawson 2009). Thick description can also capture the 'mood' of a research setting and enliven the study by the inclusion of participants contributions (Koch 1994). The transferability of case study findings has been a debated issue as has been regarded as a flaw within the methodology, primarily because case study research focuses on the particular, (Yin 2009). It is suggested that 'thick description' should be included within the study to increase the likelihood of transferability of the findings being applied to other similar settings.

Within this study, a full description of the methodology and methods used is evident. The study will also include significant and full text transcripts to allow the voices of the participants to emerge. In this way, the context and essence of the study should remain transparent and increase the likelihood of its transferability.

3.11 Sampling

Roberts Stake's (1995) advice on sampling is focussed on the case selection and states that the chosen case should be selected because of its uniqueness or typicality. There is no advice on participant sampling (op cit). There is more extensive guidance from Yin (2009), but this is focussed on multiple case selection and again does not address participant sampling. This section will address the sampling processes for the various participants: senior sisters, modern matrons, patient and national policy leads. I have sought advice from other qualitative method texts to provide direction and a sampling framework for this study.

The nature of the research questions required participants who had the appropriate knowledge and experience of nursing policy, being modern matrons who had nursed at the research site. Therefore, the sampling approach for all the participants was purposeful,

whereby the participants were intentionally selected for the needs of the study (Coyne 1997; Creswell 2007). However, once the cohort groups had been identified, the method of recruitment was of course self-selecting. In total, sixteen participants contributed to the study. In addition, the set of archives with their rich data spanned continuously on a monthly basis from 1948 – 1966. The inclusion criteria are outlined in figure 3.6.

3.12 Interviews

It has been advocated that interviews are an essential source of case study evidence (Yin 2009), as they provide an important insight into events (Noy 2009) and are the main conduit for gathering a range of perspectives in case study research (Stake 1995). The principal rationale for interviewing participants, according to Stake (1995), is to obtain descriptions and interpretations from others who would have been involved in or experienced an event on which the research is focussed. Kvale (1996) describes the interview as knowledge that evolves as a consequence of dialogue.

I was keen to ensure that the interviews were as natural or as conversational as possible (Cotterill 1992; Reinharz 1992; Rubin and Rubin 2005), and to use that time as an information sharing opportunity, whilst developing a reciprocal dialogue; although this was the aspiration, I believe it takes longer than the allocated sixty minutes to develop a sense of trust and sharing.

Table 3.7 Data set

Group	Sampling	Inclusion criteria	Recruitment process	Number recruited	Who was recruited
national policy leads	purposeful sampling of key national policy leads who would be able to respond to question 3.	direct involvement with the shaping and delivery of the national policy to have modern matrons	direct telephone and email communication to the potential participant or their team	2	<ul style="list-style-type: none"> Andrew – a parliamentarian whose previous portfolios included health Carolyn – a senior civil servant with previous responsibility for health
modern matrons	purposeful sampling of modern matrons within the bounds of the case	modern matrons who were responsible for adult areas	presentation to all modern matrons followed up with two email reminders	6	<ul style="list-style-type: none"> Tina – over 30 years of nursing knowledge - specialist units and community outreach Victoria – over 25 years of nursing knowledge – specialist units Penny – with 25 years of nursing knowledge – wards Heather – with over 30 years of nursing knowledge - emergency John – with over 40 years of nursing knowledge - wards Kerry – with 21 years of nursing knowledge – critical care
senior sisters	purposeful sampling to gain their views on the impact of the modern matron on the quality of nursing care.	senior sisters or charge nurses who had been in post in adult areas for six months or more.	email to all senior sisters and senior charge nurses	5	<ul style="list-style-type: none"> Catherine – had responsibility for a short stay unit Heather - had responsibility for an acute medical ward Beverley - had responsibility for an acute medical ward Nicola – had responsibility for an emergency area
patients and carer (sub-set)	purposeful sampling of patients who had received in-patient care within the bounds of the case	patients who had had an in-patient spell within the research site during the last six months. Had capacity to consent	posters and leaflets displayed and distributed in out-patients	3	<ul style="list-style-type: none"> Peter – Peter had recent admissions to the surgical wards Jim and June – June had been admitted to a surgical ward Alice – Alice had had frequent admissions and was preparing for surgical admission
traditional matron archives	purposeful sample of archives from 1945 – 1966	The archives belonged to a hospital which was a predecessor to the research site	purposeful	1	<ul style="list-style-type: none"> The archives are from a fifty-bed infectious diseases hospital which served a proportion of the county. The hospital had one matron. The hospital received and repatriated patients because of the specialist care it provided. The hospital was not a nurse training site, but it did accommodate nurse probationers.

3.12.1 Interview questions

Yin (2009) advised that interviews should be ‘guided conversations’ (pp 106) as opposed to structured queries, which contradicts his later assertion that interviews can be structured (pp108). I had learned from undertaking mock interviews that approaching future interviews with a structured design would not be helpful to me or the participants, as the rigidity inhibits the conversation flow. A topic guide was used to provide some structure (appendix 4). Because the time that I had with the interviewees was limited by research ethics constraints (sixty minutes) I had to ensure that an amenable and yet focussed style was employed, as the allocated time might not be fully utilised. I was aware within myself that I needed to have the verbal freedom to enable question design based on key words I had provided, which was in context with the tone and pace of the discussion at that time; any constriction in the manner in which I had to ask the questions would have resulted in hesitation and a sense of contrivement. The questions were broad and open-ended to encourage a natural approach and to allow participants to articulate their story.

The interviews were organised around a critical core set of key themes, which were raised within all participants. However, this structure allowed for flexibility in order to respond to issues raised by participants. Probes therefore were responsive to the participants’ own issues. For example, one patient participant was concerned about the absence of the modern matron and how her presence may have reduced her anxiety. It was important to remain with this line of conversation, as switching to an issue that I identified with as important may have suggested that I was not actively listening or lacked empathy.

3.13 Participant recruitment

Yin (2009) and Stake (2005) did not offer guidance about how to recruit participants for a case study and therefore I have drawn from alternative qualitative sources as guidance to ensure effective recruitment of participants.

Effective recruitment was essential to the study (Broyles, Rodriguez et al. 2011). Noy (2009) likens recruitment to selling: being careful not to oversell whilst correctly describing the product; the manner in which participants are recruited could impact on further recruitment and affect the researcher's reputation. The recruitment 'pitch' should achieve a fine balance between ensuring that potential participants feel needed but not pressurised. Whilst each participant was provided with full information regarding the research, overloading participants with too much information or exploring every risk and possibility might have had the undesired effect of limiting recruitment (op cit). I had provided my contact details on the recruitment literature to enable potential participants to speak to me regarding the research and I would have responded to their queries. Once people had indicated that they were interested in the research, I conveyed my gratitude to them for offering to help me (Noy 2009).

I considered at what times of the year would be most suitable to speak to each participant cohort to maximise recruitment and convenience. I anticipated that trying to arrange an interview with any clinical staff during October to May, the 'winter pressures' period, would be difficult to achieve and might not be welcomed by potential participants: therefore, clinical staff were accessed during the summer months.

3.13.1 Modern matron recruitment

The modern matrons were given a presentation about the research at one of their regular meetings, which was accompanied by an invitation to contribute to the study (appendix 5,

6); following this, I sent an email to all the modern matrons inviting them to participate (appendix 8). Six modern matrons responded and five subsequently contributed to the study; one declined at the last minute due to child-care problems.

3.13.2 National policy leader recruitment

One of the national policy leads held a Parliamentary position and so trying to recruit that person for an interview during Parliamentary recess periods would have been futile, as most Parliamentarians base themselves at home during that time. Although this person would have been busy when Parliament was in session, it was the prime opportunity for such an interview.

3.13.3 Patient recruitment

The recruitment of patients to the study was more challenging than I had anticipated. I had proposed and had agreed at the ethics and research governance committees that I could recruit participants from outpatients department waiting areas. I had felt that this setting, being less stressful when compared with in-patient areas, would be better suited for patients to read information about the study and consider their involvement.

The NRES approved A4 posters were designed and erected in the outpatients departments, with brief information about the study with an invitation for potential participants to contact me (appendix 7). Unfortunately, the posters were competing with a wealth of other information and so their intended impact was diminished and no patients responded. I visited the departments to ensure that my posters were centrally located and that there were sufficient supplies of the research leaflet; however, despite my efforts, the numbers of patients finally recruited were less than I had anticipated. Two patients and one carer later agreed to participate.

3.13.4 Focus group recruitment

The criteria for recruitment (Table 3.6) excluded senior sisters who had been in post for less than six months. This component of the exclusion criteria was included because drawing from my own experience of being a senior sister and working with senior sisters, it can take approximately six months for a new post holder in such a key role to become accustomed to it. However, in retrospect, a new senior sister or charge nurse may have had a fresh perspective on the modern matron role and contributed a different dynamic to the focus group.

The email method of inviting modern matrons was effective and so I used the same approach for the senior sisters. Contained within the email was an invitation to contribute to the research and a summary of the study, my role and what would be required of the participants (appendix 8). I did not receive an immediate response to the recruitment email until I sent a reminder two weeks later. Five senior sisters attended the group; one declined on the day.

Kreuger and Casey (2000) suggest giving participants a two-week notice period to convene the focus group, which would have been inappropriate in this scenario. Taking into consideration roster parameters of senior sisters (Broyles, Rodriguez et al. 2011), I arranged the focus group for ten weeks in advance during the middle of a week, as clinical activity has a tendency to increase on Mondays and Fridays. Allowing a ten-week gap may seem excessive, but the trust used an electronic rostering system, which imposed timescales for future roster submissions. Accessing the senior sisters at weekends or bank holidays would not have been productive, as most senior sisters do not work at this time due to financial constraints.

3.13.5 Participant numbers

The numbers of patients and senior sisters recruited to the study was lower than I had anticipated. I will outline the possible reasons for this below. There was a pool of approximately fifty senior sisters from which to recruit, from which five subsequently participated. However, I deliberately focussed the study on adult care. This approach narrowed the opportunities for recruiting sisters, as a proportion of that cohort would have worked in paediatric settings. Those senior sisters who were new in their post were also not encouraged to attend because they may not have had time to reflect on their own role and the impact of the modern matron from their new perspective.

The workload and pace of activity in acute settings was immense and it may have been very difficult for senior sisters to find or create time to attend. In some areas, such as accident and emergency, there was a requirement for a sister or charge nurse to be present for the whole shift and this may have restricted recruitment from that area.

The senior sisters may have questioned the value of the research, in terms of its immediate benefits for them. It is rare that any research has any immediate value for the participants, and if there was no obvious benefit, then this factor may have deterred participation. For some people, offering to participate in research is done as demonstration of altruism (Clark 2010). I relied on email recruitment rather than attending the various directorate level senior sisters' meetings, whereby personal contact and effort on my part may have encouraged more participants, but this strategy was not fully considered due to time constraints.

The research site was not saturated with primary researchers at doctorate level - I was one of two for nursing - and so I had hoped that potential participants would have been more enthusiastic and ready to engage. The lack of involvement in primary research may have

instilled a sense of unease in potential participants if it was a process with which they were unfamiliar. Similarly, had the site been awash with nurse researchers, the same low response may have been evident.

Had this research been disease or condition focussed, then I would have had a valid reason to approach self-help and charity groups focussed on specific diseases or conditions. On reflection, there was no barrier to me approaching, for example, respiratory or diabetes groups, but I was concerned that potential participants would have been more likely to engage with research that would have a direct impact on symptom alleviation as opposed to wider nursing policy. However, accessing such groups, may have given me ready access to people who frequent in-patient services at the research site.

Patients and the public are asked for their involvement and contributions on a frequent basis, whether it is for academic research or participation as a member of a foundation trust, or local government consultations, so requests for further participation may have been lost or ignored due to 'participation fatigue' (Broyles, Rodriguez et al. 2011).

3.13.6 Remuneration considerations

Financial inducements for research participants were not offered, primarily because the funds were unavailable; as an alternative, the patient participants were each given a modest gift after the interview and were also sent a thank-you letter. NHS staff participants were sent a thank-you letter and were provided with refreshments during the focus group. The national policy leads were given a modest gift and a thank-you letter.

3.14 Interviewing modern matrons

To understand what contribution modern matrons had made to improvements to the quality of nursing care, it was necessary to interview this group. Following a presentation

of the research plan to the modern matrons inviting them to participate, none responded; a further two email reminders resulted in six modern matrons responding and attending the interview.

At the start of the interview I did advise along with the consent and ethics statement that:

I am keen to learn from you and although we had the same job role, everyone's perspective is different, so please don't assume that I know, because I may not ...

I felt it was important to state this, as important aspects of their work life may have been overlooked or presumed to be not important to a fellow nurse. Because of the professional connection, relaxed informal discussions occurred prior to the interviews commencing (Garton and Copland 2010).

The interviews were guided by a thematic topic guide, (appendix 4) thus providing a steer to the modern matrons but curtailing me imposing my worldview on them. This themed approach to the interviews allowed the modern matrons to add and extend upon any other points that were relevant to them and provided them with the opportunity to provide depth and clarity (Rubin and Rubin 2005).

Rather than conducting individual interviews, I could have arranged a focus group with the modern matrons. A focus group setting for modern matrons may have been quite restrictive for them, as they may not have been able to say all that they needed to say within a constrained time frame (Kreueger and Casey 2000). I also considered that because of the modern matrons' seniority, they would be more likely to be sufficiently confident to engage in an interview and be able to articulate their thoughts without the support of peers. Planning a focus group for modern matrons would have been a logistical challenge; at this level staff have full and dynamic diaries and trying to identify a

mutually agreeable date and time for a focus group would probably have proved insurmountable and could have negatively impacted on recruitment levels.

I chose a dictation style cassette recorder to capture the interview; I understood this to be one of the best methods, as I had used it during the doctoral programme and recording the interview ensured that I was fully engaged with the participant (Rubin and Rubin 2005) and could use my communication skills of active listening, summarisation and asking a probe question at the appropriate moment (Kvale 1996).

3.14.1 Thematic topic guide

I wanted to know where the modern matrons had seen improvements in care in line with the ten key roles for modern matrons. I also needed to ascertain the modern matrons' perspective on the historical aspect of the matron role and the change from the senior nurse role to the modern matron, particularly if they had been in post at that time. The thematic topic guide is outlined in (appendix 4). The following research question was set:

From the perspective of health professionals, what impact has the modern matron had on the quality of patient care?

From this question I needed to find out from the modern matrons what aspects of care had improved since the role had been part of the nursing hierarchy. Quite often, the modern matrons would offer in-depth information or describe scenarios and subsequent consequences without the requirement for me to interject with a probe question. However, I did gently interject if I felt the participant needed to be guided back onto the research subject. The level of explicitness from the participants in some of the interviews may not have occurred had I not been a fellow nurse.

3.15 Listening to patients

Obtaining the views of patients is a valuable component of this research study, as identified in the literature review, as patients had not been included in other matron research. In section 3.10.5, I described the challenges and process for the recruitment of patients. In addition to being recipients of care, patients are observers of clinical practice and if sufficiently well, take time to informally reflect and analyse interactions with healthcare. Koch (1998) suggests that story telling can make nursing practice visible and can be a powerful vehicle for communication as well as being a familiar method to most people. This approach has its sceptics (Thorne 2009), because of the risk of dramatisation, but this is a risk that could be encountered in many human interactions. The patients all had chronic and acute illnesses; some were awaiting further treatment and all were familiar with the research site. I did not ask the patients or any of the participants for their demographic details, because this was a qualitative study: thus the participants' age and ethnic background were not fundamental to this study, unlike their experience and knowledge. I was not counting the patients, the recruitment of participants was not age group or social class dependent (Morse 2008). The reason for the recruitment was to hear the participants' experiences of their encounters with modern matrons.

The patients were happy for me to interview them in their own homes apart from one patient who wanted to be interviewed in a café close to where she lived. I wanted the patients to share with me their experience of encountering a modern matron during a recent admission.

Rather than ask the patients to tell me about when they encountered a modern matron, I asked them:

Tell me about your story and when you met or came across a modern matron

If people have a story to tell, they often prefer to start at the beginning, to set the scene and outline the context (Thorne 2009). If I had asked the patients to describe their encounter with a modern matron as the first question, it is probable that they would want to describe what brought them to hospital and then about the modern matron – that is the nature of story telling.

I had the impression from the patients and carer that they were telling me things that needed to be rectified; I resisted saying that I would not be able to do that, instead I actively listened and empathised and suggested that they could speak to someone who could help them at the Patient Advice and Liaison service which was located in the trust.

3.16 The focus group

The decision to use a focus group as a method was not taken as an easy option for data generation as suggested by some (Reed and Payton Roskell 1997; Al-Hadman and Anthony 2010), but principally to ensure that the senior sisters invited to the group were able to participate in and generate interaction. I had previous experience of working with senior sisters and I thought they would appreciate being in a group, thus reducing possible feelings of vulnerability (Patton 2002), particularly when discussing a relatively sensitive issue of their direct line managers, the modern matrons. As a method, focus groups, if diligently planned, can elicit rich data (Asbury 1995; Lane, McKenna et al. 2001; Lehoux, Poland et al. 2006) and are favoured for capturing everyday conversation with people of diverse perspectives (Redmond and Curtis 2009). The method would hopefully contribute to new dimensions of understanding (Powell and Single 1996) of the modern matron role from the worldview of the senior sisters.

3.16.1 Topic guide

A key component of a focus group is the topic guide, so it is surprising that some texts appear to omit this aspect of focus group preparation (Millar, Maggs et al. 1996; Powell and Single 1996; Parahoo 2007). The questions for the focus group were drawn from the interviews and gaps in knowledge that had transpired from the modern matron interviews and the literature review. I formulated short phrases as prompts:

- impact on care quality
- difference – senior nurse and modern matron
- senior sisters and care quality
- patients' recognition of sister
- impact of modern matron on sister role
- matrons doing what they set out to do
- an outline of a typical day
- the matrons influence on the ward environment
- barriers matrons may have encountered during their working day
- the decision about returning the matron to the health service

This list enabled me to ask questions in an appropriate manner according to the mood of the group and prevented me from reading out a scripted question, which may have sounded stilted; thus, the questions aided the discussion and allowed for natural progression and a conversational style (Ruff, Alexander et al. 2005).

3.16.2 Group size

I had decided that a group larger than eight participants may have been difficult for me to facilitate, as found by McLafferty (2004). There is wide-ranging and sometimes conflicting advice on the perfect group size (Morgan 1996; Wilkinson 2004; Barbour 2007; Redmond and Curtis 2009), which is often dependent on participant availability and researcher confidence in conducting focus groups. Kreuger and Casey (2000)

advocate the use of small groups if the participants are particularly knowledgeable, and so my plans to have a smaller group to match my facilitation skills was on that occasion, according to them, appropriate.

3.16.3 Group duration

I was restricted by NHS ethics and governance best practice to only having interviews and focus groups which would not exceed sixty minutes, thus ensuring that vital clinical staff were not removed from their duties for excessive periods. Whilst this restriction was understandable, conducting a focus group within a one-hour timeframe was challenging. Most researchers advocate 90 – 120 minutes (Ressel, Gualda et al. 2002; Lehoux, Poland et al. 2006).

3.16.4 The participants

The senior sisters had between five and ten years' experience in their roles at that trust. They worked in a range of clinical settings: emergency, medicine, surgery and elderly care. Because the senior sisters were longstanding employees, they were also familiar with their peers in attendance at the group and so participated in some lively pre-discussion and banter before the focus group began (Powell and Single 1996).

Kreuger and Casey (2000) and Hofmeyer (2007) warned against having homogenous groups, which would be difficult to avoid if the study is focussed on particular staff groups within a single organisation. The senior sisters all worked at the same grade but there were subtle differences in their workload, knowledge and worldview, and it was these different views that formed the basis of their discussion.

3.16.5 Facilitating the group

There was a good level of interaction between the participants: every participant spoke without my need for intervention. The level of interactivity could have been attributed in part to my communication style, thus allowing the participants to speak without feeling inhibited (Asbury 1995; Powell and Single 1996; Lehoux, Poland et al. 2006), but may have been predominately due to their working relationships. To balance the conversation, there were periods of brief silence to allow for content assimilation and reflection; skilled communicators such as nurses would be expected to be comfortable with moments of silence.

The group had one dominant participant who was particularly garrulous. I sat opposite her in the semi-circle formation. Although she was dominant, the other participants were able to effectively interject without my involvement (Lehoux, Poland et al. 2006), possibly due to the group's long working acquaintance, through which members had grown to tolerate each other. The level of toleration was perhaps an advantage of a group that had prior familiarisation.

3.17 Traditional matron archives

Case study methodology allows for the inclusion of archival data, providing an opportunity for additional depth and meaning (Yin 2009) and a physical connection to the past. The research sought the enlightenment traditional matron archives and academic sources. Data could have been gathered from people who may have been traditional matrons in the past or staff who worked closely with a traditional matron, but these recollections might have suffered because of distorted memory or been misguided because of their own location at that time. The research site was primarily chosen because of the ability to have long-term access to a set of matron diaries – monthly accounts of a

traditional matron's activities written in her own hand. These archives have contributed towards the unique nature of this study and are a major data source.

The trust's research governance committee approved the use of the archives (appendix 9). The archives occupied the first level of the hierarchy of primary documentary sources (McCulloch 2004) and thereby increases the level of validity and rigour to this data. The archives consisted of two large and heavy red and green leather-bound ledgers dating from 1945 to 1966. One of the ledgers had imprinted on the cover *Matron's diary*. The Matron's diary provides an account of hospital activity: staff sickness and recruitment, staffing establishment, expenditure, and summaries of communications between the traditional matron (I have called her Matron Jones) and other neighbouring matrons in nearby hospitals. It seems that the diary formed part of the administration of the hospital and was in fact a record of letters, file copies that were sent from Matron Jones to the hospital board.

The second diary was a diligent account of staff recruited and dismissed from the hospital, detailing a wealth of demographic data: qualifications, source country, references, clinical performance, demeanour, marital status and whether the domestic abode had a telephone.

It is presumed that the archives must have survived a number of moves from small local hospitals to the district general hospitals in parallel with ever-changing NHS structures. Because of the archives, the activities of the traditional matron at the hospital have not been obscured by waning memories or possibly taken to her grave, but instead the contribution that she made to the local health service were recorded, maintained and appreciated and form an important aspect of this research.

The wealth of data that these archives provided was slightly overwhelming and simultaneously seductive (Steedman 2001). The diaries encapsulated an important time in

the modern history of the United Kingdom: migration of staff from Germany as the war commenced, the end of World War II, continued food rationing, pupil nurses arriving from the Caribbean and the anticipation of the NHS.

Reviewing the archives was evocative; the level of connectivity from Matron Jones's written word to me as a fellow nurse was compelling. Reading her words and imagining her trying to rectify staffing levels, pay for repairs and report to the board was tangible.

The archives were an incredibly rich data source and unique component of this study; however, there is sage advice from historians and archaeologists to ensure that archives such as the matron diaries are not taken merely at face value (Scott 1990; McCulloch 2004). The traditional matron did not write the diaries for the purposes of a 21st century researcher, but as part of her daily work as a nurse leader (Scott 1990), and they therefore represent naturally occurring data. Although Matron Jones wrote the diaries, it is unlikely that she would have written for the record a full account of all the activities that she was aware of and involved in. It seems that the diaries may have been submitted to the hospital board each month for their approval. In a sense she was presenting her performance to the board. The archives do appear to be authentic and not copies. Although I am not an antiquarian, the style of writing and the language that Matron Jones used to describe staff - i.e. one nurse was referred to as 'coloured', a term no longer in use – suggest authenticity. The redolence of the diaries also signalled to me that the archives are over seventy years old. I had no doubt that the archives were genuine (Scott 1990) because the language used in some instances was quite nurse orientated, i.e. 'repatriation of patients': this phrase is still in current clinical parlance. The local hospitals that the traditional matron mentioned were all credible, so the archive's provenance from my perspective was not in doubt.

The archive extracts are re-created in the findings chapter to enable the reader to share a similar experience of reading typed or handwritten text; the prospect of using a modern

script would have been a departure from what was contained in the archives. Because the traditional matron used traditional cursive writing, this was quite difficult to decipher at times.

The archives were from an isolation or fever hospital. To provide some context of Matron Jones's working life, a background of fever hospitals in England is set out below.

3.17.1 Fever hospitals and fever nursing – a brief illustration

A study of fever hospitals and fever nursing in the United Kingdom (Currie 2005) will help to illustrate the context in which many matrons including Matron Jones may have worked.

Fever hospitals had been established under legislative frameworks of the late 19th century to protect public health and reduce mortality rates, which required each local authority to have its own fever hospital. In 1914 there were 755 fever hospitals in England and Wales. As each local authority differed in size, so too did the fever hospitals. Some facilities in London had hundreds of beds, whilst those in rural areas had an average of forty-one beds (Currie 2005). The hospital in which Matron Jones worked had thirty beds, which was later increased to fifty beds housed within seven blocks, although bed occupancy in fever hospitals was very variable and sometimes hospitals had no patients (Currie 2005; National Archives 2012).

Typically fever hospitals cared for patients with a range of diseases, including: typhoid, smallpox, diphtheria, salmonella, glandular fever, tuberculosis, mumps and rubella. Adults as well as children and babies were nursed in cubicles divided by walls and curtains (Currie 2005). Scrupulous and perpetual cleaning and sterilisation was the focus of nursing tasks. Staff movement was heavily restricted to reduce cross-infection (op cit).

Infection and disease were stigmatised because people were fearful of succumbing to illness and the aetiology was not at that time completely understood (Currie 2005). Fever nursing was perceived to occupy the lower or less glamorous end of the profession and this may have been because of the risk to personal health, which contributed to the difficulty of recruiting and retaining staff. Some nurses did contract infections and some did not survive (Currie 2005). The vivid accounts of former fever nurses within the study (ibid) describe hard and laborious work, in a strict regime, caring for patients whose outcome often resulted in death. Diligent and intense nursing care was often required, which involved close observation of patients for signs of respiratory distress and the monitoring and management of pyrexia. The participants described the poverty in which some patients resided, which led to their poor health, as witnessed by nurses if they were on ambulance duty, whereby they would be required to collect ill patients from their homes. Currie (2005) describes fever nursing as the forgotten branch of the profession, predominately because the fever section of the nursing register closed in 1967, as it was thought the need for fever nurses was no longer required, predominately because of pharmacological advancements.

3.18 Accessing national policy leads

Accessing national policy leads presents a challenge for researchers, as the powerful and numerous gatekeepers and resources at their disposal restrict and prevent their participation in research (Puwar 1997; Stephens 2007).

Two national policy leads were invited to be part of the research by letter, which was accompanied by a research information sheet. Neither participant contacted me for approximately six weeks after the letters were sent. I had expected such a delay and was not deterred by it. I appreciated the high volume of correspondence and requests that they received could cause a delay – patience is paramount (Harris, Kelly et al. 2008). I

followed up each letter with an email. Andrew, a Parliamentarian, emailed me and advised that I should 'call his people' to arrange a suitable time, which I did.

I telephoned Carolyn, a former senior civil servant with responsibility for health; she suggested that we conduct a telephone interview. I wanted to do a face-to-face interview, as telephone interviews do automatically introduce distance between the researcher and participants, which was, to an extent, incongruous with attempting to reduce the distance between the two parties. Although telephone interviews are time efficient and convenient (Stephens 2007), I rely on people's non-verbal cues in order to tailor my own communication (Rubin and Rubin 2005; Harris, Kelly et al. 2008). I gently declined the telephone interview and suggested that I would arrange a meeting room in a convenient location for her, which was agreed.

At his suggestion Andrew was interviewed in the Houses of Parliament tea room. I was concerned as to whether my modest recording equipment would be able to detect our voices amid the constant hubbub. He advised that he would only be with me for forty minutes and not the previously agreed sixty minutes; I swiftly set up my recording equipment and began. Because of the time pressure, it was necessary for me to 'cut the niceties' and just get on with the interview. I did feel quite uncomfortable about the revised and swift pace of the interview. Although he was time pressured, he seemed quite relaxed. The interview ended after forty-five minutes when an intern came to retrieve him. I thanked him for his time and because I had accelerated the level of conversation and he was, I think, familiar with articulating large amounts of data within limited time frames, the interview had naturally come to a conclusion. I had felt that I had taken a 'smash and grab' approach to this interview, but the timeframes afforded to the interview on that day were restricted.

I met Carolyn at the hired venue and she appeared to have an excellent recall about the events leading up to the decision-making and announcements about modern matrons

returning to the NHS. I was surprised by how much she could recall about the decisions and political context leading up to the announcement that modern matrons were to return to the leadership structure.

Patience is a virtue when working with high profile people with busy diaries and so securing an interview, which may be three months hence, should be deemed a success. My interview with Andrew was less relaxed than I had anticipated. Because of his time limitations I did feel that I was firing questions at him. However, his answers were full and detailed. For this interview I had no choice about the venue – he took control – levels of power were not equalised and could never have been because of his seniority. I did not feel able to suggest another venue.

Because of their job roles, these participants were familiar with being interviewed, probably by the media or responding to questions in Parliament and on occasion by researchers. Therefore the participants were good at answering the question that had been asked with considerable depth.

When compared with Puwar's (1997) experiences, I was privileged to have secured a modest amount of time on a one-to-one basis with both participants.

3.19 Transcription

I decided to transcribe the interviews and focus group myself. As a qualified typist, I can audio type at a good speed, and so one hour's interview took me eight hours to transcribe. The cost of transcription was an additional expense that I did not have funding for. I also wanted to prevent data loss and the delay prior to receiving the completed transcript, which would have incurred additional anxiety for me. The transcription process enabled me to familiarise myself with the transcripts and immerse myself in the data. I was careful to type what was actually said, not what I thought I heard. The interviews that

were conducted in public places were particularly difficult to transcribe and it would have been difficult for an external transcriber to ascertain the conversation threads. Although the process of transcription was time consuming, the data immersion did form the beginning of my data analysis.

3.20 Data analysis

Yin (2009) provided comprehensive guidance for the analysis of qualitative case study data. The most appropriate approach for this study according to Yin (2009) would be to review the data by using the study's propositions and questions to determine whether the questions have been answered; this process would involve constant comparison of whether the data responded to and addressed the propositions. Stake (1995) encouraged reading and re-reading the data and this will be done in conjunction with Yin's proposition-led approach. However, I have acknowledged that realistic evaluation will be employed in addition to a more traditional case study approach to illuminate data that is not always visible and to ensure progression beyond what seen (Pawson and Tilley 1997).



Yin (2009) advocated the employment of a general strategy: the key one for this study is the reliance on theoretical propositions or ensuring that the data analysis relates to the initial research questions. Yin also suggested that the data should be analysed through the detection of patterns or pattern matching - the detection of repeated coinciding patterns or occurrences. In wider qualitative contexts, pattern matching is a close relative of thematic analysis (Patton 2002). Stake (1995) outlines a more flexible approach and stresses the importance of reading and rereading and deep thinking to allow understanding to creep forward.

There was so much data that it required hours of revisiting by either reading and re-reading the transcripts or listening to the recordings. It became apparent that I was familiar with the data when, while reading a transcript, I could hear the participant's

voice in my head. During this stage I began to make notes or use highlighter pens on the transcripts – these were my initial thoughts and it was important that they were captured, as these thoughts then formed the basis of more sophisticated thought and interpretation. As familiarisation became deeper and the data as a whole began to form a mental picture within me, themes and patterns slowly began to emerge. Sometimes within the data, there was not apparently anything significant said for half a page of text, but there may have been a key word or a particular response to a question which was important or may have triggered a connection to data elsewhere in the study.

To provide order to the data, I designed data analysis tables. The tables were simple but provided a central location for text that had been identified to a particular theme. Relevant data was grouped together initially using in-vivo coding to ensure that the data analysis stayed as close as possible to the participants’ contributions. It is suggested that computers can be used to help with the development of tables, but for this study the principal tools were paper, pens and scissors and glue. An example of the data analysis table is provided in Table 3.8.

Table 3.8 Data analysis table

Public expectation of matron role				
Who	What was said	Emergent theme/code	Interpretation	How does this relate to the research questions?
MM3	If I'm working on a ward supporting them, they've said to me a few times the matron should never be doing that 	matrons being clinically involved to improve quality	being clinically involved, patients not expected to see a high level of matron involvement	direct intervention and support to improve quality 

The archival data obviously could not be subjected to cut and paste strategies and could not be photocopied, as the bright lights may have led to a hastened deterioration of the paper. However, frequent reading of the diaries and note making was undertaken. When

key text was required to be transferred to the data analyses tables, then a verbatim hand written account was provided. The synthesis and association became possible as the text could be manoeuvred and initial themes with one piece of text attributed to them were merged to create larger themes.

3.20.1 Manual versus electronic data analysis

Initially I had thought that data analysis could be conducted using electronic software and so I learned to use MAXqda©. MAXqda should have aided the process of importing transcripts, data aggregation, memos and extraction of data excerpts. The level of analysis I conducted using the software felt superficial and not the deep and messy experience that is often spoken of when analysing qualitative data (Dey 1993). I found that the use of the computer had distanced me from the data (Webb 1999), interrupted my thinking and denied me the opportunity to interact closely with the data. I am sure that I may not have learned the full functionality of the software but MAXqda may not have been the most appropriate choice of programme for my chosen process for analysis. I abandoned the electronic approach in favour of manual framework analysis. I was able to view and appreciate the data differently and I was able to physically move the data from one data analysis sheet to another and visualise and carefully consider 'fit'. The ability to touch and directly visualise all the data was fundamental to me really understanding the data. The manual method did improve my understanding of the data and the data feels more embedded within me. A deep understanding of the data was essential to be able to illuminate meaning and understanding for the nursing profession and policy makers (Ritchie and Spencer 1994; Rose and Webb 1998).

3.20.2 Working with archive data

As far as I was able, I needed to ‘enter the traditional matron’s world’ – a world which appeared slower and contained very little that I would relate to as technology in a post-war world and an office administration system which I did not recognise.

Reading the content from 1945 until 1966 was at times arduous: the traditional matron’s writing was in a cursive style using an ink pen. It seems it was only the traditional matron who wrote in the diaries and I was grateful that I did not have different styles of writing to decipher. After July 1948, it appears that the advent of the new National Health Service brought to this hospital a typewriter and so the content thereafter was clear and easier to understand.

As the temporary custodian of the archives I had responsibility to care for these artefacts of social and nursing history. I also had to wash my hands to ensure that they were grease free to minimise damage to the pages. To read the archives, I placed a pillow under the front cover as I turned the pages to support the fragile binding. I had to copy any extracts by hand in order to add them to the data analysis sheets. The pages could not be safely scanned or photocopied, as I was concerned about the fragility of the diaries’ spines and I was unsure whether the bright light would damage the paper.

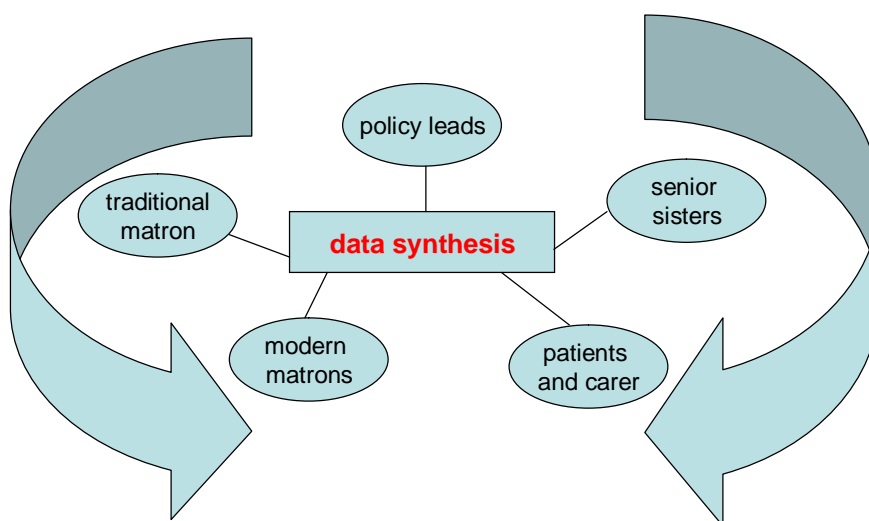
Unlike many researchers, my privileged encounter with the archives was not time limited. The Trust’s research governance committee agreed for me to access the archives, which were stored safely in a locked filing cabinet in my home for the duration of the research, thereby giving me exclusive access; this exclusivity should not be seen as a self indulgent act, as the archives were not originally on display and their existence was not widely known. When the archives are returned to the trust, I will suggest to the director of nursing that they could maybe benefit from being under the custody of the County Archaeologist to enable a wider audience and expert preservation of the diaries.

3.21 Data synthesis

A key element of a case study approach is the requirement to ensure effective data synthesis, or as it is termed by Yin ‘convergence’ (Yin 2009). For the purposes of this study I shall use the term ‘synthesis’ which means ‘putting together’ (The Chambers English Dictionary 2011).

Five sources of evidence were used for this study and Yin (2009) suggests that the researcher should enable all the data to come together or converge as illustrated in figure 3.9.

Figure 3.9 Data synthesis illustration



True convergence occurs when the data from each source is analysed together with all the sources and not separately. In this way, the richness of the data is drawn out and converging and disconfirming evidence is illuminated. All of the data was treated with equal importance and given deep consideration, however, not all of the data was included in the study because not all of the data was able to answer the study’s aims and questions (Yin 2009).

Stake (1985) proffered that data synthesis should not be rushed, but that reading and re-reading was a crucial element to fully consider all of the data. The process of synthesis was not all paper based, the majority of it was cerebral in that I needed to have an open mind and really listen to what the data was telling me and to be cautious not to leap to assumptions (Lincoln and Guba 1985). The data took many weeks to read and re-read, to think to listen and to ruminate upon what all the data was saying and then to construct meaningful relationships between all the data.

The process of synthesising the data was not necessarily to find all data that agreed, but also to acknowledge data that demonstrated inconsistencies or contradiction (Mathison 1998). The contradictions are a welcome and expected output of research that is designed to capture a variety of perspectives from different sources in relation to a single subject (Yin 2009).

Once some initial certainty about the pattern of the data began to emerge, the codes were committed to the data analysis table to provide some order. For example, from the data there was significant narrative relating to 'seeing or not seeing the modern matron' and 'the uniform of the modern matron'. These codes were then culminated into 'visibility of the modern matron'.

3.22 Conclusion

This chapter has outlined and critically appraised the chosen methodology and methods used within the study. The chapter has identified the research focus and methodology and provided assurances of rigour and trustworthiness. Also presented was the overarching philosophy or theoretical lens of realistic evaluation, which will help to provide meaning to the findings and subsequent discussion.

Secondly, the chapter critically explored the use of interviews and focus groups and the challenge of accessing national policy leads. The experience of working with archival data was described. The sampling and data analysis was critically appraised, which included self-criticism of my uncomfortable mistake of expecting a software programme to be able to conduct data analysis and provide the level of connectivity I required with the data. The chapter explored and acknowledged my own location as a researcher and concludes with data synthesis from which the main findings have emanated and outlined in the following chapter.

Chapter Four

Findings

4.1 Introduction

The major findings presented in this chapter will be structured in response to the study aims in three parts:

Part I Socio-political influences on nurse leadership's development

Part II Continuities between the traditional and modern matrons

Part III The impact of the modern matron on care quality

Part I will focus on the socio-political influences upon nurse leadership and the apparent tension between the modern matrons and general managers, the evident subservience and challenge that some traditional matrons encountered; the lack of visibility of the modern matron towards patients and the incongruence of the Department of Health's wish to have powerful modern matrons whose ability to be powerful was stymied within the same guidance document.

Comparisons and continuities between some traditional and the modern matrons studied will appear intermittently throughout this chapter and is afforded particular focus in Part II whereby continuities are most apparent with regard to clinical attire, raising and maintaining standards of care and the requirement to refocus nursing activity on the patient.

Part III identifies the key aspects upon which the modern matrons has impacted on care quality and the accompanying challenges to achieving that aim which include supporting senior sisters to deliver good quality care, increasing the number of modern matrons to

address infection rates and the apparent tension between modern matrons and their operational management and nursing roles.

Drawing from realistic evaluation, contexts, mechanisms and outcomes emanating from the findings will be identified. The next section will set out the findings which respond to the socio-political influences on modern matrons and the intermittent comparison of those findings with the traditional matron's work life.

Part I Socio-political influences on nurse leadership's development

4.2 The political decision making behind the modern matron

The literature review addressed the formation of the modern matron role from the Department of Health led consultations during the formation of the NHS Plan (Department of Health 2000). The Health Service Circular for 4 April 2001 (Department of Health 2001a) described the public-facing rationale for the necessity for the modern matrons' inclusion into NHS nursing hierarchies; Andrew described from his policy perspective and context why he wanted to ensure that matrons returned to the wards:

Andrew *So you see, coming back to why we did it, you see it is really a feeling
policy that alongside the clinical responsibility of doctors, the people around
lead which quality of care revolves is the nurse, everything really depends on
 their leadership, their authority, the profession itself is incapable of
 collectively doing that, and so that was our attempt to*

AB *Bring the profession together?*

Andrew *No, we didn't think about that: 'for God's sake get out there and start
 bossing the place about and get on with it', that's what it was about!*

Andrew stated that there was a strong political motivation for nurses to firmly take the lead in care delivery and raised an issue regarding the nursing profession's incapability: I think this can be interpreted from two perspectives. He may have meant that the profession at a national level was incapable of wholesale change because of the size and diversity of nursing. Recognising that nursing is located within the organisational substructure, his view could also suggest that the nursing profession lacks the ability to initiate the level of change that was required by the Department of Health. 'bossing the place about' has interesting connotations, as it evokes the Hattie Jaques (Thomas 1972) image of the matron in charge; it also appears to reflect a sentiment that at a basic level, the staff in the NHS rather simplistically needed a 'wake-up call'. The inference is that a crude approach to improving the quality of nursing care would suggest that the delivery of nursing practice is a simple, uncomplicated set of processes which can be cured by an outdated management style. My response to Andrew during the interview as to why I thought he wanted changes in nursing leadership at that time was *'to bring the profession together'*. My response was an unintended display of professional introspection, whereas it appears that Andrew was principally concerned with getting it right for patients.

Although not directly articulated, I sensed an element of frustration and urgency from Andrew for the nursing profession to take charge and refocus its efforts on patients:

Why on earth don't they sort it out? They just need to get on and roll their sleeves up and get it sorted – Andrew, national policy lead

Reference to rolling their sleeves up suggests a view that the problems the NHS was experiencing were located in a lack of initiative and willingness to 'get the job done' at ward level. There is evidence that the traditional matron rolled up her sleeves to provide continuity for the catering service, which presents opposing views about what it is that the modern matron should be focussed upon.

Carolyn, also a national policy lead, provided a more measured response to the rationale for modern matrons. Carolyn stated that the Department of Health was worried about the public's continued discontent with the Health Service and the damage this could inflict on the then forthcoming election.

AB *From your perspective, what was happening in the NHS before [modern] matrons came along, what was the context?*

Carolyn *I can remember the conversations, very well, very well. The conversations lasted a number of months before the final decision was made. The government had invested a lot of money, an awful lot of money into the Health Service, but ministers still couldn't understand why patients were still not happy with the service. Ministers would come to me and say, well the scores are better, the waiting times were down. I advised that patients were still not happy with the service and so there must be something about what the patient is experiencing that was colouring their view of the Health Service...In 2001, we were I think about to have an election. Ministers knew that if the public were still unhappy with the NHS prior to the election, even though there had been large-scale investment, the discontentment could be politically threatening. So the move to have matrons was politically motivated, but the move also had the patient at the heart of that decision.*

Although there had been a significant injection of financial resource to improve waiting times and general health service infrastructure, it seemed from what Carolyn said that patients wanted to see further improvements directly applied to nursing care. The Department of Health took active steps to garner the views of patients by way of surveys and consultations:

We did some questionnaire surveys, [a survey company] did them and there was an overwhelming response and just under half of the respondents said they wanted someone clearly in charge, someone like a matron. We didn't leave it there: we went further and had a round of discussions and focus groups with patients. The response from the public was that they wanted clean wards, they wanted patients to be fed, they wanted someone in charge and that that person should be a matron type figure – Carolyn, national policy lead

It was clear from the engagement exercises that the public wanted the fundamentals of nursing care to be addressed: good nutritional practice, cleanliness to be paramount and a clearly identified person to be in charge - someone 'matron-like'.

It is not unexpected that a political decision would be politically motivated, but it was reassuring to hear from Carolyn that the decision to change the approach to nursing leadership was predominantly grounded in patient feedback and that patients were, according to her, central to that decision-making process. It was compelling to learn that although nursing leadership continues to occupy an ambivalent and gendered position, nurse leadership became central to political stability and success. Conversely, it could also be argued that the ambivalent position of nurse leadership led to the manipulation of the profession, assuaging public anxieties to augment political success.

As discussed in the literature review, much of the discussion surrounding the modern matron role was the re-use of an old job title, which was juxtaposed with a national programme of modernisation. This led me to ask Carolyn about this:

AB *So where did the matron bit come from?*

Carolyn *I have to say I didn't really like the 'modern' bit, but a distinction needed to be made between the old fashioned, stern and autocratic matron and the new modern matron who needed to be a clinical expert and be supportive to her staff, and the use of the word 'modern' fell in line with the modernisation agenda at that time. Didn't someone say you can't take history with you?*

Carolyn's vision of the modern matron adopting a modern managerial and leadership style does not appear to be congruent with Andrew's, who wanted to see a more old fashioned and directive style. At policy lead level within the Department of Health, it appeared that there was lack of clarity regarding the approach the modern matron should take to improve the quality of patient care, but there was some agreement for the role to focus on meeting patients needs.

As reported by the Department of Health (2000) during the NHS Plan consultations, the public and patients had asked for a matron type figure and styling the role in this way would have suggested to patients that the Department of Health had actively listened to and acted upon their requests. During the last fifty years of nursing, a plethora of job titles have been employed, including 'matron', 'nursing officer', 'senior nurse', 'clinical nurse manager', 'senior nurse manager' and 'lead nurse'. The one definitive title of 'modern matron' possibly brought some clarity for patients to this level of nurse leadership across NHS trusts in England.

John, the modern matron who managed acute wards at the trust, questioned the use of the 'matron' title:

You cannot have a matron of today in yesterday's era. It does not work at all: the healthcare system is totally different - John, modern matron

It is possible from what patients were interpreted to have said during the Department of Health consultations that they had the same needs as patients did years before them despite the changes in the way that healthcare is currently provided. Nevertheless, a key finding suggested that the level of authority afforded to traditional and modern matrons may not have been adequate to deliver the aspirations of policy leaders and patients.

4.3 Sufficient authority

The Department of Health (2001) stated that the modern matron would have ‘sufficient authority’ to get things done and had tried to establish a new context for them to operate within. The role was positioned to appear non-threatening to existing managers within organisational structures was stymied because of mitigating this potential threat.

[the role] should not be seen as a threat to the responsibilities of middle and non-clinical managers (Department of Health 2001a) page 5, section 9

I explored authority and the modern matron with one of the national policy leads, Andrew:

You’re implying that we called them modern matrons and we really wanted traditional matrons. I’m guilty. I think that’s it exactly: we called them modern matrons to try and get the profession, erm moving forward, but what we really wanted to do was to reassert authority.

Andrew acknowledged that the policy shift or mechanism was to enable traditionally styled matrons to return to the wards in the guise of a modern matron. Andrew’s response was articulated with passion and endeavour and this was not evident in the final guidance, which may be a symptom of guidance development in large bureaucratic structures. The desire to instil a new level of asserted authority via the modern matron

role may have been undermined by the limitations of the role, as articulated in the guidance of sufficient authority.

The patients and carer interviewed perceived that the modern matron role in that trust should be powerful and be able to make things better. Peter, a patient participant, had been in hospital on two occasions for abdominal surgery. He shared with me his perspective on the modern matron role and described a situation that he had witnessed and had become involved in, seeking to silence a noisy door that had disrupted his sleep and that of his fellow patients:

Peter (patient) *I agree as you know, the matrons need to be used in the right area, they need to be there to kick estates when they don't perform and to point out how horrible it is for the patients and keeps them awake at night. It's that sort of thing where matron needs the authority to shift the resources outside the control of the senior staff nurse. She hasn't got the same authority that the matron has and so therefore, she is the person who helps enable the sister to run the wards. She needs to be able to come down on the support services like a ton of bricks to say that is simply not good enough. So that's what their role is.*

AB (researcher) *So that in turn makes our experience as a patient more comfortable?*

Peter *Well you're exactly right: I mean, the matron is the person who ensures that other units perform.*

AB *So would you see her as a conductor?*

Peter *No, definitely not. She is a manager and she's got the authority to get things done. There is that joined up working where if there are things not*

resolved, she needs to know who in which department is responsible. She is a key influencer to make things happen.

The strength and level of authority expected of a modern matron is clearly articulated. Peter raised a number of key aspects that require consideration. From Peter's viewpoint, the modern matron is expected to use authority and influence to ensure that the care environment is beneficial to patients. For instance, the modern matrons provided an example where they had to influence estate colleagues not to downgrade a relatives' room into a storeroom; the modern matron did not have direct authority, but instead had to influence estates managers and convince them of the importance of the room for relatives. The mechanism for the modern matron to have authority and to influence was limited by the contextual landscape, hence hindering the modern matron's ability to progress key initiatives.

The modern matron role is also seen by patients to be an enabler, by providing support to the senior sister. Peter recognised that the modern matron should be able to work across intra-organisational boundaries to streamline processes with the ultimate aim of improved care for patients. The modern matron, it seems, was expected by patients to fulfil a range of roles: nurse, manager, authoritarian, influencer and a direct interventionalist to get things done – a challenging portfolio of expectations. Although the modern matron role was meant to provide role clarity, the clarity was not entirely evident.

The next two corresponding archive extracts record that Matron Jones may not have had unilateral power and influence and was required to gain the permission of the hospital management committee prior to proceeding with an opportunity to improve the care of chronically ill patients, advance clinical practice and develop her staff in a London hospital:

The Hospital Management Committee Meeting 11th June 1954

To the Chairman and members of the Nursing Committee

The nursing situation is still most satisfactory, but unfortunately, we have only 13 patients on ward two and one scarlet fever case. Some of the non-residential staff have offered to go off the book for a week or two with the Committee's permission? I am sending two or three ward orderlies to [a nearby hospital] on night duty while care so slack. Last week Miss L took me to visit L Hospital where they specialise in geriatrics and I was amazed at the results they are getting from the would be chronic sick, average age 75, and feel that if we could do something on a small scale it would be a worthwhile job. Matron at L Hospital is quite prepared to take any of my staff willing to go for periods from 1-4 weeks, so that they get an insight into the care and treatment of those patients. Are the committee willing for me to do this in the quiet period?

Matron

The Hospital Management Committee Meeting 9th July 1954

To the Chairman and members of the Nursing Committee

On 29 June all the tuberculosis patients were transferred to other hospitals with the exception of three who are waiting on ward 5 for a vacancy at H Hospital. Two ward orderlies went to L Hospital on 5 July for special geriatric training, two will be going every fortnight until ward 2 is ready for patients

Matron

The record on 9 July 1954 demonstrates that permission was granted for Matron Jones to send staff as she had requested. Matron Jones also had to ask permission in terms of managing leave to enable her staff to 'go off book' or off duty during a period of reduced clinical activity. The archives and literature in Chapter Two suggest that most traditional

matrons worked in a triangulated fashion with the medical superintendent and the hospital management committee, whereas this traditional matron was required to report to the hospital committee in order to seek permission for repairs, purchases and workforce changes. There is no recorded evidence of refusal from the committee towards Matron Jones's requests, but it is probable that this matron had, over time, developed strategies for requesting items that had the greatest likelihood of approval. Depicted below is Matron Jones's request for a new food mixer for the hospital kitchen and for a garden fete for the staff in the hospital grounds, both of which were approved by the hospital management committee:

8th March 1947

Approved

Would the board consider the purchase of a Hobart mixer for the kitchen?

May staff have another Garden Fete in the grounds this year?

From the archives, it seemed that the management of estates and ancillary functions may have formed part of Matron Jones's portfolio as was the case for her contemporaries and predecessors (Editorial 1963; Lorentzon 1997).

The Department of Health in 2001 did not expect the modern matron to manage ancillary services, but instead to have a level of influence over them. It does seem that within the research site, the modern matrons were limited in their authority, as they were required to influence managers to improve such services as catering. Influencing others can take time and is dependent upon the recipient being receptive. The requirement for modern matrons to influence other managers may have encouraged them to retain their managerial attire to increase the level of perceived influence when compared with wearing a nursing uniform and this issue will be raised more fully in section 4.7 of this chapter.

The traditional and modern matrons' requests for repairs and purchases do appear to be a possible link with the historical roots of the role as the head housekeeper. Matron Jones's staff records do in part demonstrate a tangible link between that role and housekeeping with the attainment of housekeeping qualifications in addition to nursing knowledge:

Assistant Matron Muriel

State registered

Administration and housekeeping certificate

The introduction of the modern matron was followed by the recruitment of housekeepers in the trust and nationally to ensure that the wards maintained standards of cleanliness, and this was a mechanism to support the senior sisters in their roles and possibly demonstrates a nostalgic engagement of bygone clinical and domestic structures (Beeton 1861; Department of Health 2002c).

Patients and senior sisters who were interviewed identified that the modern matron should support the senior sister in her role to ensure that junior staff were equipped to deliver high standards of care (Department of Health 2001b) and maintain the focus on patient need.

4.4 Patient focus and political concern

The national policy leads referred to how nursing had somehow lost its direction and focus. Carolyn, one of the national policy leads, described from her perspective how the development of nursing as a profession may have unintentionally limited the profession's ability to wholly focus on meeting patients needs:

The profession had been focussing so hard on becoming a profession, it had lost sight of the needs of patients. The matron role was going to help refocus nursing on the patient and improve the wards, making sure that the wards were clean, free of infection, making sure that patients' needs were met and ensuring that nursing and hospitals were seen through the eyes of the patient - Carolyn, national policy lead

The findings suggest that as nursing developed, the focus of the nursing overtime may have inadvertently veered away from its core purpose – addressing the needs of patients. The two participants held convergent views on the profession's progression and the possible unintended impact on the profession:

the enrolled nurse qualifications, their phasing out, again it was all part of trying to professionalise the profession and of course the problem is the cumulative impact of all that has been seen to downgrade the authority of the nursing profession. I think the great irony of all those changes and that I also think the nursing profession itself was utterly confused about its own role and is in a much weaker position than it used to be, and the modern matron, for me, was an attempt by people like me to get the profession up again and I think the problem is that the profession itself is not up to it, not up to it. Andrew – national policy lead

The diversification and development of the nursing profession over the years may have contributed to Andrew's perception that the profession had weakened its position; however, his perspective could be due to many factors, but nevertheless is an interesting stance. The idea that the profession had in some way weakened and may have transpired because of its increasing diversification. Andrew appeared keen for nursing to re-stake its claim on the quality of patient care. From what he said, it appears that the nursing profession was unable to thrive or prosper without the support of political intervention; a

perception linked to the feminised nature of nursing in a male-orientated environment – a perception held by some about women. There have also been changes not just within the profession but also when the professional project was at its greatest momentum: the medical profession was rather keen to offload the tasks it no longer required to the nursing profession, under the guise of nurses being able to provide swifter care for patients when compared to doctors, which in turn may have resulted in nursing becoming less clearly defined (Dowling, Barrett et al. 1995; Jasper 2005). It must be noted that in most cases, the nursing profession embraced the additional roles and the acquisition of these roles as moving towards greater professionalisation (Salvage 1985).

Patients' dissatisfaction with nursing care in the late 20th and the early 21st centuries may have emanated from nursing leadership's aspiration towards management rather than having a direct focus on the quality of nursing care and the needs of patients. This detachment from nursing at senior nurse level may have resulted in a gap of highly knowledgeable clinically based nursing role models.

Part II Continuities between the traditional and modern matrons

4.5 Matrons – focussing on patients

The Department of Health consultation reported that the general public suggested a 'matron like' figure was required to address and rectify the wide ranging deficits in nursing care (Department of Health 2000). The Department of Health expected modern matrons to conduct regular walkabouts on the wards in order to be a senior presence and to monitor care quality. The role was established to be patient focussed, near to bedside, a key point of contact and a figurehead for patients and their relatives. The development of the modern matron role demonstrated that the Department of Health was responsive to public opinion. Although trusts were given freedoms on the implementation of the role,

there was no clear indication from the Department of Health that the modern matron should be operationally focussed (Department of Health 2001a).

John, who had been a modern matron since 2002, explained that the modern matron role from his perspective had changed during the last few years. He said that when the role was introduced, it was very much focussed on patients, quality and clinical care, but that it had moved towards a tick box exercise of audits and quality surveillance. John articulated that this development of the role was not wholly welcomed because although he was present on the ward, the opportunity to directly engage with patients was limited:

I think certainly there's much more value to be had by going round and speaking to patients and being involved with staff – John, modern matron

Speaking to patients as a sole intervention may not have improved care quality, but it was evident that John valued obtaining direct feedback from patients and staff and the interactions that he had had with patients may have provided them with a level of reassurance that a nurse high up in the nursing hierarchy was physically identifying deficits in care quality and then acting on them.

In contrast to the modern matron's concern with walking the wards, the archival data from Matron Jones did not make any direct reference in terms of the hospital board identifying the need for ward walkabouts or direct patient interaction. This may be because 'walking the wards' was an embedded and expected activity of Matron Jones and therefore was not reported. Conversely, Matron Jones may not have walked the wards very often as was the case of her professional predecessor (McGann 1992). In addition, she may have been prevented from walking the wards, as her hospital was solely for the purpose of infectious diseases, which may have restricted unnecessary staff movement (Currie 2005). Matron Jones was supported by an assistant matron, night manager and ward sisters, and so it may have been the case that she relied on the intelligence escalated

to her by her senior team (Castledine 2007). The image of a traditional matron walking the wards to assess quality and instil fear into her staff may have been generated as a result of anecdotal evidence and possibly media construction and influenced by nostalgia, from which the modern matron role has been partly derived.

Jim's wife, June was concerned about lack of cleanliness in relation to her bed linen during her hospital admission.

she did say that she didn't have her sheets changed once and she was in there for four days. Jim - carer

It may not have been feasible to expect a modern matron to be checking bed linen, but if a modern matron had conducted the Department of Health expected walkabouts, this action may have created the opportunity for direct conversations with patients and their families; concerns regarding cleanliness may then have been brought to the attention of a modern matron.

The modern matrons had identified occasions whereby they were able to positively impact upon the quality of patient care. On further discussion with John, he described a tangible improvement on a ward whereby all the patient call bells had been silenced; the lights indicating that a patient needed assistance were still operational, but the repetitive and audible note that should have accompanied the light had been silenced by the staff:

one good thing that's come about, although it's minor, is the call bells that all used to be off, though now on. Because again there was an issue with patients, because patients would call and the perception was that they were not being helped and not being responded to. John – modern matron

Call bells are a lifeline for patients, so it is notable that the former senior nurse managers had not identified the problem prior to the arrival of the modern matron role. The Department of Health's expectations of the modern matron role suggested a shift in perspective of senior nurses at this level and a change in mechanism, and provided a new lens through which nurse management was conducted, moving from a managerial to a nursing and patient focussed approach. John had said that the call bell issue was minor, but for patients, being without a call bell can instil anxiety, as calls for assistance cannot be amplified and acknowledged.

It is not entirely clear whether Matron Jones directly undertook activities similar to John but there is evidence that she requested repairs to hospital facilities:

Approved

9th August 1947

Will the board grant me permission to have Ward I laid with linoleum?

It is probable that Matron Jones was beginning to make progress with upgrading the fabric of her hospital building following the lack of non-essential maintenance that may have occurred during the Second World War.

Modern matrons were tasked with improving standards of cleanliness and infection control, as it was a principal concern of patients and the Department of Health. The modern matron participants had each expressed their role in addressing these concerns. One modern matron had explained what changes had occurred in her department to ensure that cleanliness and infection control was addressed not only daily but annually through 'deep cleaning'. Deep cleaning was a new threshold in cleaning and involved the full decant of a ward or a department to allow cleaners and maintenance staff to clean and repair. The process was quite disruptive, but the wholesale move out of a department highlighted where clutter had accumulated.

well we had to move one part of the department and moved the units around, it was a nightmare, but the place got absolutely scrubbed, we threw a lot of stuff out, although it was really hard work I think everyone said it was worthwhile. We've introduced weekly infection control audits, which were hand washing and care bundles for peripheral cannulas, urethral catheters, CVPs, there are others but they're not really, they don't come into this setting. Heather – modern matron

Although the modern matrons were responsible for the level of cleanliness within their respective departments, they did not, it seems, possess the authority to manage the cleaners, which suggests that the context for the revised mechanism to be enacted was not favourable. The modern matrons were responsible for cleaning standards in their areas, but had no direct line to manage the cleaners. The trust contracted cleaners and these were managed by a facilities manager. The contractual and managerial arrangement for the cleaners meant that the modern matron was left with no direct authority with regard to cleaning standards on the wards. The modern matrons were only able to influence the facilities manager to make amendments to cleaning schedules and identify where cleaning had fallen below contractual expectations.

The auditing of care mentioned by Heather is again apparent and links to the 'tick box' culture that was mentioned earlier by John. Alice did see a cleanliness inspection with domestic staff:

she [modern matron] was doing what looked like a cleanliness inspection with the domestic staff. Alice - patient

Unfortunately for Alice, she did not fully see or engage with a modern matron during her admissions, but she may have obtained assurance that the level of cleanliness was being

audited. Matron Jones made no mention of hospital cleanliness or auditing of cleaning activity in her diaries. The lack of dialogue about cleaning in the archives may have been due to the scrupulous cleaning processes that could have occurred because of necessity and the nature, custom and practice of tasks within nursing, particularly in fever nursing (Walsh and Ford 1989; Currie 2005). In addition, it seems that there was an establishment of staff to address the day to day cleanliness of the hospital. From what is known, some traditional matrons set tight parameters regarding practice expectations (Arden 2002; Castledine 2007), but this aspect of Matron Jones' activities was not apparent in her diary. Nursing's intolerance to uncleanliness may have been much lower compared to more recent decades because of the risk of more disease and the scarcity of preventative and curative pharmacology (Currie 2005). In addition to care quality and cleanliness, the modern matrons were also tasked to spend more time resolving problems and complaints for patients and relatives.

4.6 Resolving problems for patients and their relatives

To increase the quality of nursing care, the Department of Health expected the modern matron to resolve problems and respond to complaints received from patients and carers, as listening and engaging with complainants is an opportunity to raise the quality of service provision (Plymire 1991). Patients and carers can provide a valuable insight into hospital life and aspects of patient care which may need attention. All of the modern matrons at the trust were required to respond to formal and informal (written and verbal) complaints within their own directorate. Any complaint that contained references to any aspect of patient care would be directed towards the modern matron for that area. Typically, the modern matron would then investigate the complaint and seek further information from the department's sister or charge nurse: a process heavily bound by administration and strict timescales.

one of the key roles is to answer complaints and deal with that and a disproportionate amount of time is spending doing that probably Penny – modern matron

It is possible to conclude that the ‘disproportionate’ amount of time spent on complaints had a number of effects. There was inference from Penny that she felt she spent too much time responding to complainants and that she found this aspect of her role a necessary but relentless administrative duty and a contributory factor to her being desk-bound and distanced from the wards. I also noted that this tension between administration and being on the wards was a slight frustration for her. The Department of Health was keen to ensure that modern matrons were clinically present and engaged (Department of Health 2001a) but the modern matrons felt increasingly deskbound and complaints management contributed to this perspective.

It is commonly thought that lodging complaints is a modern phenomenon and not something that regularly occurred during the time that Matron Jones wrote her diaries. However, there is evidence in the archives that some patients had articulated dissatisfaction with their nursing care and by the inference of what Matron Jones wrote, it seemed that the patients had exceeded the limits of the expected passive role:

Catering Committee Meeting 12th April 1951 Matron’s report

To the Chairman and members of the Catering Committee

No further complaints have been made by the tuberculosis patients although they are still very difficult with their food.

Catering Committee Meeting 11th May 1951 Matron’s report

To the Chairman and members of the Catering Committee

Ward 2 are still occasionally difficult with their food but no official complaints have been made to me.

Catering Committee Meeting 12th October 1951 Matron's report

To the Chairman and members of the Catering Committee

Ward 2 patients are beginning to get disgruntled, but I think a good many of them have been there for far too long.

The October 1951 entry denotes a sense that Matron Jones is becoming irritated by the behaviour of the patients on Ward 2, particularly as their admissions appeared to be, from her perspective, prolonged. Patients' dissatisfaction with hospital food appears to have continued through to the present day and was a component of modern matrons' ten key roles - ensuring that patients received adequate nutrition. According to the diaries, Matron Jones and the modern matrons found this aspect of their role less than enjoyable and too time consuming.

Matron Jones referred to the tuberculosis patients, who often were in-patients for many months. The treatment at that time was quite simple, expansive in time and included copious quantities of fresh air (Currie 2005). It is rare within modern NHS secondary care sector that patients would be admitted for long durations.

Over the years and from what is known, a matron's response to complainants does not appear to have altered. Resolving and responding to complaints by the matron was seen by policy makers as a central tenet to improving care quality. Matron Jones, her contemporaries and the modern matron (Penny) appear to share a position whereby patient complaints and the administration continued to be a source of irritation for them both (Castledine 2007).

A fundamental aspect of the traditional and modern matron roles was to set and maintain standards of care by role modelling expectations a factor which was thought by the public and policy leads to be lacking in previous nurse leader job roles.

4.7 Lead by example

The modern matrons were expected to be good role models, thus ensuring that junior staff followed in their example of delivering and improving the quality of nursing care. It was anticipated that modern matrons should be strong leaders and be able to set and maintain high standards of care, while also being a key figure upon which patients could rely to ensure that the fundamentals of care were in place. The need for modern matrons to reconnect with the fundamentals of nursing following the demise of a uniformed nurse leader was most evident for those senior nurses at the trust whose roles were transformed into modern matrons. Victoria, a modern matron, had undergone role transformation and outlined her comparative perspective on the differences and opportunities between the senior nurse and modern matron roles within a changing context:

I think the change has enabled matrons to challenge practice in a more challenging way because there is an understanding from nurses that that's what matrons are there to do and they have every right to challenge – Victoria, modern matron

Victoria felt that being a modern matron gave her permission to challenge nursing practice. It seemed that Victoria was waiting for permission, which raises the gendered predicament (Davies 1995) in which nurse leadership has repeatedly found itself. The initial role clarity and structure that the modern matron role provided probably gave the modern matrons clear definition about the processes to improve the quality of nursing care. From a realistic evaluation perspective, the contextual factor of gender may have impacted on Victoria's passive approach.

The archives provided no account of Matron Jones challenging nursing practice, but it can be presumed from the overall content of the archives that the diary was not

maintained for the recording of challenges. However, the staff ledger, which was also manually maintained by Matron Jones, was a record of employees and contained evidence of her dissatisfaction with staff performance. This evidence suggested that there may have been a level of challenge from Matron Jones to her under-performing staff, which may have encouraged and contributed to these staff finding alternative employment:

Sister Maud State Enrolled Assistant Nurse

Commenced duty 1 September 1941 Left December 1949

Very good ward manager, but as she was not state registered was always coming up against the nurses. Had really been in this hospital too long and thought she could manage the place.

Staff Nurse Gertrude State Registered

Commenced duty 28th October 1942 Left 1 June 1943

Very good nurse, pleasant manners and kind to patients

Ward Orderly

Commenced duty 2 April 1947 Left 12 November 1947

A very poor worker, would never make a nurse

Staff Nurse and midwife

State Registered Nurse and State Certified Midwife

Commenced duty 11 July 1949 Left 5 September 1949

Very strange manner at times, did not get on with her fellow nurses and not always kind to her patients.

Matron Jones had defined two markers that she thought were integral to being a good nurse – kindness and teamwork. Matron Jones, without the benefit of a national policy, could be viewed as a local mechanism towards the improvement and maintenance of care quality at that time. Matron Jones has twice mentioned the level of kindness that nurses have displayed towards their patients. Being kind is clearly important and is a concept that is currently being revisited. It can be ascertained from the September 1949 entry above that Matron Jones did not find conflict that a nurse may cause within the nursing team to be palatable. Sister Maud, the state enrolled assistant nurse⁴, seemed to have stepped out of line, outside of her role boundary, by acting as if she was the manager. Knowing one's place and acting within the hierarchy also appeared to be a factor as to whether one was considered to be a good nurse.

From what is known, Matron Jones had appointed authority with her team to improve the quality of nursing care and maintain standards. There is a prevailing common perception that the traditional matron had full authority over all hospital activities. It is evidenced in the archives that Matron Jones had responsibility for workforce management, patient movement and general supplies; this authority was limited and not unilateral and was probably dependent upon the agreement of the hospital board.

Part I has demonstrated that from the findings, the impact of socio-political influences on shaping and to some degree limiting the ability for Matron Jones, some of her contemporaries and later successors in similar roles to fully operate at their optimum potential.

⁴ It was clearly documented in the archives that although she was an enrolled nurse, she held the post of Sister.

4.8 Matrons, uniform and visibility

4.8.1 The perspective of national policy leads

The Department of Health stipulated that modern matrons must wear a uniform to 'respond (Department of Health 2001b) to public perception', using the uniform as a mechanism to increase the modern matron's visibility and accessibility to staff and patients. It was unusual for the Department of Health to be directive about uniforms. My interview with Andrew, a national policy lead, progressed onto the modern matron uniform:

AB (researcher) *But when you look at the modern matron and you look at the picture, there she is with cuffs, a very traditional uniform, set in a context of modernisation.*

Andrew (policy lead) *that's how we wanted it*

AB *is that how you wanted it?*

Andrew *absolutely, I mean I must tell you that the uniform is something that I just don't understand what it is about a profession that they don't want to wear a uniform. Of course it's completely mad, why do nurses lack confidence, why do they want to be seen as managers in suits?*

Andrew was keen to have a traditionally styled modern matron, in uniform, with traditional values on the wards. Andrew expressed his bemusement about nurses' abandonment of uniform as soon as promotion took them beyond ward level. Andrew was keen to understand why nurses lacked confidence and the modern matron was his mechanism for improving confidence levels within the profession. Andrew may have

seen behaviours in the nursing profession that are a sign of nursing's secondary location within a gendered organisation, which would suggest a lack of confidence by those who are located in a female gendered role.

Andrew recalled his experience of working in the vicinity of traditional matrons. Although Andrew did not explicitly say that he expected modern matrons to follow their predecessors' frightening approach, it was gently inferred that those behaviours would help to raise the standard of nursing care:

In 1972 I think matrons were still there and they were seen to be very powerful people and they did very regular rounds in their uniform and they were frightening people and people were scared of them – Andrew, national policy lead

Although Andrew reported that the traditional matron was 'frightening and powerful', it is questionable whether this style of leadership and management would have helped to improve the quality of nursing care delivered to patients in the context of a contemporary NHS. In a modern organisation, the use of frightening and or powerful behaviours may not have been welcomed in an environment where holding people to account and influencing through others is preferred (Cook 2001). Cook (2001) advocates that nurse leaders are crucial to the success of patient care initiatives and that leaders should adopt influencing and empowering behaviours to enable others to improve the quality of nursing care. The NHS leadership quality framework sets out a preferred suite of personal qualities and attitudes, which does not advocate leaders to be frightening but instead to adopt a range of leadership styles that ensure that leaders work through and with others to effect change (Bolden, Wood et al. 2006). The traditional matron that Andrew recalls may have been 'powerful' in the ward, within her context, but this level of power may have been confined to areas that she directly managed and limited in the wider hospital structure. This is demonstrated by Matron Jones being required to seek permission from

the hospital board to instigate actions or purchases: purchase of a new food mixer, additional funds for Christmas, new linoleum and new uniforms for the senior sisters.

Carolyn, a national policy lead, articulated from her perspective the impact of the Griffiths reforms on the reduced visibility of nursing within hospital hierarchies and the disrobement of the uniform by nurses at senior nurse level:

The Griffiths reforms didn't really do a lot for nursing. Nurses had fallen down the hierarchy in the hospital and senior nurses were invisible, they were in suits. Many of the senior nurses were not clinically credible: their role was largely managerial and administrative. The idea of a matron was to have some managerial components to their role but they were to be a clinical presence on the wards and be clinically credible, the clinical expert. So to do that, they needed to be in uniform.

Carolyn described that the return of the modern matron and the requirement to be visible and clinically credible and maintain managerial duties was beneficial to nursing leadership. The visibility of nurses once outside of the ward arena seems to be a perpetual challenge. Moreover, returning nurses at a senior level to uniform made visible a connection with nursing practice and nursing staff.

4.8.2 The patient's perspective

Peter, a patient, saw two modern matrons during his two admissions; however, he did not say that he had spoken to a modern matron. Peter and I discussed the modern matron's uniform and visibility:

- AB *So when matron came back about 10 years ago and erm into the health service when the NHS plan came in, one of the key things is that matrons were visible*
- Peter (patient) *Well they certainly are in that colour uniform, I mean they could work at [a holiday camp] really*
- AB *Yeah, it is very bright, so you obviously saw them during your encounter*
- Peter *I saw two*
- AB *That's not bad. So would it have mattered if the two matrons you'd have seen were wearing suits?*
- Peter *Mmm, no not really, because if they didn't have the uniform, they wouldn't have that line with the staff, would they? They are like the admiral of the fleet, they are directly in line, if you break that continuity of appearance then they're not nursing staff anymore. These are people that have been there, done that, sorted all the problems to get to the position they're in, so they are the crème de la crème of the nursing staff, so they need to be aligned with the nursing people, not necessarily with the directors. Once they've got a suit on, they're out of nursing, you've broken free, you're at strategic level.*

Peter had recognised the brightly coloured uniform of the modern matron in the trust and in relation to the colour, mentioned two levels of occupation: holiday camp work and admiral of the fleet. This statement could suggest the uncertain or inter-changeability of the perception of the positioning of the modern matron role – a figure of fun or a role that commands. Peter almost applauds the most senior nurse as being the elite when in a clinical setting, but the same praise is not afforded if a nurse moves to a strategic level. In order for the modern matron to make changes across practice, there would have been a need for the role to be more strategic in nature (Jasper 2012). Peter's interpretation of a modern matron in uniform or in civilian dress was insightful and did to some extent correlate with the critical commentators of the managerial reforms of the 1980s:

The nurse manager who stops wearing a uniform and dons a smart suit becomes identified with managers and masculine images of organisational control.

(Owens and Glennerster 1990)

Peter could see that a modern matron or a nurse at that senior nurse level who does not wear a uniform has 'broken free' and achieved emancipation from their nursing colleagues in favour of a managerial title and attire. The level of connectivity and continuity of appearance between the nursing staff and the modern matron without a uniform may in the past have gradually diminished, hence the need for the modern matron to be present on the wards in uniform to reconnect with the nursing teams.

Matron Jones made no reference to her uniform although she did make a request to purchase new uniforms for the nursing staff.

Alice had had six admissions to the hospital in twelve months due to her chronic illness.

Alice said that she wasn't sure she had seen a modern matron during her admission:

I would really expect a matron to make herself visible and come round to see the patients, not every day, but just to check everything is all right. It would just give you that reassurance, not sure that's the right word mmm, presence, yes presence. I mean, you've got all your other nurses and sometimes you see a sister, but to see the one really in charge would be nice.

Despite frequent in-patient admissions, Alice's expectation of seeing and having a dialogue with a modern matron was not realised. There was acknowledgement of other nurses and sister on the ward, but not the ultimate nurse for Alice to see. She had clear expectations of what activities a modern matron should be engaged with in order to add

value to her hospital admission in terms of having a conversation and possibly providing feedback on her illness and the performance of the clinical staff. Alice felt that if the modern matron had created this opportunity for dialogue, then she would have benefited by being able to provide feedback to her regarding her own illness, the nursing staff and possibly the ward environment. Therefore, it seemed that patients might have valued direct and purposeful interaction as opposed to seeing a modern matron in the distance.

4.8.3 The modern matrons' perspective on their uniforms

Victoria subscribed to what the Department of Health was trying to achieve with the reintroduction of a uniform from a patient's perspective:

Patients love to see matrons in a distinctive uniform - Victoria, modern matron

It could be surmised that patients enjoy seeing members of nursing staff in uniform, as seeing this attire is an expectation of being hospital. All the modern matrons agreed that the uniform as a mechanism to increase their visibility and identifiability was a good idea. Without a uniform, John explained that he became invisible to others:

John matron *Uniform is an issue without a doubt. If I wear the uniform and I'm going down the corridor, people see me. If I wear my civvies people walk past me and don't even see me. So it's not me the person, it's the badge of honour, it's the uniform that they're seeing.... I've walked passed many people when I've been in civvies, I've had to tap them on the shoulder and say 'are you ignoring me?', whatever. When you're in the uniform, they see you from a distance and it attracts, ah matron, matron this matron that, so it does work.*

John's experience illustrated the Department of Health's aim to make the modern matron role physically visible by the wearing of clinical attire. John likened the modern matron uniform to a 'badge of honour' - a symbol of achievement and knowledge. Victoria, a modern matron, recounted the impact of the uniform when the modern matron roles were implemented at the trust:

As senior nurses, we were going around in our own clothes: there was no uniform. The new uniform gave you a sense of pride and ownership and I thought it was great; some people were horrified. To see a group of them is quite good as well because you think, they're matrons working together and it's really nice. The uniform stands out, it's instantly recognisable.

Victoria articulated a sense of unified strength and shared purpose with her colleagues that the modern matron uniform provided and recognised that the uniform gave instant acknowledgement of the modern matron role. The sense of pride that is articulated may have been associated with being proud of being a registered nurse, as opposed to physically obscuring the role under managerial attire. The instant recognition that was described by Victoria was not consistently reported by the patients. Victoria said that the new modern matrons were horrified about the thought of going back into uniform, as the perceived reversion may have been seen as a regressive step in their career trajectories; Victoria described that the lack of a uniform at senior nurse level may have contributed to little or no identity of nursing beyond ward level. The apparent lack of identity and credibility once senior nurses go beyond clinical confines was mentioned earlier by Victoria. 'Going around in their own clothes' gives the impression of informality and a lack of direction. Adopting the persona and attire of an archetypal male manager in a gendered organisation may have narrowed the gender gap and minimised the gendered predicament of nurse leadership.

The uniform did make the modern matrons visible and distinct. Many of the modern matrons were wearing their uniforms when I interviewed them. However, it is possible from what Kerry (modern matron) had said that there was an over-reliance on the uniform to provide visibility. To achieve the expected level of visibility, the modern matrons needed to wear their uniforms *and* ensure that they were physically present in the clinical areas. The frequency of visibility of the modern matron to patients and their families was raised during the patient interviews.

The uniform situation was further complicated because the modern matrons had two uniforms, one clinical and the other a suit.

we still the older senior nurse stroke matrons have probably still got two uniforms. I would probably say that they younger ones of today have probably got one. We always had a blue suit and shirt. – John, modern matron

The suit was worn for managerial occasions, attending meetings or days when clinical work was not scheduled. So the mechanism of the Department of Health introducing a uniform was met with a second uniform in the context of this trust.

Victoria, a modern matron, articulated the challenge of meeting patients' expectations whilst undertaking indirect clinical work in managerial attire. Victoria explained how difficult it was for her to maintain the balance of managerial desk-bound activity and managing the expectation of clinical visibility for patients, relatives and staff.

Patients like to see a matron on the shop floor. So now I get complaints from staff about not seeing the matron uniform all of the time, and it is really difficult, because actually, erm, you can't be in a clinical place all of the time when you're challenged with other work to do - Victoria, modern matron

Complaints about the lack of the modern matrons' clinical presence mostly came from patients and then some staff. The expectation that the modern matron would be ever present was high but generally perceived as being unmet. Conversely, when modern matrons were clinically engaged, the patients were again dissatisfied that a nurse of that level of seniority should be engaged in the fundamentals of care:

If I'm working on a ward supporting them [staff] clinically, oh they've [patients] said to me a few times, the matron should never be doing that, what are you doing emptying that bowl or you know or tidying that up. You know, I do explain that I have to stay clinically in touch and I'm just doing a couple of hours here because we're a bit short. - Penny, modern matron

Media and film images of the traditional matron (Thomas 1972) may have contributed to the premise for the modern matron to walk the wards and engage with patients. The directive for modern matrons to walk the wards, coupled with possible nostalgia, continued to impact on the modern matrons and their own and others' expectations that daily ward walks should occur (Department of Health 2001b).

4.8.4 The traditional matron

There is no record that Matron Jones engaged directly with any patients, probably due to the risks of cross infection (Currie 2005) or her style of management. It is understandable that conversations or patient identifiers were not recorded in her diary, probably for reasons of confidentiality. However, it appeared that she was aware of patients' progress and this information may have been escalated to her by her assistant matrons, sisters and night sisters. Matron Jones' hospital cared specifically for patients with infectious diseases but the management of infection was not progressing well for her contemporary colleagues. The Department of Health decided to recruit more modern matrons to help reduce healthcare acquired infections.

Part III The impact of the modern matron on care quality

4.9 Modern matrons empowering and supporting senior sisters

The Department of Health had mandated that modern matrons should support sisters and charge nurses to carry out their roles to enable them to deliver good quality nursing care (Department of Health 2001b). The modern matrons had variously expressed how they each supported their senior sisters and senior charge nurses. The modern matrons said that they held regular meetings with their sisters to enable a cascade of information and to solve problems; some modern matrons were closely managing sisters who were new to the role and others also attended wards regularly to check that the sisters had sufficient staff in relation to patient acuity and dependency. The modern matrons encouraged an open and communicative relationship with senior sisters to enable improvements in the quality of nursing care:

depending who's in charge of the wards, I might go back if there's issues the sisters want to raise with me about something or difficulties with sickness – Tina, modern matron

I mean, I like to think that I've got a very good relationship with the senior sisters and they think I hope they think the same way about me, erm, I mean it's empowering them to do, because I'm not here all the time - Heather, modern matron

I think it does give them that supporting arm without a doubt and I think that ward managers are actually pleased to have that supporting arm and I think that nowadays I know that different matrons will question whether it's appropriate for a ward manager to contact you for certain things. I personally would rather they

contact me, I don't care how silly or stupid they might feel it is to me, there's no such thing as a stupid question, if they wanted some advice that's the advice that I'm offering, if they choose not to listen to that advice that's entirely up to them –
John, modern matron

as a matron I support staff, I ensure that staff pay attention to detail and I use my peripheral vision to observe practice - Kerry, modern matron

The modern matrons reported using different management styles in order to support the senior sisters on the wards, some by covert observation, responding to queries and problem solving, all encompassed in productive and open working relationships with a shared focus of providing quality care for patients. This approach to working with senior sisters is quite modern and possibly emanates from the body of work on nursing leadership which suggests that transformative and enabling leadership styles are beneficial for empowering staff (Cook 2001; Murphy 2009). The modern leadership style displayed by modern matrons towards senior sisters is at odds with the expectations of patients and the Department of Health (Department of Health 2001b).

The senior sisters provided observational insight into the modern matron role from their position with regard to levels of support received from the role and the contribution the role may or may not have made to improve care quality. The senior sisters welcomed the support they received from the modern matrons, in the form of technical advice, support or endorsement. Beverley valued the modern matron's physical engagement:

I think that if they're on duty they should visit the wards every morning and we don't always get that – Beverley, senior sister

The senior sisters valued the presence of the modern matron and expressed the view that the role should conform with the expectation of being visible to both staff and patients on

a daily basis. When this did not transpire, there was a sense that the modern matron was not fully functioning.

John explained that the modern matron was required to support the senior sister because role had a reduced level of effectiveness or 'kudos' to get things done and the modern matron role supported the senior sister to get things done.

I don't think that the ward sister has the same kudos as what they used to have years ago so I feel that they are probably more disempowered much more these days, I'm not saying they can't get things done, it's the time to get things done or they feel that they're not being listened to - John, modern matron

Matron Jones had not recorded whether she had undertaken observation of clinical practice or how she supported her staff. Again, observation may have been an embedded role function and therefore did not warrant being reported, but from the archives, Matron Jones appeared to know how her nurses performed; whether this information was gleaned from direct observation or from reports received from her senior team is unknown. Matron Jones recorded her thoughts on each staff member within her employ:

Sister Alice

Commenced duty 2nd January 1941 Left 31 May 1946

Not a very good ward Sister was familiar with probationers. This was her first Sisters post she ought to improve with experience. She was a very nice girl and ought to do well, but could not nurse to a Sister responsibility.

Staff Nurse Margaret State Registered

Commenced duty 1st December 1944 Left 6 April 1945

Not at all suitable for the post of Staff Nurse. Very poor nurse and untidy in work and person, also very lazy.

Matron Jones's records reveal an apparent concern with the quality of her nursing staff and it appeared that she personally knew how each staff member was performing. However, the judgements are not fully evidenced, as they would be within a modern context; instead, her comments are located in general assertions about character and performance relating to manner and personality. In a modern setting, staff would more commonly be measured according to their competencies.

A key concern and a focus of discussion about modern matrons upon their introduction was the matron uniform, and the modern matrons and national policy leads were keen to share their thoughts and experiences on this aspect.

4.10 More modern matrons to reduce infection rates

As already noted, the modern matron was tasked with ten key roles to ensure ward cleanliness and control infection (Department of Health 2002c). Although the modern matrons had been in place for approximately six years at the trust, nationally, there remained much concern relating to healthcare acquired infections (Shuttleworth 2004; Department of Health 2007; Department of Health 2007; Department of Health 2007). During 2007 the new Prime Minister, Gordon Brown, instructed NHS trusts across England to increase the numbers of modern matrons to 5000 with the principal aim to reduce infection rates. The research site duly increased its modern matron cohort from

approximately twelve to thirty-two. All of the modern matrons who participated in the research were from the original cohort:

It was 2001 when they [modern matrons] actually got introduced and I think at that time we had something like eight, ten compared to today, I think we've got nearly forty altogether and I think to that extent it has diluted the role of the matron. John – modern matron

Matron Jones was, with regard to her role and seniority, a solitary figure when compared with her modern matron successors. The hierarchy for Matron Jones was simpler compared with the modern structure at the trust and it is assumed her sisters and assistant matron worked in support of her as seen in her establishment outline below. However, Matron Jones did record that she had shared resources or discussed a key issue with a fellow matron in a neighbouring hospital.

John described how the increase in modern matrons negatively impacted on the value and exclusivity of the role. An expansion of the matron body may have been part of the solution to reducing hospital acquired infections but it is now known that there is a wealth of healthcare system wide interventions that are not solely attributable to the modern matron role (Weston 2010; Dougherty 2011; Flynn and Zombolis 2011; Sexton, Tanner et al. 2011). I raised the issue of the increased modern matron numbers with Andrew:

... but do you know why we set numbers for the NHS? Because we can't trust the NHS to do it. Because I doubt chief executives really go for this – Andrew,
national policy lead

Andrew voiced that a target was required to ensure that the Department of Health's demands were met, as there was a level of distrust between the Department of Health and the NHS that certain aspirations would not be met or delivered. Targets have been set for

many other priorities in the NHS and so it would be unsafe to assume that targets are specifically required for nursing-related issues. Conversely, it can be tentatively assumed that the Department of Health was sufficiently concerned about healthcare acquired infections (Department of Health 2007) and saw as a solution, in part, to increase the modern matron cohorts; in doing so, the Department of Health may not have considered the unintended and depreciative impact of the modern matron role.

Having a plethora of modern matrons was perhaps a departure from the traditional matron model. However, Matron Jones managed a hospital of approximately fifty beds and was supported by range of staff, as outlined below in the hospital establishment:

Existing staff⁵	
26 October 1951	
1 Matron	1 part time staff nurse
1 Assistant Matron & ward sister	2 assistant nurses (1 sick)
1 Night Sister	7 ward orderlies
1 Relief Night Sister	

The modern matrons at the trust on average managed directorates of approximately two hundred beds each or emergency and critical care units. So the modern matrons' workload was considerably higher than their predecessors - there was little similarity with regard to patient volume and possibly the pace of care and bed occupancy rates between the traditional and modern matron eras. An additional area where there is little continuity between the traditional and modern matron eras was the inclusion of male nurses in a general hospital setting. Although there were no male nursing staff within Matron

⁵ The hand written accounts stopped in favour of the apparent acquisition of a typewriter one week after the hospital had become part of the NHS in 1948.

Jones's workforce establishment, the gender profile of nursing has changed and men who are nurses have been welcomed for some time (Nursing and Midwifery Council 2008). The study benefited from the contributions of a matron who was male and his perspective is considered in the next section.

4.11 Modern matrons – keeping a balance

The literature review identified that the Department of Health was careful not to overly dictate to NHS trusts about the exact framework for the modern matron and the way that the role should be integrated into existing organisational structures (Department of Health 2001b). The research site adopted the modern matron model and modified it from the previous senior nurse structure, which saw existing senior nurses metamorphosing into modern matrons. The modern matrons worked in a complex context, being line managed by the directorate general manager, but also being professionally responsible to the director of nursing. Having two 'managers' was possibly a source of tension between operational demands and the need to focus solely on the quality of nursing care. The modern matrons described the organisational frustrations and barriers that have prevented them from being able to fully focus on the ten key roles and other related aspects, such as the need for modern matrons to visit their wards:

the post holder's span of responsibility should not be so large as to limit their visibility or accessibility to patients and staff, nor prevent them from 'walking the floor' on a regular basis.

(Department of Health 2001b) pp 7

The statement in the Department of Health guidance about modern matrons' span of responsibility in terms of their portfolios and number of wards and their related accessibility was slightly vague but encouraged modern matrons to 'walk the floor' regularly. All modern matrons mentioned the importance of 'getting round the wards',

which for them was a key priority of their work, but was also a challenge, and John was no exception:

at times I really quite struggle to get round all the wards on a daily basis

John was responsible for eight acute wards and units and felt that his operational responsibilities prevented him from achieving daily ward visits; although the Department of Health guidance did not specify that modern matrons should visit their wards each day, this was the expectation of the modern matrons, which many were unable to fulfil because of operational demands.

At national policy level, Andrew articulated that '*we would like to see the matrons visit the wards every day*', thus encouraging modern matrons to emulate the perceived practice of a traditional matron. The desire for replication of the traditional and modern matrons' practices is understandable, as the traditional matron is clearly the template for contemporary practice. However, the applicability to modern healthcare is questionable. There was no evidence from Matron Jones's archives that she visited the wards daily. The diaries contained monthly entries of staff and patient activity, which provided an overview of hospital life, which again may suggest infrequent ward visiting.

John provided an insight into how the modern matron role had changed in the trust since and that the shift in focus changed to aspire to achieving financial balance:

When the matron roles were set up to be highly visible proactive leaders, to be able to implement the nursing officers' [modern matrons'] ten key roles and all the rest of it, with all the best will in the world, that was working to some extent, but unfortunately we had the financial crisis – John, modern matron

John did not say anything else about the financial crisis and how that context impacted on the modern matron role directly. It is possible that the focus of the modern matron role may have been to balance the need to improve the quality of nursing care whilst being financially prudent. Matron Jones also maintained an overview of expenditure and quality in a similar way, which highlights the continuity of the two roles.

The senior sisters identified that the modern matron role did not always appear to be fulfilling the core purpose as specified by Department of Health of focussing solely on improving the quality of nursing care. Instead, organisational demands to provide administrative accountability or 'ticking boxes' appeared to have become an increasingly core activity for the modern matron. Participants provided an insight into working in a busy and pressurised unit and what the modern matron had been required to do:

I think that majority of the job is just trouble shooting and I know from the winter we've had, which has just been diabolical, and like I say about the phone calls and if you get one phone call - and I'm not just talking about the matron's, this is way higher up - asking you why hasn't this person moved and you're trying to get on with your job and your matron has been asked to move your patients for you and transfer your patients and that just isn't good for them at all, that's donkey work just to get the flow moving and its another 2,3,4 hours that is wasted really.

Nicola, senior sister

Over the years it has changed the emphasis and moved away from being directly there at ward level to being very much more administrative and tick box - John, modern matron

Organisational demands meant that from John's perspective, the role has moved from its core clinical expert role purpose to towards being increasingly administrative. The modern matrons were primarily engaged in auditing and measuring quality standards as

opposed to engaging in clinical practice and acting as positive role models. Another contributory factor for the role deviation may have been the reduction of Department of Health led dialogue about the modern matron role due to changes in Department of Health and senior civil service administration and the achievement of the modern matron recruitment target.

Nicola expressed that the time modern matrons spent on transferring patients when operational demands were at their peak was inappropriate to the role. Nicola's (senior sister) description of the modern matron carrying out 'donkey work' – i.e. transferring patients on trolleys to maximise the flow of patients through the emergency setting - is an interesting perception. From Nicola's perspective, the modern matron was conducting tasks that were below the job role, but that the modern matron is expected by their general manager to carry out when demand for beds is high. Nicola's observations to an extent relate to John's experience of being a modern matron:

It's all target driven. Without a doubt, everything is centred around A&E: as long as A&E is reaching their 98%, everything else can waver. At a moment's notice, you know you can be pulled from doing your day job to go and deal with A&E issues to avoid a breach – John, modern matron

The accident and emergency department appeared to be an epicentre of activity and if that department was at risk of not achieving the target of patients not waiting in the department for longer than four hours, then John (modern matron) reported being diverted from his job to help in the department, a department which was not part of his portfolio. John described being pulled from the 'day job', which suggests that he saw the drive to deliver improved standards of nursing care as his day job as opposed to the delivery of corporate⁶ targets.

⁶ Ongoing nationally set standards (targets) – 95% of patients should wait no longer than four hours in an accident and emergency department, Department of Health (2008). The Operating Framework for the NHS in England 2009-2010. London, Department of Health: 52.

Catherine provided further evidence from her perspective on the modern matron role and the organisational and contextual challenges, which, according to her, appeared to have shifted the role's focus and core purpose:

their job almost feels like it's reactionary rather than proactive: it's all about fire fighting and dealing with it and what I would like and I don't think it's about them not wanting to do, they're not able in their current structure, they need to be more about 'this is how we should be doing things and this is how we make things better' and being more forward thinking and actually its just about in ten minutes and how we're going to have three breaches and like you said seeing a matron pushing a trolley through and you think...why?! (laughter) Catherine – senior sister

The senior sisters wanted to see more proactive practice from the modern matrons in the form of actively planning and supporting timely patient discharges to create space for new admissions, but they were aware of the daily challenge for the modern matrons and the split of responsibility between operational management and nursing and the consequent role diversion.

The quality focus of the modern matron would comprise some elements that would need to be addressed in a responsive manner, such as dealing with complaints; however, Catherine had identified that the organisational structure and accompanying reactive expectation of modern matrons from general managers created a barrier to the modern matrons' ability to take the time required to proactively plan and improve the quality of nursing care. The financial incentive to avoid a breach in the accident and emergency department seemed important to the trust and so it became apparent that modern matrons were expected to help with this cause, which, according to Catherine and John's accounts, shifted the focus of the modern matron role from its core purpose. It could be argued that

during times of high demand, staff in most organisations would be expected to act corporately and contribute as required. Having patients in the accident and emergency department for longer than four hours is considered to be an indicator of poor quality care, but the distraction from the core purpose of the modern matron role may have negatively impacted on the matron's ability to ensure the quality of care. If the modern matrons had time to plan ahead to streamline patient discharges, this may have created more capacity in the emergency department, thus reducing the need for unnecessary reactionary practice. In the following chapter, the interplay between corporate and professional priorities and will be examined further and illuminated via a realistic evaluation lens to fully understand what happens to modern matrons in the scenario outlined above (Pawson and Tilley 1997).

From the archives, it seems that Matron Jones was also required to 'step in' and 'roll up her sleeves' to do job roles to ensure service continuity in the absence of cook to prepare meals for patients. This is a relatively unknown but regular requirement for some traditional matrons (Emrys-Roberts 1991):

To the Chairman and Members of the Catering Committee

14th March 1952

Everything in the kitchen has been going on satisfactorily since the last meeting. The cook has been away for 9 days holiday, but the housekeeper and myself have managed to cope with the cooking.

Matron

The versatility of both the traditional and modern matrons, whereby they could be diverted from their core roles, may have made the matron role less clearly defined. The Victorian middle class wife or mistress may well have been required to step in to similar situations to maintain seamless domestic standards (Beeton 1861). It appears that little has changed since these times despite the formal recognition of nursing and the modern

matron being a clinical and operational leader; it suggests that the matrons, traditional and modern, were used as a service resource, ready to be deployed to fill a gap to maintain service continuity. This situation may have contributed to Penny's summary of the general managers' perception of the modern matron role:

I think a lot of senior management in this organisation think that matrons don't do very much. It's general criticism that we don't contribute and that we spend too much money Penny – modern matron

The criticism levelled towards the modern matron role from general managers is unhelpful. The lack of recognition of senior management of the modern matron role could be a result of feminised job roles being less valued than male job roles. The perceived level of modern matrons' financial acumen resonates with the suggestion levelled at traditional matrons in the Salmon Report (Salmon 1966) when it raised concern that the traditional matrons were also incapable of effective financial management.

As part of the Department of Health's drive to improve ward environments (Department of Health 2002c), they instructed trusts, including the research site, to give each senior sister £5000 to spend every year – ward environment funding. This provided the senior sisters and the modern matrons with financial mechanisms to improve the aesthetics of wards or units. The trust eventually removed this money from the wards and placed it into a collective fund, making it more difficult for the sisters and matrons to access.

I know that the Government wanted modern matrons to have more authority over their ward environment funds and much more control over the environment. And lots of organisations, including this one, interpreted it as 'we're not going to do that'. So essentially environment funds have been removed from wards and put into a separate budget, which we can no longer bid for. We still have to look after the environment and we've got charitable funds as well - Penny, modern matron

The Department of Health had a defined mandate and mechanism for the modern matrons to improve ward environments for patients (Department of Health 2001a), but this decision was overridden at the trust at director level, preventing the modern matrons and senior sisters from having an opportunity to improve ward environments. The provision of ward environment funds and the accompanying freedoms may have led to an increased equalisation of power between the seniors sisters, modern matrons and general managers, which may not have been palatable for some. The organisational context of financial pressures at that time may have been an opportunity to use the environment funding in different ways, possibly to reduce budgetary deficits.

The modern matron body concurred that the role had developed since it was implemented. The key principle was to be clinically engaged and visible, but the role, as the findings suggest, is now largely office-based, with a greater emphasis on operational matters as opposed to the quality of nursing care.

The senior sisters agreed that the modern matron role probably had particular challenges in relation to being able to balance competing priorities of the need to improve the quality of nursing care and being proactive and the operational demand requirements, which sometimes led to reactive responses.

I don't necessarily think that the role they have is what the public perceived that they wanted it to be, so I think the public still think of some Hattie Jacques figure coming round and being on the ward each day and not about perhaps the bigger picture that the [modern] matrons get involved in – Catherine, senior sister

Catherine suggests that the public possibly view the modern matron role as one-dimensional, whereby the majority of the role consists of walking the wards, which is

understandable, as that is what they see. However, the complexity of the modern matron role at local level is not necessarily visible or appropriate for patients to recognise.

The political rationale that led to the return of the modern matron was not presented for public consumption; the following section should provide some much-needed illumination.

4.12 Conclusion

In response to the socio-political influencers which have influenced the presentation of the modern matron was one of multiple expectations rooted in previous perceived incarnations of a traditional matron: visibility, unilateral power. The lack of clarity for the modern matron was exacerbated by many factors. The dual allegiance that the modern matrons had to maintain to nursing and corporacy created the main barrier for the modern matron to focus on improvements in the quality of nursing care.

Although the expanse of time was approximately fifty years between Matron Jones, her contemporaries and the modern matrons, there were some continuities in approach and practice: balancing quality and money, complaints responses and ambivalence with regard to how the matron role was located and perceived within their respective organisations. The modern matron guidance (Department of Health 2001b) called for a powerful and influential nurse leader; the guidance later contradicted itself by reassuring other hospital managers of their own position, which gently inferred that the modern matrons would not be powerful. This approach may have contributed to the stymied position of the role before the modern matrons were fully implemented. According to the archival records, traditional matrons were not powerful as their scope of power and influence was often limited whereby permission from a higher authority had to be sought. The desire for a powerful modern matron may have been misplaced and influenced by nostalgic recollections of a traditional matron.

The modern matron role lacked clarity predominately due to divided loyalties between general management and nursing and the role suffered from the expectations of many stakeholders. The modern matron role clearly put patients and nursing at the forefront, but at this trust, it seems, the role was impinged upon by the requirement for modern matrons to help deliver corporate targets, particularly at times of high demand when sleeves were rolled up to address operational gaps – a practice with which Matron Jones engaged. However, the senior sisters reported that the modern matron was supportive towards them, which enabled them to focus on their role as clinical leaders within their wards. The patients had very little or no contact with a modern matron, but they articulated a level of clarity with regard to what a matron role should comprise.

With regard to the continuities between some traditional matrons and the modern matrons, it seems that the modern matron role was an attempt to duplicate a template of what was thought to be the *modus operandi* of a traditional matron. However, the template appeared to have been influenced by notions of nostalgia, which was evidenced to some extent by the recordings of Matron Jones. The policy leads wanted to see modern matrons visit wards daily, but according to the archives, this level of frequency may not have occurred. Despite the new clinical attire, the modern matrons were not particularly visible, possibly due to the diversion of the modern matron to deliver corporate goals and the gradual encroachment of quality audits, which distanced them from the clinical arena.

With regard to the modern matrons' impact on care quality, policy leads recalled the traditional matron to be at times frightening, and although not explicitly stated, it was inferred that this approach should have been applied to raise the quality of nursing care within a modern context. The simplistic mechanisms that were held as beliefs at policy level to improve the quality of nursing care seemingly did not entirely take account of and consider the complexities of nursing and the modern approach to leadership (Cook

2001) within the profession and the wider healthcare arena which may have contributed to modern matrons in this study not being able to reach the role's optimal potential.

In essence, the modern matron is a role that was trying to fulfil the expectations of many, but the overriding element that created the barriers to improving the quality of nursing care emanated from their direct line managers, the general managers. The next chapter will discuss the main themes underpinned by sociological, nursing and management theories which will be further illuminated by realistic evaluation.

Chapter Five

Discussion

5.1 Introduction

The findings presented the challenges and complexities of traditional and modern matron roles. This chapter will critically interrogate and develop the thesis, which will contribute to the existing body of knowledge for nurse leadership. The major themes discussed in this chapter will be structured into three main parts to respond to the study aims:

Part I will discuss the socio-political aspects and will focus upon the tension between the modern matron participants and their line managers will be discussed. The framework for this discussion will draw from Exworthy (Exworthy, Berney et al. 2002; Exworthy, Blane et al. 2003) and Flynn's (1999) perspectives on the interrelationships of professionals and managers in the public sector.

The findings presented a unique insight into the genesis of the modern matron concept from the perspective of national policy leads. The political and policy framework provided by Kingdon (1995) will help to enlighten the complexities and processes of policy development and the various influences in a government setting. This section will acknowledge and clarify the development of new policies or government guidance and the likely path that the modern matron guidance encountered prior to its announcement. The distance and effect of national guidance and the reception of such guidance at a local level are considered (Pressman and Wildavsky 1973).

Part II will discuss the sociological and marketing impact of nostalgia to further appreciate how nostalgia may have contributed towards the matron role returning to nursing hierarchies. Nursing uniforms have perpetually generated copious dialogue and

this was evident in the findings and will be discussed here. The impact of the modern matron returning to clinical dress and the inter-changeability and retention of managerial attire will be illuminated using the sociological concept of uniform.

Part III will discuss the contribution of the modern matron to the improvements in care quality will be explored further and what is thought to be the first substantial research study on modern matrons will be used as the framework to demonstrate how the role has progressed since implementation. The discussion regarding care quality will continue with the review and implications of prevailing national concerns with regard to nursing care.

Finally, the chapter will culminate by determining the underlying causes, mechanisms and outcomes of the key points in the chapter and drawing on realistic evaluation (Pawson and Tilley 1997).

Part I Socio-political influences on nurse leadership's development

5.2 Authority given and taken

The modern matrons in this study reported a shift and a minimisation of their authority in relation to the expectation in the modern matron guidance (Department of Health 2001b) and this shift is possibly an outcome of prevailing socio-political influences that have affected this new role. The modern matron guidance (Department of Health 2001b) provided the architecture to enable the new post holders to have the authority to improve the quality of nursing care for patients. The national policy lead, Andrew, reported that he wanted the modern matrons to start '*bossing the place about*', which reflects the autocratic position that some traditional matrons previously occupied (Lorentzon 1997). The policy mechanism to provide the modern matrons with the authority that policy leads envisioned was undermined by a statement within the guidance stating that the modern

matrons would not pose a threat to other service managers. The modern matrons were caught in a tension of expectation with regard to how they should execute their roles in terms of management style. A patient participant expected the modern matron *'to kick estates'* if they were underperforming but an authoritarian approach to management was not always appropriate because modern expectation is to influence colleagues who managed areas outside of but impacting on the modern matrons' job scope (Cook 2001). This was also illustrated by the modern matron who was working with the estates team to dissuade them from converting a space for relatives into a store cupboard. If the modern matrons had been authoritative and autocratic, similar to their predecessors (Lorentzon 1997) and had a management line to the estates team, the matron would have merely ordered that the relatives' room remain untouched. Matron Jones, the traditional matron, also had to ask permission for workforce changes and for new equipment or repairs. Therefore, the authoritarian unilateral approach to matron-ship has, in this study, has so far been unfounded.

The modern matron participants had, in accordance with national policies (Department of Health 2002b; Department of Health 2002c), been given access to funding to improve clinical environments. The modern matrons had appreciated the direct funding and the autonomy that this provided. The Department of Health's expectation that modern matrons and senior sisters should retain access to the funds was prevented as a local barrier to obtaining the money was enacted. The mechanism to increase autonomy of modern matrons by allowing direct access to funds was eventually denied at trust level rendering the roles lacking in authority. The modern matrons' role was shaped by their managers' leadership and perspective, which contributed to a reduced level of authority and a source of tension and will be discussed further in the following section.

5.3 Matrons and managers – complexity, typology and tension

Frustration and tension were apparent when the matron participants spoke about aspects of their working lives, particularly in relation to the deployment of resources and the pull from their immediate managers to attend to corporate issues, which the modern matrons saw as a diversion from their core duties of improving care quality for patients; the modern matrons reported that as *'being pulled from the day job'*. The source of the tension was centred on the conflicting elements of their roles – professional and managerial. The role complexity was in part compounded by the trust's organisational structure, wherein the modern matron participants were line-managed by a general manager, but they were also influenced and professionally accountable to the director of nursing.

To enable deeper theoretical understanding of the context and mechanisms that may have contributed towards a level of tension between the two staff groups, the assertions of Causer, Exworthy and Flynn (Exworthy and Halford 1999; Flynn 1999) have been utilised in this study. Their theories (op cit) will provide insight into the working principles between professionals, i.e. nurses, doctors and managers (corporate managers, general or service managers), within the public sector.

The modern matron participants reported that they were often distracted from what they understood to be their core purpose of improving the quality of nursing care. The participants were concerned that their quality and patient-focussed role had become progressively target driven by the general managers and that they were diverted, often at short notice, to conduct corporate tasks.

Previous studies and accounts (White 1985; Withams 1992; Ardern 2002; Read, Ashman et al. 2004) found that nurse leaders had operated in a hybridised manner - caught between professional practice and managerial tasks. These studies had illuminated the daily tension and the difficult location of the senior nurse role. Nurse leadership roles

had been vulnerable to policy changes and has been influenced and shaped by local context (Pawson and Tilley 1997). The modern matron role had perhaps emphasised the polarisation between professional and managerial practice, possibly because the differences between the two staff groups was made visible – uniformed and non-uniformed, professional and manager. The next section will extend what has been previously presented with regard to the tension between modern matrons and general managers.

5.3.1 Professionals and managers – a definitive split?

An element of division between the modern matrons and their line managers was detectable through differences in opinion and different motivators with regard to the daily priorities that the modern matrons were expected to have addressed. The modern matrons were keen to deliver and maintain the focus on improvements to patient care, whereas the general managers were focussed on the delivery of corporate targets and engaged the modern matrons in this task, thereby diverting the modern matrons from their core purpose. A neat division between the modern matrons and the general managers does not wholly reflect the complexity of the context and the occupational origins of the staff involved. It has been suggested that there was not a definitive divide between managers and professionals, as is often articulated, but instead an acknowledgement of various strata of professional and managerial practice ranging from rank and file to pure management, as illustrated by Figure 5.1 (Causer and Exworthy 1999).

Figure 5.1 Managerial and professional strata
(adapted from (Causer and Exworthy 1999))

<p>General managers</p> <p>professionally grounded general manager non professionally grounded general manager motivated by the achievement of corporate goals</p>
<p>Managing professional</p> <p>practising managing professional or modern matron non-practising managing professional senior nurse primarily motivated by patient focussed activity and direct care delivery with a requirement to participate in the delivery of corporate goals</p>
<p>practising or rank-and-file professional</p> <p>quasi-managerial practitioners primary function to engage in the day-to-day professional activities motivated by patient-focussed activity and direct care delivery e.g. staff nurse</p>

The stratification identified a complex mix, which, when converged in the workplace, has the potential to complicate and contribute to a level of tension between modern matrons and general managers. According to this model, before the modern matron concept was conceived, senior nurses would probably been considered as non-practising managing professionals. The modern matron concept shifted the position to practising managing professionals. According to the findings presented, the modern matron role had reverted to a position closer to a non-practising managing professional because of the desire by general managers to achieve corporate targets⁷ and it is this change that could be the source of the tension.

Flynn (1999) stated that when professionals or managers are placed under pressure, they are most likely to revert to type. For example, if modern matrons were pressurised by their managers, it is possible, according to Flynn (1999), that the inherent behaviours and

⁷ Ongoing nationally set standards (targets) – 95% of patients should wait no longer than four hours in an accident and emergency department, Ibid.

principles of nursing would be emphasised and fully articulated, accentuating the division between the two staff groups. The modern matron participants said that they were often 'pulled' from their day job, which they perceived to be quality and patient focussed, as opposed to corporate targets; none of the modern matron participants said that they were diverted from their managerial tasks. This evidence suggested that the participants did not wholly identify with corporate goals outlined by Flynn (1999) in Table 5.1. The participants did, however, engage with the management of nursing ie workforce planning and staff development. It appeared from the findings that the modern matrons were engaged with the management of nursing and clinical care but perceived that the management and deliverance of corporate goals should not have been within their remits. The distance that the modern matrons placed between their roles and the achievement of corporate goals was tangible, but as well as being matrons, they too were managers of nursing. Whilst the participants had stated that they had targets to meet, these were clinically focussed. The aspects of their work that appeared to generate some frustration were related to corporate targets or the barriers that were installed in relation to access to money. Similarly, not all matrons would reject the need to address corporate targets.

Managers have a tendency to look towards corporacy and the delivery of targets, whereas professionals gain their impetus and focus from the inner feeling of satisfaction (Causar and Exworthy 1999; White 2002). It is suggested that professionals and managers may oscillate from one end of the continuum to the other, particularly if the manager had previous professional experience (Flynn 1999). Managers who are also professionals exist. The advancement of a professional career typically involves increased distance from practice delivery and instead a move towards a role which is focussed on controlling subordinates and resources. Managers are typically orientated towards corporate success and efficiency, which can, as presented in the findings, be a source of tension; however, gross simplifications would benefit from careful application (Flynn 1999).

Figure 5.2 Matrons' and managers' contradictions

	Traditional and Modern Matrons	Managers
Goals or objectives	Professional knowledge and expertise	Hierarchal authority
Mode of control	Effectiveness and technical competency	Efficiency and budgetary control
Clients	Trust dependency	Compliance and targets
Reference group	Patients and carers	Corporate
Regulation	Professional peers and regulatory bodies	Bureaucratic superiors



(Adapted from Flynn, 2009, p. 25)

The polarities between professionals and managers have been set out in Table 5.2 has been adapted to illustrate the current discussion. Professional actions are based on judgement, trust, self-regulation and peer approval, all rooted in a body of knowledge and experience. Therefore, the tension may have arisen because of a gap between the values of professionals and managers. One set of values does not necessarily supersede the other. However, from the participants' perspective, their professional priorities should have taken precedence, but were diminished because of local complexities (Causar and Exworthy 1999).

Together Flynn (1999) and Causar and Exworthy's (1999) models describe the context in which the modern matron participants in this study operated each day. The findings presented offer an insight into the managerial responsibilities of the modern and traditional matron: recruitment of staff, workforce management, meeting attendance and budgetary oversight. The modern matron concept may have contributed to a possible exacerbated division between professionals and managers. The modern matrons' quality mandate and the adoption of clinical dress were the signals of that change. However, the

modern matron participants had not been able to wholly maintain the status of practising professional manager. The employment of two uniforms may have unintentionally served to close the apparent divide and assuage tensions between the two staff groups. Conversely, the use of managerial attire may have brought the modern matrons' position closer to that of a non-practising managing professional.

5.3.2 Who is in charge?

The findings demonstrated that there were occasions when the modern matrons were stymied in the progression of services for patients because resources were not always made directly available to them. For example, the need for modern matrons to retain space in critical care for relatives was dependent upon the estates department (Chapter Four, section 4.5); modern matrons' access to environment funding was blocked by general managers (Chapter Four, section 4.9). The modern matrons were able to move and manipulate the nursing workforce and titrate it where possible to areas of greater need, but they had little influence in respect of the cleaning standards of ward areas or the management of patient flow. Within public services, power is often inextricably linked with the control of resources (Flynn 1999) and the scenario outlined above has revealed from a different perspective the source of decision-making and power which limited the modern matrons' ability to operate as per the Department of Health mandate (Department of Health 2001b). Restricted access to environment monies for the modern matrons and their senior sisters may have been due to the waning dialogue regarding modern matrons at Department of Health level, which is a known risk with policies, as well as the waning of enthusiasm and focus (Pressman and Wildavsky 1973). The nature of policy development and the depreciation of focus from central to local levels will be explored further in section 5.4.5.

Moreover, the tension between professionals and managers had prevailed partly because of numerous public sector reforms which have sought to achieve efficiencies (Owens and Glennerster 1990) by placing the control of resources with managers (Flynn 1999), as

professionals were suspected of liberal resource allocation. Flynn (op cit) acknowledges that political reform has periodically shifted the emphasis and balance of power between professionals and managers. The concern that professionals would not be fiscally adept has continued, but more recently health reforms (Department of Health 2010) have secured legitimate leadership for clinicians for the commissioning of health services, but this change is unlikely to impact on the relationship between the modern matron participants and their line managers in secondary care settings.

Although professionals have been seen as often being positioned as subordinate to managers in NHS organisations (Flynn 1999), that control is often subject to resistance and subversion by professionals. This was evident in the findings whereby the modern matron participants received numerous requests to walk the wards to check the bed state. Modern matrons had devised their own systems for gathering this data. John, a modern matron, had said he devised a system whereby the nurse in charge of each ward every morning submitted information via email which provided a summary of the bed state; this revised process for collecting data may have been a method of self-protection from the reactive requests from general managers for matrons to constantly walk the wards. However, the consequences of this may have contributed to the modern matrons' lack of visibility in the clinical areas, but possibly only with other nursing staff and not with patients.

The different value sets of the participants and their line managers could have been a contributory factor as to why the modern matrons' quality focus had waned and had moved towards the role of non-practising managing professionals. The focus of this study was the modern matrons and did not include their line managers, but this could provide an opportunity for further research.

5.4 Policy, politics and matrons

This study has presented two main reasons for the return of the modern matron: growing public discontent and the related threat that this could politically threaten and contribute to an election defeat. The findings benefited from direct accounts from national policy leads regarding the concerns, frustrations and the development of the modern matron concept. When the change to modern matrons was announced, there was an initial sense of slight dismay from the modern matron participants and commentators and there was no apparent understanding of how or why the Department of Health supported what seemed to be a reincarnated role for modern healthcare.

To offer a theoretical appreciation regarding the complexities of how this particular policy may have been conceived, the discussion will draw from Kingdon's (1995) work on political and policy stages, which helps to enlighten the policy-making process and extend what is known about the modern matron policy beyond the level of superficial speculation.

Secondly, the findings identified the local modifications to national guidance that may have impacted on the ability of the modern matrons to conduct the role as per the Department of Health's mandate. The theoretical perspective of why a guidance document loses its definition once it has left its genesis will be explored via the policy science perspectives of Pressman and Wildavsky (1973) and Exworthy, Berney et al (2002).

This section will continue with a summary of Kingdon's (1995) political and policy stages, explaining the complexity of policy development, and provide one possible response as to why the matron role was revived.

5.4.1 Politics, politics and policy

The revival of a matron role as outlined in the literature review and also by the modern matron participants was a somewhat unexpected development within nursing leadership. This study has benefited from the contributions of national policy leads, significant participants who were at the centre of the decision-making with regard to the modern matron role. The national policy leads explained the bemusement and frustration articulated by Government ministers in relation to the public's continued poor experience and perception of nursing care despite substantial fiscal investment prior to the implementation of the modern matron role. The political landscape during 2000 and early 2001 was shifting and a general election was imminent. The literature review had identified that some commentators had stated that the move to have modern matrons was political, but further depth on that issue was not offered. It is important for nursing and nurse leadership to influence and shape policies that may have an impact on the profession. Therefore, it is incumbent upon nurse leaders to understand the political mechanisms which generate new policies and to be involved in political decision-making at an early stage and influence future changes in nurse leadership for themselves. Kingdon (1995) has described a model that explains the mechanisms and processes that generate policies. This level of understanding is pertinent to the modern matron guidance and will illuminate the political influences that may have impacted upon and shaped nurse leadership.

Policies are developed to address problems (Kingdon 1995). Kingdon (op cit) acknowledged that a prominent issue for the public that had been seen to be addressed by government would quell public dissatisfaction and contribute to election victory. It is argued that public opinion is instrumental in ensuring that key issues are placed on a government's agenda (Kingdon 1995). Ministers and officials learn of such problems via various means: the media, constituents, complaints, crises or disasters. Some problems may reach a minister's desk and then be superseded by other more pressing priorities: therefore, the nursing care quality concern must have prevailed. According to Kingdon

(1995), such concerns remain uppermost because other mechanisms such as the media or general public keep issues alive by the maintenance of pressure, which in turn maintains the profile.

Whilst Kingdon's model explains the genesis of new policies and guidance, the model lacks the opportunity to explain why current policies are discarded. The traditional matron, whilst not enshrined in national policy but adopted as best practice for the management of nursing, was discarded in favour of nursing officers (Salmon 1966).

Kingdon's (1995) model has four key stages: political stream, policy stream, coupling and policy window.

5.4.2 The political stream

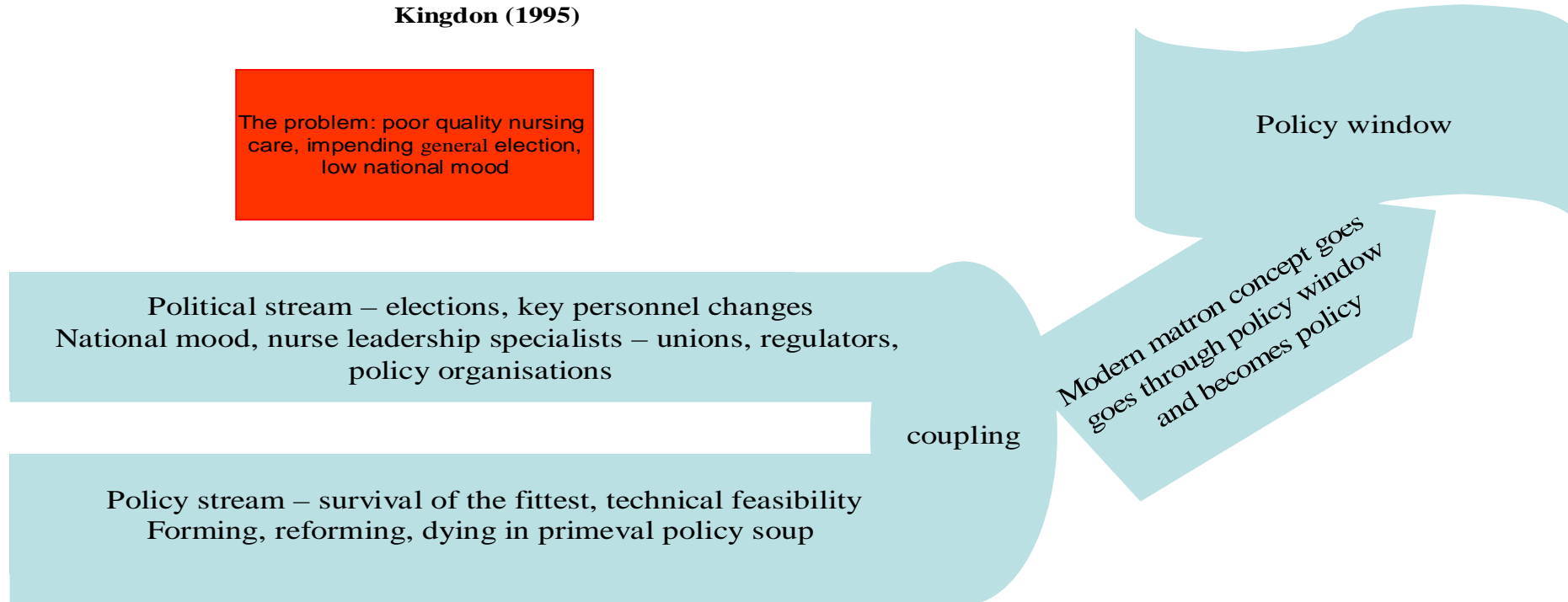
The political stream (Kingdon 1995) is comprised of many components and interrelated influencers, as illustrated in Figure 5.3. Within the political stream, there are participants. In the case of this study, these are the national policy leads. The participants receive information and are influenced by many factors. With regard to care quality, prior to the modern matrons' return, the national mood with regard to nursing care (Chapter Four section 4.10) was perceived to be despondent. However, Kingdon (1995) cautioned that the national mood is not necessarily representative of the whole nation, but just those who have managed to get their voices heard.

The participants had articulated their awareness of the national mood. Government ministers had queried Carolyn, a national policy lead, as to why patients remained unhappy with nursing care despite additional investment to improve health service infrastructure and waiting times.

Imminent general elections can pose a risk to political infrastructures (Kingdon 1995), particularly if problems remain in key services such as health or transport. There is a view that the health agenda is understood to be mostly a vote winner or loser because of the sector's tangibility and emotive connectivity to the wider electorate (Kingdon 1995). Ministers were keen to improve the national mood.

Figure 5.3

Policy development in government – adapted from Kingdon (1995)



A new government or a change in key personnel such as ministers or civil servants has the potential to ignite a change of direction and re-prioritisation of problems and re-shape the wider political context (Kingdon 1995).

Also contained within the political stream are specialists. In relation to health and nursing, specialists may include professional bodies, senior nurses, unions, regulators, policy experts and academics. These key groups conduct their work in a somewhat covert fashion. Although it is generally known that specialists are frequently called to advise governments, this level of activity is not always apparent to others outside of a political arena or 'Westminster village'. The specialists would, according to Kingdon (1995), meet and work together to form new ideas and responses to a government policy and influence policy to achieve the most favourable outcomes. This work would occur by way of dissemination of papers at conferences, speeches and draft policy documents, and a process of bargaining and consensus would be employed during this phase. At this stage there would be a wealth of ideas and specialists would be able to critique each other's work to eventually refine and shape potential policy options. The next and concurrent stage, as illustrated in figure 5.5, is the policy stream.

5.4.3 The policy stream – no thing new

Kingdon (1995) views this stage as a selection process of policies and likens this state to what biologists refer to as primeval soup, before life began - a disorganised and unformed state. At this stage there are many policy ideas floating around in the stream. The process is typically disordered as policy ideas collide, converge, form and re-form and some die. This process is augmented by the policy discussions that occur at specialist level. The technical feasibility of the policy ideas is tested by the speciality groups: the affordability, palatability and congruence with wider political ideology. Policy ideas that do not meet these tests fail to survive (Kingdon 1995).

Kingdon's (1995) assertion that there is 'no thing new' in the policy stream is pertinent to this study. The modern matron role was criticised for its reincarnation, for reverting to the past and for failing to present a new role in line with a modernised National Health Service. A modern matron criticised the role and suggested that '*you cannot have a matron of today in yesterday's era*'. Similarly, the traditional matron role during the 1960s was criticised for not being in line with the new National Health Service ambitions and was discarded in favour of nursing officers (White 1985). There is no thing new, merely re-combination (Kingdon 1995). The notion that there is no new thing resonates with section 5.3 regarding the impact of nostalgia on nurse leadership. A nostalgic view of matrons was potentially kept alive in the policy primeval soup and the policy stream until such time as an appropriate problem became apparent. The next crucial stage is a convergence of the policy and political streams and involves coupling and windows.

5.4.4 Coupling and windows

A policy window is an opportunity to have a draft policy adopted and used. A policy window can be opened for two reasons: a crisis or an anticipated change of direction. In the case of nurse leadership, the second reason applied. The problem had been identified earlier, but a solution was not yet conceived.

A pressing problem provides the policy's advocate - for example, a government minister - with the platform to present their policy as a solution to the problem, which opens the 'window of opportunity'. The predictability of windows and opening and closing is difficult to determine (Kingdon 1995). To illustrate, a train crash would unpredictably open a policy window for a review of rail safety policies. Predictable windows open for scheduled events, such as the Chancellor of the Exchequer's budget; preceding an event such as this, Her Majesty's Treasury may be more receptive towards new or reformulated fiscal policies to solve budgetary problems.

A Conservative Secretary of State for Health visited a trust site in 1992 and requested that the director of nursing change her title to 'matron' (Brown 1992). Following the visit, the director of nursing swapped her title to 'matron' and discarded her managerial attire in favour of a navy dress with a lace neck ruffle and nurse's hat. This approach was not supported by a Government policy and did not at that time address a pressing problem. This vignette demonstrates that the key components of policy development must be aligned and converge to achieve the delivery of a policy. The event also suggests that the desire to have matrons return to the nursing leadership infrastructure transcended political divides and was in the political stream for many years. Although the drive for change and enthusiasm may have been tangible for a change in nurse leadership, as expressed by both national policy lead participants, national policies can be vulnerable to local contexts and differing priorities.

5.4.5 Enthused in Westminster, locally despondent

The drive and enthusiasm for the change of emphasis in nurse leadership was articulated by the national policy leads in the findings chapter. The policy leads could probably envision the intended outcome of improved nursing care, reduced complaints and visible nurse leaders; nationally, various levels of achievement were evidenced (Department of Health 2002b; Read, Ashman et al. 2004). The modern matron participants were concerned that they were not able to engage in the level of clinical care that they felt was incumbent upon them, but as outlined in Section 5.3.1, they were diverted towards the delivery of targets. Exworthy, Berney et al. (2002) provide a theoretical viewpoint with regard to what happened to dispel the enthusiasm for the policy.

Using a socio-political lens (Exworthy, Berney et al. 2002), the contextual influences that have the potential to negatively impact on national policies within a local arena have been explored. Exworthy, Berney et al. (2002) found that there was much enthusiasm to implement various changes to social policy at national level. During their study (op cit) it

was found that national policy decisions to reduce health inequalities were prone to modification, ambivalence or rejection at local level, primarily because a new policy or guidance contradicted local priorities or other policy imperatives. Therefore, new national approaches or policies did not always carry the same resonance at local level. Exworthy, Berney et al (2002) found that health economies had existing targets in place and so a programme which was perceived locally to be unimportant was not afforded the same level of zeal as expressed by the national policy leads in Westminster. They found (op cit) that local contextual constraints such as relationships between different organisations and individuals negatively affected policy implementation and outcomes.

The importance of policy makers taking into consideration local contexts prior to implementation should be noted (Pressman and Wildavsky 1973). With regard to the modern matron policy, it is doubtful that the Department of Health would have considered the optimum context within which modern matrons should have operated to achieve successful implementation. In addition, the modern matron policy did allow for some local interpretation. At the research site, the modern matron policy was not wholly adhered to: access to funding was removed, there was no direct control from the modern matron participants regarding the performance of cleaning staff and the location of the modern matron involved working between professional and managerial requirements. These restrictions may have been identified if a review of the context had been conducted prior to the implementation of the modern matron role.

Kingdon's (1995) model has provided a deeper understanding from a theoretical perspective concerning the emergence of NHS policy towards modern matrons. This section has presented an understanding of the primeval soup and the perpetual motion of policy ideas that float in policy streams for prolonged periods. The problem of poor nursing care, a despondent national mood and an imminent general election may have been the catalyst for a solution from the policy stream to be matched to the problem. At this point, coupling occurred and the window opened. Kingdon's (1995) model provides

a means of interpreting the process of how some policies appear to be merely reformed from pre-existing, sometimes previously discredited ideas, as opposed to being brand new.

The personal recollections of a matron concept being locally applied in the 1990s completes and partially substantiates Kingdon's (1995) assertions that policy ideas are often in the system for many years, but only come to the fore once the political context and a suitable solution by way of a pre-agreed policy are coupled, enabling them to transcend the policy window.

Part II will discuss the continuities and commonalities between traditional matrons and their modern day successors in this study.

Part II Continuities between traditional and modern matrons in this study

5.5 Uniform and visibility

Predecessor to modern matrons, the senior nurses had worked in a context of prevailing managerialist structures whereby clinical dress had been discarded (Owens and Glennerster 1990). The arrival of a uniform for the modern matrons in the study was a mechanism that was largely welcomed, but was amended locally by them matrons through the acquisition of two uniforms, clinical and managerial. For the Department of Health, the intended outcome was for the modern matrons to have increased visibility (Department of Health 2001b; Department of Health 2002b). Although limited in number, the patients and carers had stated that they had not or had only briefly seen a modern matron. The modern matrons may have been more visible if they had not tampered with the mechanism of being present in clinical dress. The use of both uniforms may have contributed to mixed messages and reduced the visibility of the post holders. The delivery of corporate goals and targets may not have presented themselves

so readily if the modern matron participants had wholly accepted the clinical attire. The decision by the modern matron participants to wear managerial dress as a local mechanism may have afforded them a perceived increase in power and or status (Joseph and Alex 1972). The issue of uniform will be further explored in sections 5.6.2 and 5.6.4 there are parallel relationships with the uniform and the impact of the modern matron role and nostalgia.

5.5.1 Complaints management

It was reported that modern matrons had worked hard to ensure that they developed positive relationships with ward staff and staff across the trust, so that when patients did raise complaints, those relationships could be called upon to help resolve the issues (Read, Ashman et al. 2004). Read focussed on the informal aspect of complaints management, with modern matrons reporting that they walked the wards where possible to listen to and address the concerns raised by patients. The study (ibid) noted that overall, there had been a marked improvement in complaint handling since it had become an element of the modern matron role. However, at that time, patient advisory liaison services became a requirement and these services in some cases enabled complainants to achieve a swift resolution to their concerns (Abbott, Brentley et al. 2003). Therefore, a reduction in complaints may not be solely attributable to modern matrons.

5.5.2 Reducing hospital⁸ (healthcare) acquired infection

The national study demonstrated that the modern matrons had some impact on control of infections (Read, Ashman et al. 2004), as they were involved in the promotion of best practice, teaching and observing practice and worked collaboratively with infection control clinical nurse specialists. It was suggested that whilst the modern matrons had

⁸ At the time when modern matrons were introduced, the terminology was 'hospital acquired infection'. However, as the nature and transmission of infections were further understood the terminology was amended to reflect the broad nature of transmission, which was beyond the confines of hospital: hence, 'healthcare acquired infection' is the current term.

contributed to the improvements, the reduction of infections was not solely attributable to the modern matrons, but perhaps also to the revised systems and processes in place. The modern matron guidance did not allow the new post holders to manage the services that support nursing care including cleaning (White 1985; Lorentzon 1997). The guidance suggested that matrons could fine cleaning contractors who were not delivering the standards expected (Department of Health 2001b). Therefore the level of influence and authority that the modern matron had in this aspect was limited. However, traditional matrons did have more control with regard to ward cleanliness and so the modern matron concept and the manner in which it was adopted at the research site meant that the modern matron had less authority than some traditional matrons in this regard.

5.6 Bring back matron – the power of nostalgia

It was apparent from the findings that the participants welcomed the return of the modern matron. The juxtaposition of a historical role located in modernity, however, was the main source of discussion amongst modern matrons, whereas the national policy leads, it seemed, wanted an old-fashioned role to improve modern practice.

The connection with the past via the matron role and its influence on current practice is evident and requires further theoretical explanation. The employment of the sociology of memory (Jedlowski 2001) was considered as the lens through which to understand historical and contemporary aspects of the matron role. However, the concept did not illuminate the continued influence of the past on the present and the ignition of the popular belief that '*when we had matrons, everything was better*'. In contrast, the concept of nostalgia (Davis 1979) provides meaning to the historical and contemporary aspects of the matron roles whilst appreciating the context and mechanisms which may have led to the role's development. The use of nostalgia in commerce will be touched upon, as some aspects of its use in that field are applicable to modern matrons (Havelena and Holak 1991).

Nostalgia relates to events that have been personally experienced in one's past but cannot occur by association. The trigger for nostalgic experience is located in the present, as it allows people to reflect on aspects of personal experiences whilst comparing the contemporary or current position (Davis 1979). Nostalgia is frequently accompanied by feelings of joy, happiness or a warm glow - all positive and cossetting emotions. It is asserted that nostalgia is rarely tinged with negativity, as the nostalgic experience is subjected to involuntary cognitive filtering, which in turn leads to reconstruction and or distortion of the event (Davis 1979; Pickering and Keightly 2006).

The concept of nostalgia (Davis 1979) is commonly activated by a bleak or grey present and creates a contrast between good and bad. The past presents itself as a time when things, people, food or nursing were so much better – an idealized past (Pickering and Keightly 2006). In these moments, past times appear to be superior when compared with the present. The adulation of lost values, standards and ways of being and a yearning for a return to those times is a recurrent theme in nostalgia during periods of uncertainty and change. The findings presented a period of dissatisfaction with nursing and the policy solution was to bring back the matron.

The use once more of a uniform and the matron title all point to a bygone time, which was largely welcomed by the nurse participants interviewed as part of this study. The packaging of familiar items in period design is known, within the realms of marketing, to encourage nostalgic responses (Havelena and Holak 1991). The modern matron in clinical attire could also be viewed as the re-packaging of senior nurses. It may have been assumed by national policy leads that the modern matron in a traditional uniform would evoke a 'feel good' response from wearers and patients and the public. Although the trust in this study did not adopt 'traditional' nurses' attire, others did revert to a 1970s pre-NHS uniform, complete with the nursing regalia of belt buckle and cuffs (Nursing Standard 2009).

Nostalgia is described as an ‘opiate of the people’, as its effect can dampen public unrest, which in turn can delay reform and progression (Davis 1979; Pickering and Keightly 2006). There was evident dissatisfaction from the public concerning standards of care, which were regularly featured and examined by the media. The re-introduction of an obsolete job title and attire may have been used as a political tool to convince the public that nursing care would revert to a perceived time when standards were better.

Film and television also utilise nostalgia. In relation to nurse leadership, the most striking and enduring creation emanated from the *Carry On* films (Thomas 1972; Hallam 1998). However, the films presented no sense that nursing care was less than satisfactory; indeed, the films were not documentaries but sources of entertainment. The films conveyed a fictional time when matron was in charge and order on the wards was largely maintained. The perpetual display of *Carry On* films and the nostalgic feelings that they evoke may have contributed to the template for the modern matron, which in turn may have helped to reassure the public that nursing standards would revert and improve. Nostalgia, it seems, may have distorted the reality of the traditional matron’s role and this is further explored in the next section.

5.6.1 Traditional matron and setting the record straight

The widespread perception and nostalgic prevailing assumptions that the traditional matron had unilateral authority over nursing is challenged within this thesis (Pickering and Keightly 2006). The traditional matron evidence and archives suggested that unilateral power was not afforded to her, and her levels of power were (depending upon the context) rather limited and variable dependent upon other external factors (White 1985; Emrys-Roberts 1991; Helmstadter 2008). The literature and archives suggested a subservient or possibly on occasion bilateral relationship with immediate colleagues, as it was required of her to seek permission for some of the most basic but essential elements of her role, i.e. to change or upgrade equipment or consumables, workforce deployment

and staff development. The limited authority may have contributed to the apparent autocratic style used by some traditional matrons (Lorentzon 1997).

It could be tentatively assumed that the national policy leads were influenced by nostalgic constructions of the traditional matron and tried to transfer that imagery into the essence of modern nurse leadership policy.

Ardern (2002) presented a collection of factual accounts from nursing staff and former matrons in the United Kingdom. However, the accounts may have been unwittingly affected by nostalgia. These recollections illustrated a time when some traditional matrons visited the wards, which ranged from twice daily to twice a week, the frequency dependent upon on the size of the hospital, personal style of the matron and resource availability. Traditional matrons in cottage hospitals were constantly on duty and delivering direct care whilst others in elite settings were more remote (Bedford Fenwick 1909; McGann 1992). The concept of daily ward visits appeared, according to the findings from this study, to have been distorted, and a nostalgic view of this aspect of the matron's role activity has developed into a created reality of the past which was transferred into modern clinical practice.

In Ardern's (2002) study of traditional matrons, there were dominant traditional matrons who provided a framework for care quality and they expected the elements of care quality to be delivered. In contrast to the modern popular view that matrons from the 1950s and 1960s were centrally engaged in clinical practice, there was no evidence from the archive diaries that supported this. Moreover, Ardern (2002) documented little evidence that traditional matrons were directly involved in patient care: instead, they had a more distant and supervisory role. It seems that the Department of Health guidance on modern matrons was a departure from the previous incarnation of the matron. Therefore, Department of Health policy may have been partially based on nostalgic and unfounded experiences as opposed to actual events. Nevertheless, the requirement for modern

matrons to be clinically engaged was well received by the modern matron participants but was unable to be consistently achieved.

The concept of nostalgia provides meaning regarding the genesis of the modern matron role, as the challenges and limitations faced by traditional matrons can be viewed as being filtered by nostalgia both publicly and in policy terms. Nostalgia has the ability to engage people and to evoke feelings of better times and the modern matron concept may have triggered this emotional response in the public and within the profession. The implications of policy development in this manner will be explored was explored in section 5.4. The parallels between the re-packaging of commercial products and the revised nursing apparel for modern matrons added to the nostalgic feeling that nursing care was bound to improve and revert to the standards of a bygone era. The uniform for modern matrons is considered in the next section, which will draw on the sociological concept of uniform. Within Chapter Four, it became evident that the modern matron concept was designed to be a carbon copy of a traditional matron. The act of looking back and the perception of what had gone before were much better than the current situation, which forms part of the sociological concept of nostalgia. The effect of nostalgia on the modern matron will be explored in the next section.

5.6.2 Repackaging nurse leaders

Nostalgia may have also influenced the uniform of the modern matrons. The mention of a uniform at the implementation stage of the modern matron was greeted by some participants with horror; the underlying cause of the horror, it could be assumed, is that the juxtaposition of the modern matron uniform and the managerialist phase in nursing of going into civilian dress may have been interpreted as role regression with regard to the professional project. The uniform may have unsuspectingly signalled a cessation of the professional project and instead the direction was altered and re-focussed on the core

aspects of patients needs. As time progressed, it seemed that after the initial horror, the return to uniform was broadly welcomed.

The sociological meaning of uniform will be employed as the main lens in this section to enable a fuller understanding of the findings presented. Joseph and Alex's study (1972), although old, remains relevant because the underpinning principles of a uniform do not appear to have changed, and this work will be principally used to illuminate the many perspectives of uniform. Their theory will be supported by other nursing focussed theories on uniform.

A uniform makes visible the wearer's status (Joseph and Alex 1972) and it was this level of visibility that the patient participants expected of modern matrons during their admissions. The lack of visibility of the modern matron to the intended audience - patients and their carers was evident. The modern matrons felt that they were more visible whilst wearing clinical attire, but the expectation of seeing a modern matron was not achieved from the patients' perspectives. The modern matron participants may have been more visible towards their immediate colleagues, but to achieve the level of visibility that would have satisfied patient expectations would have required an increased level of physical presence in clinical areas. Although it is asserted that uniform signals the wearer's status (Joseph and Alex 1972), it is necessary for the wearer to be present in the space that they are required to occupy.

5.6.3 Control and consistency

The arrival of the uniform was felt to contribute to the feeling of shared allegiance and a signal for the modern matrons to focus on nursing and improve the quality of patient care as laid down by the Department of Health and as presented in the findings. It was suggested that a uniform can be a mechanism for organisational control (Joseph and Alex 1972), as deviation of behaviour outside of what is expected whilst wearing a uniform is

not welcomed. From the perspective of Andrew, a national policy lead, the traditional matron used her uniform and approach to be '*frightening and powerful*'. Joseph and Alex (1972) argue that the actions of the wearer must remain consistent with the needs of the organisation, thereby suppressing individual whim, and instead the wearer may be more inclined to focus on the delivery of organisational goals.

The return of the uniform was accompanied by urgency at national level. The national policy lead, Andrew, spoke of his eagerness to see uniformed matrons return to the wards. It was apparent also from Carolyn, also a national policy lead, that politicians were concerned that rapid action was required to satisfy public angst about nursing care before a forthcoming general election. The uniform coupled with the traditional matron concept embodied a drive for order, control of clinical practice and subordinates (Joseph and Alex 1972). The modern matron role was focussed on the achievement of consistent practice for nurse leadership and served as a symbol of that new consistency. The move away from personal attire to a uniform provided a homogeneous appearance for modern matrons. The quality mandate and newly found group identity for the modern matron's role may have contributed to reduced variability in care quality (Joseph and Alex 1972).

The modern matron participants spoke of the lack of structure and a slight *laissez faire* approach to nurse leadership when the senior nurse model prevailed and talked of '*going around in their own clothes*', which conveyed a sense of minimal structure and less corporate control (op cit). The national policy lead, Carolyn, stated that a clinical uniform for the modern matron would enhance '*clinical credibility*'. Control of modern matron practice, subordinates and care delivery and a traditional style of nursing leadership which was envisioned by the national policy leads was evident in the policy for modern matrons (Department of Health 2001b). The uniform may have been inadvertently reintroduced partly as a control mechanism. The increased visibility and identification of staff can serve to aid accountability of uniformed individuals and reduce the likelihood

that those staff will go undetected (Joseph and Alex 1972). The nursing link prior to the modern matrons' arrival was otherwise hidden and shrouded in managerial attire.

5.6.4 Visible hierarchy

A uniform also implies that there is a group structure (Joseph and Alex 1972) with subordinates, leadership and clear demarcations between status, tasks and roles. The modern matron uniform indicated that there was nursing leadership beyond the level of a senior sister.

The value of working in a defined group with shared goals was valued by the modern matron participants in this study. The group effect of a uniform was important and should not be underestimated. The power and influence of working in a group can result in shared behaviours, norms and self-regulation, and it is possible that these group characteristics helped to generate a sense of the modern matrons working in a collegiate manner towards the improvement of care quality (Joseph and Alex 1972).

Nursing uniforms have been central to the portrayal of nurses and at times this subject has been a pre-occupation for the public and the profession (Savage 1985; Pearson, Baker et al. 2001). The participants broadly agreed that the modern matron uniform outwardly gestured that the wearers were senior and that wearing that uniform was symbolic of their legitimacy and knowledge (Joseph and Alex 1972). Wearers of a senior uniform, it is advanced, have the ability to control subordinates to ensure conformity. A patient participant likened a matron with a uniform to an '*admiral of the fleet*' with a visible chain of command.

5.6.5 Two uniforms, two messages

The findings presented a tangible frustration from the national participants with regard to nurses' urgency to discard clinical dress in favour of managerial attire. The participants did not wholly embrace the return of the uniform, but instead, at the beginning of the implementation of the modern matron concept, the participants had two uniforms, clinical and managerial. Joseph and Alex (1972) suggested that having two uniforms could be seen as a rejection of one of the roles. Their theory describes the non-uniformed status as having greater autonomy when compared with uniformed staff. The move to a uniform may have signalled to the participants the possibility of reduced autonomy and more control by their line managers. Stepping out of uniform had been perceived as a powerful act (Joseph and Alex 1972). The retention of managerial attire could be seen as reluctance to lose perceived power. The possession of two uniforms may also have been a residual response from the managerial and Griffiths influences (Owens and Glennerster 1990), which outwardly signalled the tension in the modern matron role. The symbolic nature of a nursing uniform could possibly be viewed as contradictory to the Department of Health's mandate set out for the modern matron and the desire for an authoritative nurse leader, as it is acknowledged that uniformed staff are perceived to be less powerful and belonging to junior ranks (Joseph and Alex 1972). The use of two uniforms may have unintentionally weakened the clinical positioning of the modern matron and created the opportunity for the general managers to steer the modern matrons towards the delivery of corporate goals.

The predicament of a military chaplain described by Joseph and Alex (1972) is similar to the position that the modern matrons experienced. An army chaplain has two roles, religious ministry and soldier. The chaplains do not have two uniforms, but instead there is an accepted practice of wearing military fatigues and a 'dog collar'. Chaplains have managed to fuse both roles by way of their attire, but this was not possible for the modern matron. Similarly, two modern matron uniforms served two purposes. The clinical dress

demonstrated clinical expertise and connectivity to nursing. The managerial dress articulated the managerial functions of the modern matron role and may have signalled the retention of autonomy and power that may have been perceived to have been lost by wearing clinical dress (Buckenham and McGrath 1983). The inter-changeability of two uniforms may have caused some confusion in others with regard to the purpose and positioning of the modern matron participants and may have contributed to the participants' perceived lack of visibility by patients. If having two uniforms was related to perceived power levels, moving from clinical dress to managerial attire could have indicated to others that the modern matron was more powerful on some days than on others. The findings suggest that having two uniforms was perhaps a position which better reflected the complexity of the modern matron role and their oft-divided loyalties between nursing and management. However, the dual presentation of the modern matron role may not have fulfilled the expectations of the patient and carer participants.

The uniform coupled with the modern matrons' quality mandate was possibly a form of control disseminated from Department of Health level and locally implemented to improve, clarify and streamline nurse leadership and nursing practice. The importance of connectivity of the uniformed modern matron in relation to ward staff was discussed. The two uniforms were possibly a realistic decision, but one that may have contributed to the modern matrons' reduced visibility and role confusion as perceived by others. The drive for a traditional uniform and accompanying traditional values and approach to nursing may have been influenced by nostalgia (Davis 1979). The following section will illuminate the articulated tension in the findings between the modern matrons and their managers and the impact this had on the matrons' ability to focus fully on care quality. The next section will commence by determining the impact of the modern matrons using Read et al's study (2004) as the framework.

5.7 Modern matrons and care quality

The Department of Health commissioned research to evaluate the impact of the modern matron. The nationwide multiple case study surveyed patients and carers, modern matrons, general managers, medical consultants and directors of nursing and included observation of the modern matrons at work (Read, Ashman et al. 2004). The research was probably the first major study of the modern matron role (ibid). The exploration of modern matrons explored their day-to-day working lives and the range of responses reflected the multi-faceted and complex nature of their roles. This more recent study has responded to the suggestion that further research about modern matrons should be conducted once the role had more time to embed (Read, Ashman et al. 2004).

Read et al's study (ibid) had self-acknowledged limitations, primarily because it was conducted so soon after the implementation of the modern matron role (Read, Ashman et al. 2004); it was also recognised that participants' responses during the study may have been partly based on aspirations for the new role and early experiences rather than being based on actual interactions or events. The original study was published in 2004 (op cit): using this work should help to illuminate how the role has progressed and been shaped by local context and interpretation (Pawson and Tilley 1997; Department of Health 2001b; Department of Health 2001c).

The modern matron participants in Read et al's study (2004) reported that their roles were complex. From the job descriptions that were reviewed as part of the research, it transpired that the modern matron roles were broadly focussed on four main areas: professional standards and clinical governance, management and leadership, engaging with patients, families and carers and human resource management. Encompassed within those remits were the requirements to contribute to the achievement of corporate targets

such as waiting times, bed management and cleanliness, recruitment of nursing staff and professional development and targets to improve infection control. The targets (Department of Health 2002c; Department of Health 2007; Department of Health 2007) appeared to be implemented to support improvements in care quality. However, it was found that the pursuance of the targets might have exacerbated a situation which reduced the clinical visibility of the post holders.

5.7.1 Expectation

Read et al's (2004) research found that some modern matrons were apologetic that they had not, from their perspective, fulfilled the expectations of the role as prescribed with regard to the apparent lack of visibility towards patients and their families and levels of clinical involvement. Volume of work was identified as a shortcoming and possible threat to the success of the modern matron and was perceived by the directors of nursing in the study as a key concern and a possible barrier to the modern matrons' ability to effectively deliver on all of the ten key roles. The modern matron guidance (Department of Health 2001b) may have been influenced by nostalgic notions of a traditional matron, which developed into actual expectations for the modern matron that could not be fulfilled.

Modern matrons articulated that because in the initial stages the roles were seen to be successful with regard to their outputs, these roles became vulnerable to having other tasks bestowed upon them. The additional tasks were often outside of the modern matrons' ten key roles but may have fulfilled local expectation.

5.7.2 Modern matrons in this study – impacting on care quality

The modern matron participants felt that they had made contributions to improving care quality, with a particular focus on nursing care, patient need, cleanliness and clinical

environments, striving for nursing care improvements and concerted efforts to control infections.

The modern matron concept created a framework that allowed the participants to be more patient-focussed and this created space for the modern matrons to influence and impact upon the quality of nursing care. However, the 'space' created for the nurse leaders to improve quality became occupied by competing demands placed upon them by local contexts. The senior sisters were aware of the demands placed upon the modern matrons, which may have impacted upon the modern matrons' ability to fully focus on care quality challenges. The modern matrons recognised that the role was at times pressurised and compounded by frequent diversions from their core business of ensuring and delivering quality care and referred to this as '*being pulled from the day job*'. It was acknowledged by both the modern matrons and the senior sisters that the diversions made the execution of the modern matron role more challenging.

5.7.3 Leading by example

The modern matrons provided support to the senior sisters, which was welcomed. The modern matrons recognised that the senior sisters could not always get certain tasks done, because of the apparent reduction in that role's '*kudos*'. The senior sisters appeared to value the contribution that the modern matrons had made towards the improvement of care quality and the day-to-day support. The senior sisters regularly accessed the expertise and knowledge of their modern matrons to gain advice about complex clinical decisions, which was seen as supportive and a measure of good leadership.

The modern matron participants did begin to focus upon fundamental aspects of patient care and in doing so began to challenge poor nursing practice. The participants started to challenge the practice of junior staff, which the matrons felt was an expected component of their role. The senior sisters articulated that improvements in the quality of patient care

had created more opportunities for collaboration between themselves and the modern matrons and the shared purpose of improvement appeared to be valued by both staff groups.

The progression of nursing and nurse leadership may have contributed to the profession's preoccupation and subsequent diversion from patients needs (Keogh 1997). The national policy leads had attributed nurse leadership's loss of focus on patient care to the quest for professionalisation. The modern matron role had been used in part as a mechanism to reconnect nurse leadership towards the needs of patients. Professionalism may not have been the only cause for nurse leadership's diversion from patients. The arrival of managerialism and the desire for nurse leaders to adopt the new approach may also have contributed to nurse leaderships diversion from patients (Owens and Glennerster 1990).

Complaints management was an identified element of the modern matron role, although it was a task not entirely relished by the modern matron because of the '*disproportionate amount of time*' required to administer the complaints. Similar feelings of irritation were conveyed by the traditional matron (see section 4.2). One modern matron did find the new process helpful, as it provided direct connectivity to patients. However, the volume and complexity of complaints was viewed negatively and was an unwelcome barrier and a possible source of tension between clinical and desk-based activities.

5.7.4 Unrealistic expectations

The components that comprised the modern matron role were broad-ranging. The modern matrons had many wards to cover, emergency areas to oversee and in one case acute and community services to lead. In this study, the modern matrons' diversion to deliver corporate targets may have been a sign of the inherent tension between managerial and professional staff groups, exacerbated by the location of the modern matron within the line management arrangements.

The patients and carer reported that the modern matron was rarely visible to them; they also said that the wards were clean. Any influence that the modern matron may have had upon cleaning may not have been attributed to the role, as there was no apparent physical connection between the matrons and cleanliness. Within this study, there was minimal focus on the modern matron's impact with regard to infection control. Since Read et al's study (2004), there has been a reduction of HCAs, due to the wealth of work and new knowledge, which has impacted upon hospital cleanliness and infection control (Goddard 2006; Weston 2010; Dougherty 2011; Flynn and Zombolis 2011).

This point is broadly extended on from the contributions of the patients and carer that the modern matron was not an active contributor to patient care, and to a degree this is also reflected in the archives and evidence, except in cottage hospital settings (Bedford Fenwick 1909). It is known that much of nursing work is hidden and so the Department of Health's demand to ensure visibility for modern matrons may have been unachievable when much of nursing work is conducted behind closed doors or curtains (Lawler 1991).

The modern matron contributed to some of the improvements in patient care, particularly when the environment in which they operated was fully considered. The complexity of the modern matrons' location between management and nursing, the burden of patient, staff and Department of Health expectations and the nostalgic impact of the perceptions of the modern matron have been described. There remain continued concerns about the quality of nursing care and these concerns are explored in the next section. Because the concerns are similar to those that were evident prior to the arrival of the modern matron, it is important to consider whether the mechanisms that the Department of Health had implemented to improve the quality of nursing care were appropriate and or sustainable.

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prior to the arrival of the modern matron, it is important to consider whether the mechanisms that the Department of Health had implemented to improve the quality of nursing care were appropriate and or sustainable.

5.8 Nursing care quality – prevailing concerns

The public expects nurses to provide good quality care (Nursing and Midwifery Council 2008; Department of Health 2012a). When patients' expectations are not met, this results in public dissatisfaction and attracts political focus, as set out in the literature review, and this was the genesis for the modern matron role. However, during the last few years, there have been a number of high profile reports of poor quality nursing care. Table 5.1 summarises the national reviews of care quality from 2010 to 2012. The table identifies the commonalities of concern with regard to nursing care. The section at the bottom of the table highlights the key roles of the modern matron, which were meant to address the deficits that have been nationally identified. There is a wealth of key contextual and mechanistic factors that need to be addressed with regard to valuing the core tenet of nurses and nursing to provide good quality nursing care.

5.8.1 Mid Staffordshire Hospitals

Between 2005 and 2009, patients in a Staffordshire Hospital were subjected to systematic poor standards of nursing and medical care, which led to higher than expected mortality rates (Department of Health 2010). The Francis Inquiries (Department of Health 2010; Francis 2013) heard of and scrutinised appalling failures in care: numerous unobserved patient falls, lack of food and water, absence of privacy and dignity and overall uncaring and disinterested staff. The first Inquiry presented accounts from patients' relatives who stated that nurses did not always have the time to provide care, which then left their loved ones uncared for. The nurses at the Inquiry knew that they had not been able to provide the care that they had been educated to deliver. The nurses recognised that the

complexity of the way in which money was managed affected the ability to ensure adequate staffing numbers and skill mix. The context in which the nursing and medical staff were working was unusual and complex – an environment where oppression and bullying were commonplace. Mid Staffordshire’s focus on money was central to their activities at that time. The hospital did employ modern matrons, but how they specifically were able to enact their role is not entirely known.

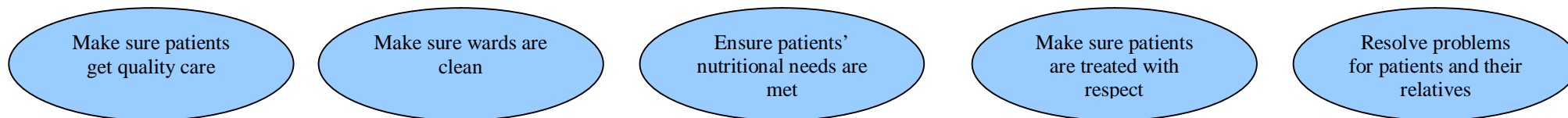
A concern of both Inquiries (Department of Health 2010; Francis 2013) was the ambivalence and disconnected approach, in which nursing staff appeared not to relate to patients in a vocational fashion. The reasons behind these failings have been published and are wide-ranging. The non-attendance to patients’ fundamental needs for drink or food was recorded during the Inquiry. The Inquiry interviewed nurses who stated that they were often caught in a dilemma and that they tried hard to continue to provide care for patients amid oppressive and restrictive working conditions, such as the lack of access to additional staff to cover workforce shortfalls. The importance of the context in which nurses and nurse leaders are expected to work is important and had, in Mid Staffordshire Hospital, negatively impacted upon the quality of care for patients (Pawson and Tilley 1997).

The second inquiry published in 2013 (Francis 2013) provided copious recommendations for the English NHS to improve nurse education, increased staffing on wards and ensuring that senior sisters are able to work in a supervisory capacity to oversee the quality of patient care.

Figure 5.4 Themes from inspections and reviews of NHS care quality concerns in England with the Modern Matrons' ten key roles 2010 – 2012

	Mid Staffordshire NHS Foundation Trust Independent inquiry 2010 and public inquiry 2013	Front Line Care: the future of nursing and midwifery in England 2010	Care Quality Commission Dignity and Nutrition Inspections 2011	Parliamentary and Health Service Ombudsman – Care and Compassion 2011
What prompted the review?	<ul style="list-style-type: none"> complaints regarding poor care increased death rates 	<ul style="list-style-type: none"> Mid Staffordshire Basildon hospital 	<ul style="list-style-type: none"> Mid Staffordshire concerns 	<ul style="list-style-type: none"> Complaints about poor care from elderly people
Key themes	<ul style="list-style-type: none"> lack of hydration lack of nutrition lack of personal hygiene uncaring staff no dignity misguided trust board disengaged staff focus on money 	<ul style="list-style-type: none"> variations in practice 	<ul style="list-style-type: none"> staff not helping patients to eat or drink no dignity call bells out of reach or answered too late uncaring staff 	<ul style="list-style-type: none"> no nutrition no hydration no basic personal hygiene no toileting uncaring and disengaged staff

Modern matrons key roles that were applicable here:



The role of the healthcare regulator was scrutinised during the Inquiry, but since that time, the approach to healthcare regulation has been amended, which has illuminated similar concerns in other hospitals.

5.8.2 Omissions of dignity and nutrition

The Health Act 2008 provided for a revised healthcare regulatory regime, which saw the establishment of the Care Quality Commission (CQC: (Care Quality Commission 2010). The previous regulator, the Healthcare Commission, undertook reviews of hospitals using desktop methodology only. The CQC utilised different methods to gain assurance of clinical practice by direct engagement with staff, patients and relatives, observation of practice and policy review to provide a triangulated and holistic perspective of healthcare provision.

During 2011, one hundred acute hospital trusts in England were thematically inspected against two CQC quality outcomes: dignity and nutrition in elderly care (Care Quality Commission 2011). The outcomes related to two of the modern matron's ten key roles as illustrated in Figure 5.5:

Figure 5.5 CQC outcomes and relevant modern matron key role

<p>Outcome 1 - Respecting and involving people who use services This outcome includes ensuring that patients are engaged in their plan of care, that they have their dignity maintained, that care is personalised and risks are explained for treatment options.</p> <p>Modern matron ten key roles: make sure patients are treated with respect</p>
<p>Outcome 5 – Nutrition This outcome includes ensuring that personalised nutritional needs are met, that assessments of nutritional requirements are completed and acted upon, and where patients need help and support to eat and drink, that this support is readily available.</p> <p>Modern matron ten key roles: ensure patients nutritional needs are met</p>

One quarter of the inspected hospitals in England did not meet the required standards. The research site was inspected and the findings were satisfactory. It would be difficult to attribute that inspection outcome solely to the modern matrons, particularly as the impact of organisational behaviour has been previously highlighted, but it does provide some evidence of the modern matrons' positive impact and influence, which may have enabled nursing staff to refocus and deliver the fundamental elements of nursing care.

Across England, the Care Quality Commission (CQC) observed nursing care that varied in quality. In some hospitals, some staff (mainly nursing) were found to be disrespectful towards patients in the way in which they spoke to them. Some patients were not being helped to eat or drink. Often call bells were placed out of reach, so that patients were unable to summon help; when call bells were to hand and were activated, sometimes nurses took a long time to respond and the delayed responses led to patients being left in soiled bedding. In some cases, dignity was compromised whilst personal care was being given. Some of the inspections found that nursing staff were pressurised because of lack of staff and this may have led them to be less responsive, but would not necessarily account for not protecting someone's dignity. There was a tangible sense that some of the nurses were found to be uncaring or ambivalent about the needs of their patients (Care Quality Commission 2011).

The fundamentals of care were being missed in varying amounts across the country. The context for most hospital trusts was not as concerning or extreme as was found at Staffordshire, but the patients were still not receiving good quality nursing care. The widespread and varied quality of nursing care once again heightened concern amongst patients and politicians (Campbell 2011).

The recommendations from the CQC's Dignity and Nutrition inspections did not address the behaviours of the nurses, but instead suggested that the gaps in care would be met by additional education. Nursing staff would have received sufficient education in this area during their initial nurse education and it is possible that some refresher education may

have been helpful. However, the supporting infrastructures illustrated by the Francis Inquiry (Department of Health 2010) are fundamental to ensure that nursing staff are able to deliver good quality patient care.

When patients or their families are unhappy with the standard of care, they are able to complain. If the complaint response from the hospital is not forthcoming or is deemed to be inadequate, complainants have the opportunity to escalate their concerns to the Parliamentary and Health Service Ombudsman (PHSO: (Parliamentary and Health Service Ombudsman 2012). A selection of these complaints was compiled in a report published by the Ombudsman and will be considered in the next section.

5.8.3 Care and Compassion

The Parliamentary and Health Service Ombudsman is the final point of escalation and consideration for complaints regarding National Health Service care. The Ombudsman was concerned that there appeared to be a theme to complaints that related to the care of elderly patients. The Ombudsman selected ten cases from the many complaints received during 2009 and 2010. The stories selected highlight a lack of fundamental nursing and medical care. The Report, Care and Compassion (Parliamentary and Health Service Ombudsman 2012) was concerned that the lack of care was not solely attributable to a lack of resources, but merely to a lack of compassionate staff. Recurring themes of nurses not providing food and drinks for patients, delayed pain relief and unmet hygiene and toileting needs are evident in the Report.

The Ombudsman believed that a balance should be achieved between competency, care and compassion. The report states that nurses should pledge themselves to society to give high quality care, but in a sense this is already achieved when nurses are registered via the Code of Conduct (Nursing and Midwifery Council 2008). Because of the prevailing concerns and many national reports on the apparent state of nursing care, a Prime

Minster's Commission was established to determine what was needed to improve and sustain the quality of nursing care.

5.8.4 Frontline care – a review of nursing

The then Prime Minister, Gordon Brown, requested a commission for nursing⁹ and midwifery – Frontline Care (The Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010). Other hospitals apart from Mid Staffordshire were also harbouring poor standards of care quality (Martin 2009). This Commission was focussed on the complexities of nursing in respect to a profession that was acknowledged to be at times undervalued and hidden. The Commission recognised that key factors from education, workforce and hospital culture all influenced the context in which nurses were required to work effectively. The Commission stressed the importance of maintaining a balance between compassion and competency and advocated that senior nurses should uphold standards and support the delivery of good quality patient care care. To an extent this was partly the remit of the modern matrons when they were introduced. The Commission published its findings in March 2010. By May 2010, the Government had changed. The new Prime Minister continued the work to improve the quality of nursing care via a new national work stream.

5.8.5 Intentional rounding to improve nursing care

A new framework for the provision of care - intentional rounding (National Nursing Research Unit 2012) - had arrived in England from North America and was endorsed by the Prime Minister as a mechanism to improve the quality of nursing care (Topping 2012). The characteristics of hourly rounding are just that: nurses undertake an hourly review of each patient's needs: toileting, hydration, pressure area care, pain assessment and management – a structured mechanism of purposeful surveillance at regular intervals. The evidence suggested that patients favoured frequent contact with their nurses: it made

⁹ For the purposes of this thesis, nursing will be the sole focus.

them feel reassured and from their perception, increased the quality of nursing care (National Nursing Research Unit 2012). The Prime Minister demanded hourly rounding be implemented in all hospitals to address care deficits (Topping 2012). It is again evident from the Prime Minister's response that the underlying reasons for nurses failing to attend to the needs of patients has not been fully addressed and this is a concern.

The implementation of the modern matron role was possibly quite timely and made contributions towards the improved quality of nursing care. Since that time, the prevailing concerns and reactive solutions have been focussed on the apparent deficits within nursing. It seems that the onus for poor patient care is directed towards nursing and nurse leadership. To some extent, this stance would be correct, but there is a deeper perspective to be considered, as identified in section 4.9 of Chapter Four. There has been minimal dialogue regarding the environment and context, which impact upon the way manner in which nursing care is delivered. From this study, it has been identified that the line management arrangements for the modern matrons have been a barrier to their ability to conduct their role fully with regard to care quality. The drive to meet corporate targets and the modern matrons' diversions from quality, which have been identified within this study, may need to be addressed to support a sustained focus on quality and patients and thereby deliver sustained and good quality nursing care.

5.8.6 Nursing and midwifery strategy – compassion in practice

The national strategy, following consultations, has defined the areas that all nursing, midwifery and care staff need to focus upon to ensure that overall, patients receive good quality care (NHS Commissioning Board and Department of Health 2012). This strategy has been articulated as the 6 C's for nurses and midwives to underpin their daily practice: compassion, care, courage, commitment, competence and communication. The 6 Cs are intended to help to shape values and behaviours which should positively impact on the quality of care received by patients. The 'good quality' is further defined by patients having a positive experience of staff, nurses recognising and staff delivering care that is

compassionate and kind. The measurement of caring impacts is also a fundamental element of the new strategy to determine whether new interventions are having the desired outcomes for patients. The strategy advises that the National Commissioning Board and the Department of Health will work closely with staff in order to ‘understand the barriers that we need to address and overcome’ (pp 26).

General concerns remain regarding the quality of nursing care; however, other staff groups are also implicated. The various reviews and inspections into the causes of sub-standard care were considered and they all share recurring themes. Until the underlying mechanisms and contexts are addressed to ensure that the environments in which nurse leaders and nurses work are effective, superficial changes that are repeatedly offered may have minimal long-term impact.

The following section will further consider the discussion, drawing from the framework of realistic evaluation to identify the underlying causes of the key themes that have been identified in this study.

5.9 Realistic evaluation of the study findings

This chapter has begun to illuminate and identify the stratified perspectives of the study’s findings through the lens of realistic evaluation. The purpose of this section is to draw from and expand upon the realistic evaluation framework (Pawson and Tilley 1997) and to synthesise those strands raised in this chapter and identify how realistic evaluation may illuminate previously unseen factors that may contribute to the current body of knowledge. In addition to utilising Pawson and Tilley’s (1997) context, mechanism and outcome configuration, additional perspectives have been added to compare the actual outcome with the intended outcome. Current mechanisms will be critiqued here, but once again suggested revised mechanisms, which will serve as a comparison to the actual mechanism, will be included. Five context, mechanism and outcome configurations have been identified and four of them are interrelated in respect of the relationship and on-

going tension between the modern matrons and the general managers. This section will suggest why an assessment of contexts may be a helpful process prior to the implementation of policies.

The revised context, mechanism and outcome formation has been presented in Table 5.5 with the key elements from this chapter included. The tension between the modern matron participants and their line managers will be expanded below and will be subjected to a stratified perspective and a deeper ontological understanding.

5.9.1 Matrons and managers – a stratified perspective of the challenges towards achieving improved care quality

As detailed in section 5.3, the context in which the modern matron participants worked was largely influenced by their line managers, the general managers. Four context, mechanism and outcome configurations have been identified, which all appear to be influenced by the interplay between these two staff groups. The diametrically opposed ideals and perspectives between the two groups (Flynn 1999) was magnified here; in relation to this, the Department of Health had introduced two mechanisms. The first was the admission within the modern matron policy, which advised managers that the new modern matron would not pose a threat to them. To an extent, this is a true statement, as the modern matrons' purpose was not to intimidate others but to work with others to improve care quality. However, this phrase may have had the effect of managers dismissing and or diminishing the status of the modern matron role prior to its implementation.

This second mechanism of the modern matron role being much more clinically engaged when compared with the predecessor role may, according to what is known (Flynn 1999), have unintentionally increased the distance and tension between the matrons and their managers and consequently eroded the clinical core of the role. Alternative mechanisms to enable the modern matrons to remain more clinically engaged may have been helpful.

Flynn's (1999) contribution on the divisions between professionals and managers has enlightened the discussion, but it is doubtful whether professionals and managers would be aware of the different perspectives. Successful continuation of the modern matron role may have been augmented by creating an opportunity for the modern matron participants and general managers to engage in a facilitated discussion about understanding each party's perspectives to better enable improved working relationships. The outcome of this discussion could have contributed to developing and amending the receiving context. An opportunity such as this may have helped, but the wider organisational structure may have required some change. To enable the modern matrons to remain clinically focussed, the director of nursing would need to manage nursing and be supported by the director of operations. The revised mechanism may have the effect of reducing the conflict and tension that the modern matron participants had articulated and keeping them clinically focussed. The next context, mechanism and outcome configuration is also concerned with the perceptions held between the modern matrons and their line managers.

Maintaining cleanliness and improving ward environments for patients was outlined as a key modern matron objective. The context for the management of cleaning at the trust was managed by a contracts manager. The mechanism within the modern matron policy expected the modern matron participants to have direct authority to stop payment of cleaning contractors if their work fell below expected standards. The trust context could not enable this mechanism because the contract was managed by a facilities manager. The modern matrons were able to influence some contractual decisions and were involved in auditing the service. The trust context limited the matrons' ability to have full authority and so this Department of Health endorsed authority was not locally enabled. The intended outcome for ward areas to have increased cleaning standards was achieved, but possibly to the detriment of the undermining of the modern matrons.

Similarly the Department of Health allowed £5000 of funding each year to improve ward environments. The modern matrons and senior sisters were able to spend the funds collaboratively to purchase new items to improve ward environments for patients. The

mechanism of the direct funds served to provide the modern matrons with more autonomy. For the first few years, the funds were directly available as per the Department of Health's request. However, the local context changed and there was less money in the health economy, and financial prudence was a key priority. As a result, the environment funding was still provided by the Department of Health but the trust did not make the funds directly available to the senior sisters and the modern matrons. Access was only available by application.

To ensure that the Department of Health mechanism of direct access to the funds was consistently available to the modern matrons, it may have been helpful to introduce an additional mechanism, periodic data capture or audit, which would not have been unusual when assessing the continued success of implementation and of a new target. The modern matron would then be able to provide feedback to the Department of Health or health authority if the context had impeded upon the ability to carry out the role.

Although the mechanism of introducing modern matrons was designed to be flexible for the receiving context or trust, the level of pliability may have altered the intentions of the mechanism, as has been demonstrated. It appears that the mechanisms were not only about access to funds or withholding payments from contractors, but that a 'sub-mechanism' was also present. The sub-mechanism was the drive from the Department of Health to have modern matrons take charge of their services and provide them with the authority that they thought should be intrinsic to the role. The local modification of the mechanisms may have led to an erosion of the role's authority. The intended outcomes had improved cleanliness and ward environments, but amidst a context in which nurse leaders who were meant to be afforded some power and authority witnessed these mechanisms being removed or declined by managers because of the limiting context in which they worked.

The context of poor nursing care nationally prompted the architecture for the ten key roles as the mechanism for change. The mechanism, as is the nature of some guidance

documents (Pawson and Tilley 1997), was rather short-term. The modern matron participants were able to outline the improvements in care that they had led or contributed to. However the modern matron was not able to affect change on all ten key roles, possibly because of the widespread challenges and the nature of the organisational infrastructure, which by default placed barriers in the path of modern matrons.

Figure 5.6 Adapted realistic evaluation framework with intended and unintended outcomes (Pawson and Tilley 1997)

Context	Actual mechanism	Suggested new mechanism	Intended outcome	Actual outcome
1. Predecessor senior nurses were more corporately focussed managed by corporate focused general managers	Modern matrons with a nursing and quality focus	Modern matrons with a nursing and quality focus Facilitated discussion between managers and matrons to enable a greater understanding between the two staff groups. A change in line management for the modern matrons from operations to nursing	Improved nursing care quality with clinically focussed modern matrons	Improved nursing care quality in part. Modern matrons who have been diverted from clinical practice due to corporate demands
2. Cleaning contracts were managed by a contracts manager	Modern matrons to have the power and authority to withhold payment to cleaning contractors if levels of hygiene fell below expected standards.	Facilitated discussion between managers and matrons to enable a greater understanding between the two staff groups. Modern matrons to have the power and authority to withhold payment to cleaning contractors if levels of hygiene fell below expected standards but supported by a method of data submission and audit to the health authority or the Department of Health to identify barriers to the delivery of this mechanism.	Improved cleanliness in clinical areas Empowered modern matron participants with authority to withhold payment.	Improved cleanliness in clinical areas Disempowered modern matron participants with authority to withhold payment.

Context	Actual mechanism	Suggested new mechanism	Intended outcome	Actual outcome
3. No specified money for improving wards areas at the disposal of the modern matron participants.	Modern matrons and senior sisters receive £5000 per annum to improve ward areas.	Modern matrons and senior sisters receive £5000 per annum to improve ward areas. Modern matrons to maintain access to funds and would be supported by a method of data submission and audit to the health authority or the Department of Health to identify barriers to the delivery of this mechanism.	Improved ward environments. Empowered and authorised modern matron participants whereby purchases could be directly made.	Improved ward environments. Disempowered and deauthorised modern matron participants with no access to the funds to enable direct purchases.
4. Poor and variable nursing care quality	Modern matrons' 10 key roles	Modern matrons 10 key roles Review of entry requirements for nursing to ensure entrants are vocationally motivated	Improved quality of nursing care	Improved quality of nursing care, but short term in nature.
5. Predecessor senior nurses not engaged clinically in an environment where the Griffiths ideology remains intact and the delivery of corporate goals was priority.	Modern matrons return to clinical dress which was locally amended to include the wearing of managerial attire.	Modern matrons to only wear clinical attire and to spend a specified percentage of time within their clinical areas.	Modern matrons to be visible and clinically engaged.	Modern matrons were not always visible to patients and relatives. The use of two uniforms possibly gave two messages and contributed to the modern matrons lack of visibility.

5.10 Conclusion

This chapter has employed a number of theoretical frameworks to provide structure to illuminate the discussion of the key themes raised in the findings chapter. A number of themes appear to be interrelated and have converged to impact upon the ability of the modern matron to improve the quality of nursing care.

With regard to the socio-political influences, the articulated tension between the modern matrons and their line managers was further explored. The modern matrons were working in a difficult environment whereby their efforts to focus on improving the quality of nursing care were to an extent prevented by their corporately motivated general managers. This barrier was exacerbated by the limited scope of the modern matron. Once again, the nostalgic notion that traditional matrons were singularly powerful was did not appear to be consistently evident in the literature and archives. Whilst a powerful and authoritative nurse leader was envisaged in the modern matron, this 'fact' did not emerge from this study possibly because, the style of management and leadership in the National Health Service has developed since its inception (Cook 2001; Casey 2003). Secondly, the modern matron's ability to be powerful was limited because the scope of the role was limited by their general managers and was displayed by the removal of access to some resources.

With regard to the socio-political influencers of the traditional and modern matrons, nostalgia appears to have impacted upon the direction of nurse leadership and the way in which nurse leaders are presented. Nostalgia also appears to have influenced policy makers to ensure that the modern matron was a uniformed member of the nursing team by repackaging them in uniform, possibly to gain a sense of regression to the 'good old days'.

The continuity between traditional matrons and modern day successors were periodically revealed in the irritations that complaints sometimes caused. The visibility that uniforms

were meant to augment was not evident for patients and carers, but was for staff. The methods employed by the modern matron to subvert the direction of general managers to 'walk the wards' to collect data eliminated the need for physical ward presence. This subversion may have unintentionally reduced the visibility of the modern matron. The dynamic nature of autonomy as ascertained in the literature for traditional and the modern matrons in this study was a challenging aspect of both roles and the perceived total authority of some traditional matrons and the modern matrons has never completely been realised.

The illumination of the policy journey provided clarity as to why new policies appear familiar when they are reissued as the next new thing. The vulnerability of nursing with regard to political cycles was evident, as the launch of the modern matron concept appears to have been orchestrated to secure political success. It is very useful for nurse leaders to be aware of the policy process as described by Kingdon (1995) to ensure that the nursing voice is involved at the early stages of policy development.

The modern matrons' impact on the quality of nursing care has been difficult to determine, as there were many obstacles and diversions to navigate and these reduced the amount of time that they had to devote to improving the quality of nursing care. Some of the achievements with ward cleanliness, dignity and complaints management may have been achieved through other colleagues. There were aspects of the ten key roles where some improvements had been made: ward cleanliness, increased awareness of protecting patients' dignity and complaints management.

In summary, the modern matron appeared to be constructed from the nostalgic notions of the traditional matron, but these notions were unfounded according to the archives and other evidence. Therefore, the expectations of the modern matron were difficult to achieve, as they probably were not completely achieved by their traditional predecessor. However, the modern matron guidance did ensure that the quality of patient care gained a renewed focus (Department of Health 2001b).

It has been a challenge to determine the impact of the modern matron role. The role was influenced by many factors, which mostly led to a reduced capability of the role and the full potential for the post holders in this study was probably not completely realised. The restriction of the proposed authority levels of the modern matrons also compromised the impact of the role. However, the anticipated authority levels were possibly incongruent with modern management styles. The modern matron contributed to some improvements in care quality, but were not able to achieve substantial improvements without the support of colleagues in other disciplines; the requirement for a multidisciplinary approach to achieving good quality care seemed to be necessary which renders the idealise powerful and authoritarian nature of the modern matron role as envisioned by the Department of Health as slightly obsolete. The pursuance of corporate targets may have limited the visibility of the modern matron and increased the deskbound nature of the role. Had the modern matron role been accountable to a nursing hierarchy and been able to solely focus on enhancing care quality, the possibilities for nursing and for patients will remain untapped.

In essence a range of theories have unveiled a number of barriers that have beset the modern matron, some of which were experienced by Matron Jones. The next chapter will present the implications of this thesis for practitioners, nurse leaders and policy makers and will suggest ways of taking the themes raised in this study forward.

Chapter Six

Conclusion

6.1 Introduction

I have constructed this thesis around the experience of the modern matron, which was illuminated by historical accounts of a traditional matron's working life supported by other evidence; both roles encountered similar challenges and successes. The thesis has drawn from a number of theoretical frameworks. Realistic evaluation (Pawson and Tilley 1997) has been the lens through which the study has been viewed and this has enabled the unveiling of unknown or previously unacknowledged challenges, which has identified new knowledge. The thesis has also identified historical and socio-political influences, which have continued to shape the multi-faceted nature of the modern matron.

The NHS Constitution is the legally binding façade to legislation which should ensure that patients, carers and NHS staff all fully recognise and engage with their respective responsibilities to ensure that the NHS remains equal and fair for everyone (Department of Health 2012a). The NHS Constitution will be utilised here to augment the points raised below. The chapter will be structured in three parts which reflect the aims of this study.

The chapter will identify the unique contributions of this study to new knowledge and the possible implications for the stakeholders that were included in this study as participants. This chapter will acknowledge the unique contribution made by a traditional matron, Matron Jones, whose accounts have provided insight devoid of nostalgia into nurse leadership during the post-Second World War era. The chapter will reflect on this study's limitations and will conclude with suggested areas for future research opportunities.

6.2 Contribution to new knowledge and understanding

I have argued that the modern matron concept was broadly welcomed but has been subjected to limitation. This study has unveiled four significant areas of new knowledge: the predicament between modern matrons and general managers and the impact this has had on care quality; the vulnerability of nursing guidance once it leaves the confines of Westminster; the political and policy influences that may have contributed to the development of the modern matron guidance; the impact of nostalgia juxtaposed with the modern matron guidance viewed in parallel with the role of the traditional matron. These areas will be expanded upon in the next section, during the chapter via the lens of realistic evaluation.

6.3 Realistic evaluation – the lens for this study

The thesis has also argued that the possibility of tighter mechanisms in future policies would be beneficial. In this way, policy intentions derived in government may be more likely to be fully implemented locally, particularly if context assessments were conducted prior to a policy or guidance finalisation. The employment of realistic evaluation (Pawson and Tilley 1997) has enabled the consideration and highlighted the value of context and context assessment, which may have been a valuable addition to the modern matron guidance. An assessment of the context against pre-set criteria may have identified and removed some of the diversions that the modern matrons had experienced and ensured that supporting infrastructures were in place prior to implementation of the role. Periodic assessment of trusts' progress with the guidance may have alerted national policy leads to unexpected and undesirable outcomes, which could have been addressed at an early stage to ensure that the modern matrons had optimum opportunity to fulfil their job as nationally prescribed.

Part I Socio-political influences on nurse leadership's development

6.4 Modern matrons and general managers – the predicament

This thesis has provided a deeper and applied understanding of the realities and nature of a professional and managerial relationship as described by the modern matron in relation to general managers. The typology of professionals and managers (Flynn 1999) demonstrated the division of ideologies, expectations and priorities between the two staff groups and because of this, tensions between the modern matron participants and their line managers was palpable. The modern matrons stated that their job roles had positively impacted upon hospital cleanliness, patient dignity, handling complaints and providing leadership to the senior sisters. The impact of the modern matron role does need to be considered amid the complexities of their daily work context, some aspects of which are now appreciated in this thesis.

6.5 The policy journey

The complexities of policy and the political world were demonstrated within this thesis. The thesis argued that the modern matron role was not a new but an old concept, which was waiting for an opportune policy window (Kingdon 1995). It appeared that the development of the role was vulnerable to the short-term and the superficial nature of policy development for political gain (Kingdon 1995; Pawson and Tilley 1997).

This study has exposed, with the help of Kingdon's (1995) model, that the context at that time (immediately prior to the announcement that modern matrons would return to the NHS) of a dissatisfied general public and an imminent general election were the triggers to amend the approach to nurse leadership.

6.5.1 Policy and politics

This study has revealed how the modern matron guidance left the confines of Westminster, was absorbed by the trust but then over time became vulnerable to local interpretation and was overtaken by local priorities. The thesis has demonstrated how centrally derived national policies could have the potential to lose their potency when subjected to local influences and interpretation, which in turn impacted upon the nature and original intentions of the policy (Pressman and Wildavsky 1973). This was illustrated in this study by the Department of Health's mandate to give modern matrons more authority by allowing them access to funds, which was eventually removed by the trust management.

6.5.2 Implications for national policy leads

The modern matron guidance was in parts unclear, ambiguous and lost its potency following implementation at the trust. National policy leads may need to consider the context into which new policies and guidance are being introduced. The modern matron guidance may have addressed national political concerns but local demands superseded those. Well-intentioned mechanisms within the guidance conflicted with other equally deserving elements of health service delivery: for example, the eventual denial of environment funding for the modern matrons appeared to have been influenced by the trust's focus on saving money.

A 'policy' as opposed to 'guidance' may have helped to enforce compliance from all implicated stakeholders such as general managers. In government terms, a 'policy' instructs NHS trusts what they must do, whereas a guidance document is optional (Difference between.net 2013). The research site did implement the modern matron guidance, but as this study has demonstrated, the elements of the guidance were dismissed, whereas a national policy may have avoided this scenario.

As further reports on the state of care quality are due to be published, it may be incumbent upon national policy leads to insist that hospital trusts change the emphasis of how hospitals are managed. The NHS commissioning sector is currently being redesigned to ensure that clinicians are at the forefront of clinical commissioning decisions whilst being supported by managers (Department of Health 2010); it may now be time for secondary care to similarly shape their organisations to enable modern matrons and their clinical colleagues to be supported by corporate management as opposed to being driven by them. The size of the proposed task has not been underestimated, as it would require structural as well as long-term cultural change; moreover, if those changes benefited the quality of patient care in a sustained manner by supporting nurse leadership, then change may be prudent. The increased number of NHS foundation trusts would make the stipulation of such change by the Department of Health increasingly difficult to achieve, as they are not bound by their demands (Monitor 2013).

Part II Continuities between the traditional and modern matrons

6.6 The impact of nostalgia on modern matron guidance

The impact of nostalgia upon the modern matron guidance was evident at a superficial level with regard to the redefinition of nurse leadership at that time, but there were deeper aspects, which appeared to be drawn from nostalgic perceptions. The desire for a ‘matron-like figure’ was originally articulated by the public and conceptualised within the guidance. The national policy leads had envisioned a nurse leader, with authority and power to be in control of nursing practice standards and to put the needs of patients first. The nostalgic perception that the traditional matron had unilateral power was, from the evidence available to this study, unfounded. Therefore the Department of Health’s desire to give modern matrons the same perceived power and authority did not reflect the working life or location of the traditional matron. The modern matron guidance replicated the working life of a traditional matron: ambivalently located, subservient and with limited authority in a modern and complex setting.

Matron Jones's steadfast focus on nursing was probably central to ensuring the provision of good quality nursing care; it is this tenet that was eroded at the trust. A position needs to be reached whereby modern matrons are supported by an organisational framework to maintain a dedicated focus on nursing care.

Part III The impact of the modern matron on care quality

6.7 Implications for patients

The modern matron was barely visible to patients and so the expectations of the Department of Health and the patients were unmet. If the modern matron role continues to be eroded of its fundamental requirements to focus on the quality of nursing care, then this could contribute towards a detrimental effect for patients. Patients had reported what they had expected of a modern matron, but (albeit from a limited sample) two patients saw a modern matron but none had the opportunity to engage with one. From the perspective of patients, the modern matron role was unable fully deliver; patients expected an authoritarian role that would physically monitor the performance of junior staff and purposefully engage with patients, but neither of these expectations was evident. Although modern matrons did occasionally and briefly engage with patient care, it was clear from the findings that this was difficult for them to achieve because of the corporate demands placed upon them.

The modern matron role was created following patient consultation (Department of Health 2000). Gradually the role at the study site was eroded. It could be perceived that the patient voice has less value and also diminishes over time, as their expectations appear to carry less weight when compared with other demands in a hospital. The NHS is required by its own commitment to listen to the views of its patients. The NHS Constitution is the operational façade of legal requirements which stipulate that the NHS is held to account regarding,

amongst other things, the quality of care and the necessity for the organisation to actively listen to patients (Department of Health 2012a). It seems apparent that participants within this study did not have the opportunity to have their concerns taken forward by a modern matron because of the role's diversion from clinical practice. Moreover, patients and carers could escalate their concerns and have them substantiated by the NHS Constitution *ibid*, but the Constitution is a rarely mentioned framework. It has been acknowledged more recently by the Department of Health that the NHS Constitution would benefit from 'greater traction' and increased promotion to ensure that patients and carers are clear about what to expect from the NHS (Department of Health 2012b).

6.7.1 Implications for senior sisters

The modern matrons' diversion towards the delivery of targets did mean that the consistent leadership that the senior sisters wanted was not always available. The findings acknowledged that senior sisters valued the support and guidance that they received from modern matrons. The participants did recognise that the modern matron role could have had greater impact had it had the opportunity to plan ahead as opposed to being diverted to deliver corporate targets. The senior sisters appreciated, however, that if the modern matrons had been more engaged with patients, the opportunity to proactively improve and expedite the quality of care may have had a more sustained effect.

The NHS Constitution states that all staff should aim to maintain high standards of care (Department of Health 2012a). Whilst the senior sisters appeared to be fully engaged and committed to their roles, they did believe that the increased focus of a modern matron on planning ahead and nursing activities may have helped to deliver further and sustained improvements in the quality of patient care.

The eroded and diverted role of the modern matron means that the senior sisters do not receive a consistent approach to leadership and clinical expertise; this could create some

uncertainty and add to the difficulties of managing nursing care in a fast-paced and dynamic environment, which in turn can negatively impact upon the goal of delivering good quality care.

6.7.2 Implications for modern matrons

The modern matrons were required to deliver on clinical and corporate priorities amid vast and expansive portfolios. The essence of the modern matron was gradually diluted and shifted from a position that was designed to be clinically focussed and resulted in a role which was increasingly desk-bound. The modern matron was hailed to be a visible clinical leader and was visible to senior sisters, but was relatively absent with regard to patients and carers. The role of the modern matron and the overarching question of this study were to ensure that public confidence was restored in the quality of nursing care via the physical presence and activities influenced and led by the modern matron. Restoration of public confidence was not wholly possible because of the modern matrons' lack of physical presence. The activities in which the modern matron was engaged with to improve cleanliness or patient dignity may not have been seen by patients as it is known that much of nursing work is a hidden activity (Lawler 1991).

The NHS Constitution states that staff should aim to maintain high standards of care. The modern matron role was designed to do that in conjunction with senior sisters and other staff. Due to the distraction and expectation for the modern matrons to be frequently involved with the delivery of targets, it could be argued that that aim as set out in the NHS Constitution has not been fully met (Department of Health 2012a).

The modern matrons with their director of nursing and their general managers need to consider whether the focus of the role is to improve the quality of patient care or the delivery of corporate targets. If the role is to conduct both aspects, then this hybridisation, as the

findings have demonstrated, is difficult to achieve, as neither stakeholder was entirely satisfied with the outcomes of the role.

6.7.3 Implications for directors of nursing

Although directors of nursing at trust and national levels were not included in the study, the role is influential upon the quality of nursing care and therefore consideration of implications for this group are outlined here. The main barriers to the modern matron participants achieving all the requirements of the role were because of the local interpretation by their line managers and minimal monitoring of the role's progression and ability to focus on the core aspects of their role. The division of ideologies between the two staff groups was compounded by the modern matrons' innate focus and role requirement on nursing and quality, juxtaposed with the corporate worldview of general managers. This division may have been further exacerbated because of professional and line management structures at director level. This thesis raises the question of whether it would be opportune for nurse directors to manage nursing whilst being supported by their operational colleagues as opposed to the current arrangements. In order to make use of this new knowledge, it may be incumbent upon national policy leads and nurse leaders to consider a review of organisational structures to ensure that good quality nursing care is consistently delivered without the barriers and challenges as presented during this study.

There have been many changes within nurse leadership during the last sixty years (White 1985; Owens and Glennerster 1990) – changes to titles, emphasis, skills and knowledge requirements - but the needs of patients have largely remained constant. The archival documents provided a flavour of what 1950s patients expected of their hospital stay and it is likely that 21st century patients would expect similar standards (Department of Health 2003); nevertheless, the approach to nursing leadership continues to change. Directors of nursing should endeavour to fully appreciate the complexities of policy development and contribute

to policy debates and lobby political leaders to actively and positively shape the profession and safeguard nursing leadership from political whim.

6.8 Limitations of this study

The patients and carer made valuable contributions to this study. However, the recruitment of patients could have been improved by widening the search. Accessing community groups or health-focussed charity groups may have secured more participants, as patients with chronic illnesses invariably have frequent contact with the health service.

The use of social media may have improved recruitment, but this form of communication has only really been generally accepted as a reliable method of communication during the last two years. Email communication to local towns and villages and also advertising in local newspapers or on a local radio station may have helped to boost the patient cohort.

The archives of one traditional matron was made available to this study. Criticism could be levelled at this study, because the concept of a traditional matron was extracted from one traditional matron rather than many. Therefore to be able to draw from another traditional matron from that research site would not have been possible because any other related archives unavailable or inaccessible. However, to provide a broader perspective on the work of traditional matrons other sources were utilised (Emrys-Roberts 1991; Lorentzon 1997; Arden 2002; Castledine 2007; Helmstadter 2008).

6.9 Further research

Research to explore the perceptions of general managers regarding nurse leadership would help to provide further insight and understanding into that working relationship, as the full extent of this identified tension is not fully understood because general managers were not participants in this study. Furthermore, the relationship between the director of operations

and the director of nursing with regard to improving the quality of patient care may also be a useful research avenue.

The political dimension of nursing care and the perception of national policy leads could be a focus for further research. This study has identified how the modern matron guidance had great expectations of the role, but in fact the guidance was self-limiting. The resolve of national policy leads to go beyond a superficial and expedient response fix to improve the quality of nursing care could be worthy of further exploration.

6.10 Concluding personal remark

I was motivated to conduct this primary research because of my passion for nursing and personal curiosity about a role which was apparently secured in the annals of the profession. I too was a modern matron and I needed to understand what my professional predecessors had experienced. My experience of working at national policy level drew me to enquire as to why policy leaders had looked to the past for a modern solution. This study has in a small way helped to illuminate the role of a traditional matron and has identified the challenges of some of today's modern matrons.

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[Redacted]
East and North Hertfordshire



NHS Trust

Direct Line: [Redacted]
Direct Fax: [Redacted]
Our Ref: NS/avc
Email: [Redacted]@nhs.net

6th November 2008

April Brown
[Redacted]
15 Great Lawne
Datchworth
Knebworth
Herts
SG3 6SX

Dear Ms Brown

Re: Doctoral Nursing Research

With reference to your letter of 1st October I confirm that I am happy for you to undertake your research within the Trust subject to ethics approval.

With best wishes

Yours sincerely

[Redacted Signature]

[Redacted]
Director of Nursing



National Research Ethics Service

REC
9th
Hadlow
[Redacted]
[Redacted]

10 March 2009

Mrs April S Brown
Assessor
Healthcare Commission
15 Great Lawne
Datchworth Knebworth
Hertfordshire
SG3 6SX

Dear Mrs Brown

Full title of study: The 20th century concept of the modern matrons' contribution to restoring public confidence in nursing care quality in an acute NHS trust: a qualitative case study.
REC reference number: 09/H0311/22

Thank you for your letter of 07 March 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0311/22

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

[Redacted signature]

Chair

Email: [Redacted]

Enclosures: "After ethical review – guidance for researchers"

Copy to: Prof John Senior
University of Hertfordshire
College Lane
Hatfield
Herts AL10 9AB

[Redacted]



Senior sisters and senior charge nurses information sheet

Evaluating the mid 20th Century concept of the traditional matron and how the modern matron has contributed to restoring public confidence in nursing in an acute NHS setting.

Researcher: April Brown doctoral student University of Hertfordshire

You are being invited to take part in this research study taking place at:

xx

Please take time to read the following information carefully. Before you decide, it is important for you to understand why the research is being done and what it will involve. You may want to talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Part 1

What is the purpose of the study?

The purpose of the research is to see what difference the modern matron has made to the NHS in relation to restoring public confidence in the nursing service. The research will also compare the experience of the traditional and modern matrons.

Why have I been chosen?

I am inviting a sample of senior sisters and senior charge nurses who work in adult settings because you work directly with a modern matron and I am interested to hear your views on the modern matron role.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will be accepted and will not affect your role within the trust.

What will happen to me if I take part?

You will be asked to take part in a focus group. Approximately eight or nine other senior sisters and senior charge nurses will be there too. The focus group with your consent, will be tape recorded and will be held in a convenient but private room. The

discussion should last no longer than 60 minutes. The tape will be held in a secure place and will only be listened to by the researcher. Once the discussion has been typed all names and other identifiable information will be removed and the tape will be destroyed.

What do I have to do?

If you would like to participate please contact me on:

aprilsbrown@btinternet.com

What are the possible disadvantages and risks of taking part?

There are no disadvantages except the time element required from you. You can withdraw from the study at any time.

What are the possible benefits of taking part?

There is unlikely to be any personal benefit from taking part. However, your participation may contribute to the development of nursing policy.

What happens when the study finishes?

A summary of the findings will be sent to you once the study has been completed.

What if there is a problem?

It is unlikely that something may go wrong during a study of this nature; however, if this does happen it will be dealt with immediately. The detailed information is given in **Part 2**.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in the study will be kept confidential. The details are included in Part 2.

For more information about this study, please contact:

April Brown University of Hertfordshire

aprilsbrown@btinternet.com or telephone xx

Part 2

What if there is a problem?

As this is a study whereby people's thoughts and ideas are gathered, it is unlikely that anything will go wrong. However, if you have a concern about any aspect of this study, you should ask to speak to me, the researcher, April Brown using the contact details above.

If you are harmed in taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for a legal action for compensation against the University of Hertfordshire, but you may have to pay for it. For independent advice you may contact:

Independent Complaints Advisory Service
address etc

If you wish to complain about the conduct of the research, then please contact either of the following:

Research supervisor	Director of nursing
---------------------	---------------------

Will my taking part in this study be kept confidential?

All information collected in this project will only be accessible by the researcher and her research supervisors. The information I collect will be kept on a secure password protected computer. All the information you provide will be treated confidentially. You will not be identified in any report or publication arising from this study.

What will happen to the results of the study?

The research will be submitted for the award of a Doctorate in Health Research. The findings and process of the study will be published in nursing and health related journals and there may be some sharing of the work at conferences.

Who is organising and funding the research?

The research is organised by the researcher in conjunction with the University of Hertfordshire as part of a doctoral study programme. The research has been awarded a modest amount of financial support from the Florence Nightingale Institute, but 99% of the programme has been self funded.

Who has reviewed the study?

The study has been reviewed by the University of Hertfordshire Research Degrees Board and has been given a favourable opinion by x Research Ethics Committee.



Public participants' information sheet

Evaluating the mid 20th Century concept of the traditional matron and how the modern matron has contributed to restoring public confidence in nursing in an acute NHS setting.

Researcher: April Brown – University of Hertfordshire

You are being invited to take part in this research study taking place at:

xx

Please take time to read the following information carefully. Before you decide, it is important for you to understand why the research is being done and what it will involve. You may want to talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Part 1

What is the purpose of the study?

The purpose of the research is to see what difference the modern matron has made to the NHS in relation to restoring public confidence in the nursing service. The research will also compare the experience of the traditional and modern matrons.

Why have I been chosen?

I am inviting all those members of the public who have been in-patients at x Hospital during the last 12 months.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to be involved, will not affect your treatment and care.

What will happen to me if I take part?

You will be interviewed by the researcher in a setting of your choice. The interview should last no longer than 60 minutes. The interview, with your consent, will be tape recorded. The content of the tapes will be typed. Names and other identifiable information will be removed from the typed transcript. Once the transcript has been typed, the tapes will be destroyed.

What do I have to do?

If you would like participate please contact me on:

aprilbrown@btinternet.com or telephone tbc:

What are the possible disadvantages and risks of taking part?

There are no disadvantages except the time element required from you. You can withdraw from the study at any time.

What are the possible benefits of taking part?

There is unlikely to be any personal benefit from taking part. However, your participation may contribute to the development of nursing policy.

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A summary of the findings will be sent to you once the study has been completed.

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For more information about this study, please contact:

**April Brown
University of Hertfordshire**

aprilbrown@btinternet.com or telephone tbc:

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What if there is a problem?

As this is a study whereby people's thoughts and ideas are gathered, it is unlikely that anything will go wrong. However, if you have a concern about any aspect of this study, you should ask to speak to me, the researcher, April Brown using the contact details above.

If you are harmed in taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for a legal action for compensation against the University of Hertfordshire, but you may have to pay for it. The NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study.

Independent Complaints Advisory Service
address etc

If you wish to complain about the conduct of the research, then please contact either of the following:

research supervisor	director of nursing
---------------------	---------------------

Will my taking part in this study be kept confidential?

All information collected in this project will only be accessible by the researcher and her research supervisors. The information I collect will be kept on a secure password protected computer. All the information you provide will be treated confidentially. You will not be identified in any report or publication arising from this study.

What will happen to the results of the study?

The research will be submitted for the award of a Doctorate in Health Research. The findings and process of the study will be published in nursing and health related journals and there may be some discussion of the work at conferences.

Who is organising and funding the research?

The research is organised by the researcher in conjunction with the University of Hertfordshire as part of a doctoral study programme. The research has been awarded a modest amount of financial support from the Florence Nightingale Institute.

Who has reviewed the study?

The study has been reviewed by the University of Hertfordshire Research Degrees Board and has been given a favourable opinion by x Research Ethics Committee.



Modern matron information sheet

Evaluating the mid 20th Century concept of the traditional matron and how the modern matron has contributed to restoring public confidence in nursing in an acute NHS setting.

Researcher: April Brown doctoral student University of Hertfordshire

You are being invited to take part in this research study taking place at:

xx

Please take time to read the following information carefully. Before you decide, it is important for you to understand why the research is being done and what it will involve. You may want to talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Part 1

What is the purpose of the study?

The purpose of the research is to see what difference the modern matron has made to the NHS in relation to restoring public confidence in the nursing service. The research will also compare the experience of the traditional and modern matrons.

Why have I been chosen?

I am inviting all those with ‘matron’ in their job title and who work in adult settings within xx NHS Trust to participate in the study. To be eligible, you will need to have been a nursing matron in the trust for six months or longer.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to be involved.

What will happen to me if I take part?

You will be asked to take part in a 1:1 interview. The interview should last no longer than 60 minutes and with your consent, will be tape recorded. The tape will be held in a secure place and will only be listened to by the researcher and the research supervisors. The content of the tapes will be typed. Names and other identifiable

information will be removed from the typed transcript. Once the transcript has been typed, the tapes will be destroyed.

What do I have to do?

If you would like to find out more please contact me on:

aprilsbrown@btinternet.com or telephone tbc

What are the possible disadvantages and risks of taking part?

There are no disadvantages except the time element required from you. You can withdraw from the study at any time.

What are the possible benefits of taking part?

There is unlikely to be any personal benefit from taking part. However, your participation may contribute to the development of nursing policy.

What happens when the study finishes?

A summary of the findings will be sent to you once the study has been completed.

What if there is a problem?

It is unlikely that something may go wrong during a study of this nature; however, if this does happen it will be dealt with immediately. The detailed information is given in **Part 2**.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in the study will be kept confidential. The details are included in Part 2.

For more information about this study, please contact:

**April Brown
University of Hertfordshire**

aprilsbrown@btinternet.com or telephone tbc

Part 2

What if there is a problem?

As this is a study whereby people's thoughts and ideas are gathered, it is unlikely that anything will go wrong. However, if you have a concern about any aspect of this study, you should ask to speak to me, the researcher, April Brown using the contact details above.

If you are harmed in taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for a legal action for compensation against the University of Hertfordshire, but you may have to pay for it. For independent advice you may contact:

Independent Complaints Advisory Service

If you wish to complain about the conduct of the research, then please contact either of the following:

Research supervisor	Director of nursing
---------------------	---------------------

Will my taking part in this study be kept confidential?

All information collected in this project will only be accessible by the researcher and her research supervisors. The information I collect will be kept on a secure password protected computer. All the information you provide will be treated confidentially. You will not be identified in any report or publication arising from this study.

What will happen to the results of the study?

The research will be submitted for the award of a Doctorate in Health Research. The findings and process of the study will be published in nursing and health related journals and there may be some discussion of the work at conferences.

Who is organising and funding the research?

The research is organised by the researcher in conjunction with the University of Hertfordshire as part of a doctoral study programme. The research has been awarded a modest amount of financial support from the Florence Nightingale Institute.

Who has reviewed the study?

The study has been reviewed by the University of Hertfordshire Research Degrees Board and has been given a favourable opinion by x Research Ethics Committee.



Stakeholder information sheet

Evaluating the mid 20th Century concept of the traditional matron and how the modern matron has contributed to restoring public confidence in nursing in an acute NHS setting.

Researcher: April Brown doctoral student University of Hertfordshire

You are being invited to take part in this research study taking place at:

x

Please take time to read the following information carefully. Before you decide, it is important for you to understand why the research is being done and what it will involve. You may want to talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Part 1

What is the purpose of the study?

The purpose of the research is to see what difference the modern matron has made to the NHS in relation to restoring public confidence in the nursing service. The research will also compare the experience of the traditional and modern matrons.

Why have I been chosen?

I am inviting key stakeholders who are involved with managing and developing policies for modern matrons.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to take part in a 1:1 interview. The interview should last no longer than 60 minutes and with your consent, will be tape recorded. The tape will be held in a secure place and will only be listened to by the researcher and the research supervisors. The content of the tapes will be typed. Names and other identifiable information will be removed from the typed transcript. Once the transcript has been typed, the tapes will be destroyed.

What do I have to do?

If you would like to participate, then please contact me on:

aprilbrown@btinternet.com or telephone tbc

What are the possible disadvantages and risks of taking part?

There are no disadvantages except the time element required from you. You can withdraw from the study at any time.

What are the possible benefits of taking part?

There is unlikely to be any personal benefit from taking part. However, your participation may contribute to nursing policy.

What happens when the study finishes?

A summary of the findings will be sent to you once the study has been completed.

What if there is a problem?

It is unlikely that something may go wrong during a study of this nature; however, if this does happen it will be dealt with immediately. The detailed information is given in **Part 2**.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in the study will be kept confidential. The details are included in Part 2.

For more information about this study, please contact:

**April Brown
University of Hertfordshire**

aprilbrown@btinternet.com or telephone tbc

Part 2

What if there is a problem?

As this is a study whereby people's thoughts and ideas are gathered, it is unlikely that anything will go wrong. However, if you have a concern about any aspect of this study, you should ask to speak to me, the researcher, April Brown using the contact details above.

If you are harmed in taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for a legal action for compensation against the University of Hertfordshire, but you may have to pay for it. For independent advice you may contact:

Independent Complaints Advisory Service

If you wish to complain about the conduct of the research, then please contact either of the following:

Research supervisor	Director of nursing
---------------------	---------------------

Will my taking part in this study be kept confidential?

All information collected in this project will only be accessible by the researcher and her research supervisors. The information I collect will be kept on a secure password protected computer. All the information you provide will be treated confidentially. You will not be identified in any report or publication arising from this study.

What will happen to the results of the study?

The research will be submitted for the award of a Doctorate in Health Research.

The findings and process of the study will be published in professional journals and there may be some sharing of the work at conferences.

Who is organising and funding the research?

The research is organised by the researcher in conjunction with the University of Hertfordshire as part of a doctoral study programme. The research has been awarded a modest amount of financial support from the Florence Nightingale Institute.

Who has reviewed the study?


The study has been reviewed by the University of Hertfordshire Research Degrees Board and has been given a favourable opinion by x Research Ethics Committee.

Appendix 4 – Topic guide summary, all participants

The mid 20th century concept of the traditional matron and how the modern matron has contributed to restoring public confidence in nursing in an acute NHS setting

Modern matrons
Method: interview following the diary
<ul style="list-style-type: none">• Question outline<ul style="list-style-type: none">• an outline of a typical day• the matrons influence on the ward environment• impact on care quality• senior sisters and care quality• matrons doing what they set out to do• barriers matrons may have encountered during their working day• difference – senior nurse, modern matron• impact of matron on sister role• the decision about returning the matron to the health service
Senior sisters and Senior charge nurses
Method: focus group
<ul style="list-style-type: none">• Question outline<ul style="list-style-type: none">• level of influence the modern matron has on care quality• what would they change about the modern matron role• the role of the modern matron on improving the ward environment
Public participants
Method: individual interview
<ul style="list-style-type: none">• Question outline<ul style="list-style-type: none">• the traditional matron• expectations of the modern matron• visibility of the modern matron during admission• what changes would they like to see regarding the modern matron role• has the modern matron contributed to restoring confidence in nursing care in the English NHS<ul style="list-style-type: none">○ ward environment○ cleanliness
Key stakeholders
Method: individual interview
<ul style="list-style-type: none">• Question outline<ul style="list-style-type: none">• what influenced the government to re-introduce the modern matron• the success of the modern matron role• what changes would they make to the modern matron role• implementation of the matron role• modern matron role and the future

Appendix 5 – Presentation to modern matrons



Researching matrons

April Brown
RGN BSc
doctoral student

Outline

- Background
- Research questions
- Methodology
- Sample and methods
- What this research might add
- Questions

Background

- Doctorate Health Research – part time 6 years
- Revival of matrons
- Florence Nightingale Scholar
- Favourable approval from Bedfordshire and Hertfordshire Research Ethics Committee and East & North Hertfordshire Research and Development Committee

Research questions

- Title
 - The 20th century concept of the modern matron and the contribution to nursing care quality in an acute NHS trust: a qualitative case study
 - Has the traditional concept of the matron re-designed into the modern matron, helped to reassure the general public about the quality of nursing care ????
 - What barriers if any, has the modern matron encountered when working to improve care and environment standards
 - What similarities are there between the experiences of the traditional matrons of the 1950s and 1960s and the modern matron of today.

Methodology

- Qualitative case study (Yin, 2003, 2009; Stake 1995)
- Bound by geography or setting
- Various methods to gather data

Sample, recruitment and methods

Group	sample	recruitment	method
modern matrons	6	via nurse executive presentation	individual interview
senior sisters & charge nurses	8	via directorate meetings presentation	focus group
general public	8	out patients discharge lounges	individual interview
traditional matrons	6	Hertfordshire nurses group	individual interview
key stakeholders	6	letter and individual engagement	individual interview
archival diaries (1946-1966)		nurse director	documentary review

Consent

- All participants will be required to sign a consent form – one copy to be retained by the participant:
 - Agree to be involved
 - Interview to be tape recorded
 - Participants can withdraw at any time

Protecting you

Anonymity and confidentiality are assured.
Coding will be employed.

Data stored in password protected computer.
Hard copy data and tapes stored in locked filing cabinet only accessible by the researcher.

When, where....

- Interviews and focus groups held in a quiet area to avoid disturbance, in a mutually agreeable place
- Your time is precious: interviews and focus groups should not last longer than 60 minutes

What this research might add

- Further knowledge about modern and traditional matrons
- Patient and staff expectation of the modern matron
- Cyclical nature of management style and or leadership styles

Appendix 6 – Email to modern matrons

Matron research

Monday, 15 June, 2009 19:49

From:

"aprilbrown@btinternet.com" <aprilbrown@btinternet.com>

[Add sender to Contacts](#)

Message contains attachments

2 Files (143KB) | [Download All](#)

Dear [director of nursing]

Would it be possible to forward on this email to matrons across the trust? As you know I attended the nurse executive committee on 25 May to invite matrons onto the study. There were quite a few matrons there. To date I've had one interview confirmed, but I really need a few more.

I have attached the information sheet and the presentation. I look forward to hearing from a few more matrons very soon. Many thanks for your continued support.

Sincerely and best wishes

April Brown

Researching traditional and modern matrons

I am conducting research into the role of the modern matron at East & North Hertfordshire NHS Trust and comparing it with the traditional matron of the mid 20th century.

I am hoping to speak to:

- members of the general public, 18 years and older, who have been patients in the trust during the last 12 months

If you would like to participate then please contact:

07887 XXXXX

aprilbrown@btinternet.com

I look forward to hearing from you. Thank you

**April Brown – registered nurse
Research student - University of Hertfordshire**

The research has been approved by Bedfordshire & Hertfordshire Research Ethics Committee and East & North Hertfordshire NHS Trust Research and Development Committee

Appendix 8 – Email invitation to senior sisters

5 February 2010

Dear Band 7 Senior Sister or Senior Charge Nurse

As some of you may know I am doing doctoral level research on modern and traditional matrons. To date I have interviewed matrons in the trust. Part of my work is to listen to the views senior sisters and senior charge nurses who work in adult in-patient or emergency settings. I am keen to listen to your views about modern matrons, any improvements in care since the matrons returned to the NHS workforce, care quality and how this works with your role.

I have arranged a venue for a focus group for a maximum of 8-10 people. I am only permitted by ethics to undertake one focus group and so I am unable to conduct one on each of the acute sites, therefore, I have chosen the xx site.

Date: 25 March 2010

Venue: Seminar Room - Postgraduate Centre

Time: 1100 - 1200 hrs

You are most welcome if you:

- hold a band 7 post managing an in-patient, emergency or day setting
- are permanent or acting into a band 7 role

Please find attached further details. Refreshments will be provided. I would be most grateful if you could email me to let me know if you can come along so that I know how many people to expect. If you have any queries, then please don't hesitate to contact me, I will be very pleased to hear from you.

I look forward to meeting you.

Many thanks

April Brown RGN BSc

doctoral student - University of Hertfordshire

Nurse Researcher (honorary contract with East & North Hertfordshire NHS Trust)

Appendix 9 – Archive ethics correspondence

From: ABrown1442@aol.com [mailto:ABrown1442@aol.com]
Sent: 31 August 2008 14:26
To: NRES Queries Line
Subject: Qualitative Research - review of archival diaries

Dear Colleague

I hope to be submitting my application for my PhD research before the end of this year. The research is qualitative with a historical perspective. I have access to a set of diaries that belong to an NHS trust. The diaries are professional in nature and were written by a matron in the 1950s and 1960s. Do I need to include this detail in my IRAS application or do you view this review of historical professional diaries as audit? I look forward to your advice.

Yours faithfully

April Brown

From: NRES Queries Line <queries@nres.npsa.nhs.uk>
To: ABrown1442@aol.com
Sent: Mon, 1 Sep 2008 12:53
Subject: RE: Qualitative Research - review of archival diaries

Your query was reviewed by our Queries Line Advisers

As historical research, I would simply get Trust approval.

Regards

Streamline your research application process with IRAS (Integrated Research Application System). To view IRAS and for further information visit www.myresearchproject.org.uk
Queries Line
National Patient Safety Agency
National Research Ethics Service
4-8 Maple Street
London
W1T 5HD