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

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Conflict of interest

None declared

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## **Abstract**

At the time of writing, the author was a modern matron in a surgical division in a NHS teaching hospital in central London. In this article the author considers the differences between leadership and management, and discusses the skills modern matrons require to lead safe and successful clinical services. It also examines three leadership styles, transactional, transformational, and situational, and their relevance to the role of modern matron.

## **Leadership styles, management theories, modern matron, NHS, nursing management**

### **Background**

The NHS Plan (Department of Health (DH) 2000) outlined the targets and changes required to improve and modernise the NHS over the subsequent 10 years. Following its implementation, there was much concern from the public, and the NHS workforce, about the lack of visible clinical leadership at ward level. To address this, modern matrons were introduced, as accountable, accessible professionals who could manage groups of wards, and improve patients' experiences and care.

The NHS Plan (2000) proposed that every hospital should appoint matrons to provide two important functions, strengthen clinical leadership at ward level, and increase public confidence by addressing concerns at ward level (Smith

2008). However, even before implementation of the role there were concerns about what modern matrons would require, in terms of preparation, scope of practice, personality, and experience, since immense pressure would be placed on them (Wildman et al 2009). Cole (2002) agreed that modern matrons would be under tremendous pressure, but believed that they would feel empowered in their new roles, and that success would depend on the style of leadership they adopted.

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

Health service managers and leaders are under constant pressure, with nursing and medical directors trying their best to improve the quality of services through initiatives such as harm free care, compliance audits, patient experience feedback, user groups, and other local and national initiatives (Royal College of Nursing (RCN) 2013). There are various motivators for these initiatives, including that patients have the right to choose a care provider, scoring care providers for services and patient experiences, and compliance with Care Quality Commission regulations and inspections. In clinical practice, the evolution of the NHS has affected matrons' already challenging and demanding roles, and requires them to be quick thinking managers who can resolve issues at the bedside.

In the 1960s, the Salmon Review advocated the abolition of traditional matrons, and the creation of senior nurses who would be detached from the wards and bedside patient care (Brown 2013). During this time the role of the senior nurses and matrons was significantly changing. In 2003, the Chief Nursing Officer for England said that it was becoming clear that the range of functions that matrons perform, and the ways in which they could improve patients' experiences, was 'even greater than originally foreseen' (Mullally 2003). During this period, plans to extend the role of matrons in emergency departments were put in to place, by giving them budgets of £10,000 to help improve patients' experiences of emergency care (DH 2003).

### **Historical nursing management**

During the 1980s nurse managers were perceived as detached from clinical practice, and separated from ward-level nursing staff (Brown 2013). This suggests they had poor insight into clinical staffs' performance, and poor understanding of the challenges they faced (King's Fund 2011). At this time, nurse managers were accountable to non-nurses, such as NHS graduates, administrative, and clerical managers (Kings Fund 2011), which might have created friction through a lack of understanding of each other's roles and goals (Bach and Ellis 2011).

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

The UKCC, who were the governing body before the Nursing and Midwifery Council, managed professional misconduct and complaints, maintained a record of registrants, had a code of professional conduct, and influenced and guided nurses' decision-making processes. It identified and promoted professional leadership, as opposed to the 'management duties' of administrative managers, who lacked understanding of the value of clinical leadership.

### **Challenges faced by matrons**

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

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

Stanley (2006) stated that credible and competent registered nurses are placed in managerial posts, but are burdened by the expectation that they will retain clinical responsibilities, resulting in conflict, confusion, ineffective

leadership and management, dysfunctional clinical areas, and poor quality care. Many nurses are excellent leaders, but there is an assumption that, because of this, they are also skilled in managing staff and services, and that the two concepts are interchangeable. However, leaders do not necessarily make good managers as the role and skills required are different.

### **Management compared to leadership**

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

**Table 1: Distinction between managers and leaders (Hughes et al 2006)**

Managers	Leaders
Administer	Innovate
Maintain	Develop
Control	Inspire
Short term views	Long term views
Ask how and when	Ask what and why
Accept status quo	Challenge status quo

Nursing management and nursing leadership overlap significantly, and the terms are used interchangeably (Cook 2004). However, what determines matrons' influence and credibility, whether the role is management or leadership, is displayed behaviour (Hughes et al 2006, Edmonstone 2008). Target-driven, short-sighted, and goal-achieving management pressures in healthcare organisations cause conflict, potentially leading to hostility between managers and senior nurses (Edmonstone 2008). Yet clinical leadership roles are fundamental to good patient care delivery and creative work environments (Stanley 2006).

Murphy et al (2009) support this, stating that clinical leadership encourages patient safety, professional accountability, and delivery of best practice. To recognise and develop leadership skills, and to equip them with the skills required to become modern matrons, nurses must have access to courses such as the RCN leadership programme (RCN 2009) (Figure 1).

**Figure 1: Royal College of Nursing leadership programme**





It could be argued that every manager should be a leader, while leadership without management can result in chaos and failure for organisations and post holders (Marquis and Huston 2012). NHS England (2014) suggested that leaders are the inspiration for, and directors of, actions, and use a combination of personality and skills in a way that makes others want to follow the same direction. These ideas lead to the question are matron's managers or leaders?

There are many links between managers and leaders, and both roles are needed to influence and guide others. In clinical practice, managers must be able to react to multiple situations, which can result in a sense of firefighting and crisis control. Mullins (2010) suggests that managers strive for productivity, trying to create faster services, and reduce spending while following policies and procedures, while Stonehouse (2013) believes that leaders do not have the same anxieties and restraints as managers, so have more time to be proactive and innovative. This is why leaders are often viewed as role models, as they are visible and available, rather than absent because of meetings or desk duties. Bennis and Nanus (2004) stated that 'managers are people who do things right, and leaders are people who do the right thing', which suggests that managers do what needs to be done at the time, while leaders have a wider vision, possibly with less time constraints.

When I worked as a modern matron, I believe I adopted both leadership and management personas in practice, by doing what needed to be done, but first considering the long-term effects of the action, and whether it was right

for patients and staff. This might be because there was an expectation in the trust I worked for, that matrons display and carry out both roles. Additionally, my own perspectives, culture, clinical experience, and leadership style affected whether I was regarded as a manager or a leader by my colleagues.

### **Leadership styles**

Matrons' leadership styles greatly influence work environments, and staff behaviour, negatively or positively. For many years, hospital leaders displayed a dominant leadership style (Barr and Dowding 2013), but current thinking suggests that leaders move dynamically between different styles when reacting to different situations (Politis 2001). Two distinct styles have long been discussed in the literature, transactional and transformational leadership.

### **Transactional leadership**

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

## **Transformational leadership**

Burns (1978) described transformational leadership as a 'process in which leaders and followers help each other to advance to a higher level of morale and motivation.' Transformational leadership is based on how things should or could be done, and effectively communicating this 'vision' to others.

Transformational leaders are passionate about what they do, and about getting the right people involved to make a difference, and usually gain 'followers' who respect them, share their vision, and feel energised, valued and enthusiastic.

The NHS benefitted from transactional leadership during periods of stability (Nash and Govier 2009), and in the past leaders and their staff were satisfied with transactional relationships because they knew where they stood and what was expected of them (Govier and Nash 2009). However, in response to the vast changes in the NHS over the last few decades a more transformational leadership style has evolved, that encourages flexibility, creativity, and the involvement of patients and staff.

Leadership has to work within the context and culture of an organisation, and I would argue that, at times, both styles are required. For example, the Francis report (2013) highlighted the failure of senior nurses to manage clinical areas safely at Mid Staffordshire Hospitals. Neither transactional nor transformational styles of leadership alone could have rectified the situation there, but perhaps a mix of both were required. Enabling others through transformational role modelling has its place, but using a transactional style to manage staff who require structured, prescriptive direction, for example junior

or new nurses, or those who do not conform to policies, might also have been beneficial. This mix of styles is encapsulated in situational leadership theory.

### **Situational Leadership**

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

#### **Table 2: four leadership styles and four levels of staff maturity in situational leadership (Hersey and Blanchard 1969?)**

1. Telling. Directing and taking charge.
2. Selling. Encouraging the desired performance from staff.
3. Participating. Improving working relationships.
4. Delegating. Encouraging employees to work to their strengths and full potential.

1. Staff who lack knowledge, skills, and willingness
2. Willing and enthusiastic staff who lack ability.
3. Capable and skilled staff who are unwilling to take on responsibilities.
4. Highly skilled and willing staff.

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

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

## **Conclusion**

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

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