Role Development: Modern Matrons

Quality Impact *Evidence Summaries*

Measurable evidence of the impact of policy interventions on quality

A rapid evidence review for

The Health Foundation

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February 2018

The Health Foundation

research matters

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About Quality Impact *Evidence Summaries* (QI*ES*)

Quality Impact *Evidence Summaries* (QI*ES*) present measurable evidence of the impact of policy interventions within the NHS. Distinctively, impact is viewed through the lens of quality, using the Institute of Medicine (IOM) domains of quality as a framework.[1]

QIES began as a series of structured reviews featured in A Clear Road Ahead, a 2016 Health Foundation project delivered in collaboration with Professor Sheila Leatherman, to shape a quality strategy for the NHS.[2] The Health Foundation re-commissioned Research Matters in 2017-18 to develop the structured reviews further, with the aim of exploring the potential to develop a sustainable tool or service to support and promote evidence-based policy and decision making across the NHS in England.

Scope

QIES focus exclusively on national policy interventions in the English health care sector. Typically, these are centrally developed by the Department of Health, NHS England or other national bodies and rolled out nationally, albeit with local variations in implementation. Some interventions may have initiated at a local or institutional level and been adopted nationally. The time period for both policies reviewed and evidence used is from 1997 onwards.

NHS Taxonomy

As the scope and volume of relevant policy interventions is significant, a Taxonomy of Policy Interventions for the NHS in England was developed. Policies are grouped into four policy areas - governance, finance, delivery and improvement - split further into focus areas. Groups of policy interventions combine as policy levers, which forms a thematic basis for a series of QIES. Each individual QIES focuses on a single policy intervention as an example of the use of that policy lever. This enables groups of policy interventions which share conceptual or practical similarities to be described alongside each other, allowing for comparison about what works.

For further information, see the separate working paper: *Taxonomy of health care policy interventions for the NHS in England, Working paper for Quality Impact Evidence Summaries (QIES) project*, February 2018.[3]

Impact on quality

In assessing and presenting the impact on quality of policy interventions, we have used the Institute of Medicine (IOM) framework for the quality of health care.[1] This describes six domains (or aims), across which improvements in quality can occur. These are:

- **Safe:** avoiding harm to patients from the care that is intended to help them.
- **Effective:** decision-making and service provision based on clinical and scientific evidence and knowledge, as well as refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centred:** providing care that centres on the patient, respecting and responding to individual patient preferences, needs, and values and ensuring the patient is in control.
- **Timely:** reducing waits and delays for both those who receive and those who give care.
- **Efficient:** providing care that is cost-effective and avoids waste.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Evidence about a policy intervention is reviewed and findings which show impact against one or more domain of quality form the basis of results gathered and presented in a QIES. Assessments of the level of impact within each domain are made: impact on quality can be positive, uneven and can also be unintended.

Methodology
QIES identify the key and most relevant evidence, only where measurable impact on quality is demonstrated, resulting in a sufficiently secure evidence base for conclusions to be tested and drawn. The approach is time-limited and pragmatic and is not intended to be comprehensive or meet the academic standards of a systematic review.

For each policy intervention, a structured search of published literature is conducted using, key databases, such as NHS Evidence, PubMed and Cochrane Library, as well as relevant sources of grey literature and stakeholder reports. Searching combines database searching, reference scans, looking at recommended studies/authors and targeted desk research. Full texts of reports and studies are obtained and viewed for the majority of studies, but sometimes the abstract provides sufficient information.

A discussion of the evidence used describes the key sources used to produce the QIES, including the number of relevant studies and different evidence types. Results are presented thematically, based on the IOM domains and describe the measurable impact of the policy intervention on aspects of quality of care in the English NHS. This is supported by a summary table with judgements about the strength of the impact for each IOM domain.

About Research Matters
Research Matters is a small, well-established research company delivering high quality, client-focused research to tight time-scales for clients across many sectors. Our work is bespoke, pragmatic and insight driven and our style is always friendly, flexible and professional.

We have completed a number of rapid evidence reviews for the Health Foundation, as well as developed a methodology for Quality Impact Evidence Summaries and an NHS taxonomy to facilitate a structured approach to producing of evidence reviews. Most recently, we have completed a review on retention in the health and social care workforce.

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Role Development: Modern Matrons

In this Quality Impact Evidence Summary (QIES), we examine the impact on quality of the modern matron role. This policy intervention sits within the policy lever of Role Development within the NHS Taxonomy.

NHS Taxonomy: Positioning of Policy Intervention

Policy area	Policy focus	National policy levers
Governance		
Finance		
Delivery	Service provision	
	Workforce strategy	Workforce planning
		Role development *Adjustments to NHS roles, including developing existing roles, task shifting and creating new roles*
		Team-based-working and collaboration
	Patient involvement	
	Public health programmes	
Improvement		

Related evidence summaries within the policy lever of Role Development are: Emergency Care Practitioners, Physician Associates, Community Matrons, Clinical Pharmacists and Clinical Nurse Specialists.

Description of intervention

Role description

Modern matrons were placed in charge of 5-6 wards and had responsibility for the care that was being delivered there. The matrons had three main responsibilities: to promote high standards of clinical care and leadership; to ensure that administrative and support services were in place; and to provide a visible, accessible and authoritative presence in ward settings where patients and their families could turn for assistance, advice and support.

Policy context and implementation

Emerging from The NHS Plan and in response to public consultation, the overall aim in developing the modern matron role was to improve clinical care standards, ensure best practice in infection control and provide a clean environment for care.[4]

All trusts with in-patient beds were required to develop plans to establish matron posts by April 2002. The role was embedded further in 2004 with a set of 'ten key responsibilities' for matrons, published by the Department of Health (DoH).[5] These included: making sure patients received quality care, improving wards for patients, ensuring patients were treated with respect, and resolving problems for patients and their relatives through closer relationships. Trusts were given scope to design structures that best suited local needs. Some created entirely new posts, while others re-designed senior nurse posts to embrace the new matron role and responsibilities. As a result, the national evaluation reported: "*enormous variability in the ways in which the modern matron role is being implemented*".[6]

Initially, it was proposed that 2,000 modern matrons should be in place across the NHS by 2004, which was increased to 5,000 by May 2008. A 2008 National Audit Office (NAO) survey across all trusts (including primary care trusts and mental health trusts) found there were 5,066 modern matron, of which 1,527 were new posts created in the trusts.[7] However, numbers seemed to have dropped slightly over in recent years: in 2010 there were over 4,800 modern matrons employed across the NHS in England, falling again to just under 4,000 in 2015.[8]

Funding

No extra funding was provided to trusts specifically for modern matrons and the DoH did not carry out a formal costing of the programme, however the NAO estimated, that based on NHS pay bands, the cost of an extra 1,527 new matron posts in 2008-09 would have been over £56 million.[7]

Discussion of evidence

10 relevant studies were identified as contributing evidence of impact on quality, all published in the period 2004-2009. This included an independent evaluation commissioned by the DoH in 2004, which included a questionnaire about the impact of modern matrons sent to all Directors of Nursing in NHS trusts, as well as in-depth follow up of 10 case study trusts.[6,9] The NAO examined efforts to reduce healthcare associated infections (HCAI), which included the introduction of modern matrons.[7] The most methodologically robust approach seen was semi-structured interviews of matrons and other stakeholders, usually from single-site locations.[10–14]

Often, evaluations focused on the development and implementation of the modern matron role within organisations, rather than direct impact on patient care. Where this was addressed, there was reliance on qualitative research and few quantifiable changes in impact. There was no real assessment of the cost-effectiveness of the role. The evaluations of modern matrons reported that "*very few trusts, nationally or in our case studies, have attempted to evaluate the impact of their matrons*" and "*whilst there were difficulties with evaluating the impact of modern matrons, due to the shortage of verifiable information, there was plenty of anecdotal evidence to suggest that individual matrons were having a positive impact.*"[6]

Variation in how the modern matron role was implemented meant that many single-site studies, while individually robust and insightful, were not directly comparable or generalisable. The reliance on qualitative data and analysis and limited quantifiable effects means the evidence is viewed as useful for trusts implementing the role and for policy makers, but only moderately secure.

Impact on quality

The evidence focused most on the impact on safety, in line with the policy aims of the modern matron role. It provides strong indications that modern matrons had the anticipated effect of improving safety on the wards, including reducing infection rates and improving cleanliness, as well as signs of some positive impact on effectiveness. Impact on efficiency and patient-centredness was marginal, but this was not a focus of evaluations.

Safety

There was considerable evidence that the new modern matron role had a positive impact on aspects of safety, from multiple sources. The NAO found that modern matrons had "*contributed to improvements in cleanliness, infection control compliance and patient confidence.*" 65% of trusts felt they had contributed to improved standards of cleanliness in clinical areas and 68% to improved infection prevention and control.[7] A further study across ten sites found that matrons were key to implementing quality initiatives such as infection control, cleanliness and nutrition interventions as well as establishing procedures, protocols and audits.[9]

This was echoed in single site studies. One reported that modern matrons had a significant effect on developing systems and cultures which influence HCAI, as well as improving environmental cleanliness and infection control practices.[10] A second saw an 11.6% reduction in cases of MSRA, and a 45% reduction in drug administration errors, as well as "*many improvements such as a reduction in drug errors, complaints and MRSA bacteraemia.*"[11]

The final DoH commissioned evaluation of the role of modern matrons found that "*matrons involved in tighter enforcement of uniform policy and the removal of jewellery and better control of hygiene and hand washing .... there were also indications of increased compliance with procedures for the decontamination of equipment.*"[6]

However, there were questions over the ability of modern matrons to influence some aspects of infection control. It was reported that lack of direct budgetary control and therefore influence over contract cleaners was a barrier: *"Attempts to promote high standards of cleanliness and infection control were less effective because of the shortcomings of the domestic service…. matrons' ability to promote adequate levels of environmental cleanliness and control infection is a cause for concern."*[12]

Effectiveness

Evaluations of the impact of modern matrons did not make a strong link with improved care. A consistent theme in interviews was that the matrons were not always empowered enough to effect change or influence the quality of care. Organisational issues such as lack of budgetary control, lack of clear reporting lines and accountability were identified as the main barriers to greater impact. [9,13–15]

Other studies reported that matrons brought more consistency, contributed to staff development and strengthened clinical governance by developing protocols and ensuring compliance, all of which contributed to an improvement in standards in two particular acute trusts.[6] One single site, qualitative study reported on modern matrons' self-assessment of their effectiveness: they felt they were effective in clinical leadership and maintaining a high clinical profile.[12] Another single site audit gathered views from other staff members - 80% felt that modern matrons had had an impact on patient care.[11]

Efficiency

There was little evidence of impact on efficiency, although the conclusion of the NAO report on HCAI reported that the benefits of modern matrons were likely to outweigh the cost.[7] The national evaluation also found that in some areas, protocols introduced by the matrons resulted in more efficient use of beds by increasing occupancy rates and reducing length of stay of some patients.[6]

Patient-centred

Impact on patient-centredness was mixed. One evaluation found that "*nurse-led protocols had been developed by some matrons to improve patient experience. In some trusts, matrons had been seen to influence the way staff dealt with patients.*"[6] However from the perspective of some, the additional administrative and managerial aspects of the role meant that modern matrons were not able to "*spend enough time in direct patient care, or did not establish strong links with patients or their families.*"[9,16]

Timeliness

Evidence of impact on timeliness of patient care was not seen.

Equity

The local implementation of all of these interventions led to uneven provision and availability, which implies an impact on equity. However, this feedback was not reported in the evidence seen.

In summary …

- Modern matrons were brought in to raise care standards, reduce infections and provide a clean environment. The evidence indicates that they achieved this, but the depth and extent to which they were effecting change and improving the quality of patient care was not quantified.
- The lack of strong implementation guidance resulted in wide local variation in how the role was adopted.
- Matrons were often limited in making the changes they felt were required. One of the most consistent themes was the need for greater role definition, including its place within an organisation's hierarchy and lines of accountability and budgetary authority attached to the role.

- Modern matrons reported that the administrative burden and, in particular, time spent in meetings impacted on patient care, visibility and accessibility.

Summary of evidence of impact on quality: Modern Matrons

Domains of quality	Impact
Safe	• Evidence of modern matrons reducing in drug errors and health-care related infections • Full impact may be limited by lack of budgetary controls
Effective	• No evidence seen with a quantitative impact on effectiveness • Commentary suggesting that effectiveness limited by internal barriers • Qualitative evidence of improved clinical governance and leadership
Efficient	• NAO concluded that the benefits were likely to outweigh the costs
Patient-centred	• National evaluation found that some matrons had developed nurse-led protocols to improve patient experience • Matrons themselves often reported lack of time to spend on direct patient care
Timely	
Equity	
Strength of evidence	• Useful for trusts implementing the role and for policy makers, but only moderately secure • Evidence reviewed drawn from 10 studies
Funding	• No central funding allocation • Paid for locally, by different means

Strong impact | Some impact | Mixed impact

No impact | Possible negative impact | No evidence

Date reviewed: January 2018

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