The dynamics of professions and development of new roles in public services organizations: The case of modern matrons in the English NHS

Abstract

This study contributes to research examining how professional autonomy and hierarchy impacts upon the implementation of policy designed to improve the quality of public services delivery through the introduction of new managerial roles. It is based on an empirical examination of a new role for nurses - modern matrons - who are expected by policy makers to drive organizational change aimed at tackling health care acquired infections [HCAI] in the National Health Service [NHS] within England. First, we show that the changing role of nurses associated with their ongoing professionalisation limit modern matron's influence over their own ranks in tackling HCAI. Second, modern matrons influence over doctors is limited. Third, government policy itself appears inconsistent in its support for the role of modern matrons. Modern matrons' attempts to tackle HCAI appear more effective where infection control activity is situated in professional practice and where modern matrons integrate aspirations for improved infection control within mainstream audit mechanisms in a health care organization.

Key words: professions, NHS, modern matrons, health care acquired infections

Introduction

The organization and management of professional work remains a significant

area of analysis (Ackroyd, 1996; Freidson, 2001; Murphy, 1990; Reed, 1996).

It is argued that professional autonomy and hierarchy conflict with

bureaucratic and managerial methods of organizing work, especially attempts

at supervision (Broadbent and Laughlin, 2002; Freidson, 2001; Larson, 1979).

Consequently, the extension of managerial prerogatives and organizational

controls are seen to challenge the autonomy, legitimacy and power of

professional groups (Clarke and Newman, 1997; Exworthy and Halford,

1999). In our study we contribute to this debate through examining a

significant organizational challenge to professional autonomy and hierarchy --

the introduction of modern matrons, who are expected to tackle health care acquired infections [HCAI] in the National Health Service [NHS] within England. To analyse our case and enhance transferability of findings, we draw upon sociology of professions literature focused upon the case of nursing, on the basis that the key to understanding the introduction of new 'managerial' roles within professionalised organizations lies with consideration of the relationship of new roles with other pre-existing, but dynamic, roles in professional hierarchies.

Our paper is structured as follows. Our literature review discusses professional modes of organizing, changes in the way the nursing profession is organized and its impact upon the implementation of the modern matron role. Following this, we describe and rationalise our research design. We then present our data along four inter-related themes – [i] What do modern matrons actually do?; [ii] The inconsistency of policy; [iii] Professional hierarchy: where is the modern matron located?; [iv] Mediating professional autonomy and hierarchy. Finally, we highlight our contribution to literature, suggest policy recommendations for attempts aimed to improve service quality that take account of the professionalised public services context, and identify a need for further research.

Professional modes of organizing, nursing and the modern matron

Professional groups are characterised by their possession of, and claim to autonomy. They have high degrees of discretion in their work and freedom from external supervision. In essence, professions have autonomy in both the social organization of work, for example, within the division of labour, and also in the technical substance of work, premised on the exclusive control of

knowledge (Broadbent and Laughlin , 2002; Freidson, 2001; Larson, 1979). This limits the scope for others, such as managers, within the division of labour, from legitimately competing with, directing or evaluating work. Professionalism can therefore be interpreted as a mechanism for control towards occupational priorities, with professional groups potentially resisting organizational and management controls (Freidson, 2001; Kirkpatrick et al., 2004). However, current policy initiatives in England seek to privilege organizational priorities and, in so doing, provide a challenge to professional autonomy and hierarchy (Clarke and Newman, 1997). One such policy initiative in England has been through the introduction of modern matrons charged with driving organizational change to tackle health care acquired infections [HCAI].

For those readers unfamiliar with the concept of HCAI, these are infections acquired following admission to hospital or as a result of health care interventions in other health care facilities. HCAI can be caused by a wide range of micro-organisms and often these are ones that are normally carried by the patients themselves but have taken advantage of a route into the body provided by an invasive device or procedure associated with a clinical intervention. One of the micro-organisms causing HCAI is methicillin-resistant *staphylococcus aureus* (MRSA). MRSA appeared soon after the introduction of methicillin but there were only very low levels of infection in the UK until the appearance of two new virulent strains in the early 1990s. By 1997 MRSA was endemic in NHS hospitals. As it is believed that action to counter MRSA will have an impact on the incidence of other HCAI, it was chosen as a marker for HCAI generally and was used as an NHS target (to reduce levels of MRSA

infection year on year) because it has the best available data set (Department of Health, 2005). The increased incidence of MRSA in England in recent years has been paralleled by an increased focus on MRSA by policymakers, the mass media and the public itself. In England, MRSA has regularly featured as an important party political issue, and the Government has produced a number of reports focusing on hospital hygiene (e.g. Department of Health, 2004). Media and policy makers in the United States have been less visibly concerned about MRSA as a HCAI, but things are changing rapidly at the moment as community acquired MRSA is becoming a widely debated issue, especially via two clones or strains, called USA300 and USA400.

Following a sustained public outcry about dirty wards in UK hospitals, modern matrons were introduced in 2001 by the Department of Health to lead clinical teams in the prevention of HCAI, particularly MRSA (Department of Health, 2001, 2002). The contributing factors to HCAI over which modern matrons are expected to exert control are: failure to introduce and maintain suitable infection control procedures, particularly handwashing (Pittet et al., 2000); increases in movement of patients, visitors and staff who may be carriers into, out of, and between wards and hospitals, and inadequate ward staffing levels (Grundmann et al., 2002); inadequate isolation facilities (O'Connell and Humphries, 2000); high bed occupancy rates (Enright, 2005); and overall poor hospital cleanliness (Rampling et al., 2001).

In response to HCAI, policy-makers, and indeed the wider public, demanded 'highly visible, accessible and authoritative figures to whom patients and their families can turn for assistance, advice and support'

(Department of Health, 2001:1). The modern matron role is visualised as enjoying a kind of authoritative freedom, to command cleanliness and excellent patient care, whilst being liberated from bureaucratic constraint (Department of Health, 2000). Buttressing the introduction of the modern matron role are long-established perceptions of the power of matrons; i.e. there exists a strong myth about leadership by matrons within hospitals. This relates to longstanding and idealised public perceptions of a 'golden age' of health services where matron was a figure of authority over others, including ensuring cleanliness of wards and smart appearance of staff (Barrett, 2003; Snell, 2001; Watson and Thompson, 2003). Girvin (1996) suggests that the traditional matron developed as an autocratic figure set apart from the rank and file of working nurses. The image symbolised order, tradition and a controlling style of management. This reflects the legacy of Florence Nightingale herself, which appears to drive nostalgia on the part of policy-makers towards re-introducing a modern version of the matron's role as a panacea for sorting out HCAI (Koteyko and Nerlich, 2008).

However, it may be difficult for those positioned as modern matrons to enact their role as intended by policy-makers (Koteyko and Nerlich, 2008; Royal College of Nursing, 2004; Savage and Scott, 2004) since modern matrons have been introduced within a dynamic system of professions (Abbott, 1988) that is much changed from that within which they exercised authority in the past. Consequently, there is considerable uncertainty regarding how the authoritative style of management that harks back to the matron's role fits into today's nursing and healthcare culture (Oughtibridge, 2003). There are four dimensions of contemporary professional organization

relevant to the introduction of modern matrons, which render their introduction problematic: the professionalisation of nursing during the period from the mid-1960s onwards; the changing role of nursing associated with this; the relationship between the nursing profession and doctors; the relationship between the nursing profession and organizational management.

In England, as in much of the rest of the economically developed world, there has been a significant push to raise the professional standing of nursing, and in the process improve autonomy, power and respect for the occupation (Iley, 2004). In England this has been accompanied by abolition of the traditional matron role (Rivett, 2007). Senior-level clinical posts for nurses have been introduced, particularly in nurse-led services and in substituting for certain roles traditionally fulfilled by medics (Robinson et al., 1997), with posts such as nurse specialist, nurse prescriber and nurse consultant introduced with enhanced clinical responsibilities (Jasper, 2002). The outcome is one where there has been a narrowing of the role of specialist nursing, with nursing care increasingly fragmented in a way that may drive out a broad, flexible generic nurse role (While, 2005). Evidence from other countries shows nursing has been professionalised in a similar manner for some time and this has prompted further specialisation (Rognstad et al., 2004). Over the last decade in particular, leading figures in the nursing professions have sought to establish nursing at its highest levels as a graduate profession. A key facet of this has been an attempt to establish a distinctive knowledge base for nursing, with an associated stress on the role of the qualified nurse in the management of patient care (Causer and Exworthy, 1999). Thus, nursing is increasingly a profession whose work is highly technical and likely to be increasingly so

(Dingwall and Allen, 2001). Consequently, some commentators express concern that modern matrons damage the new, more professionalised image of nursing because it requires little in the way of formal qualifications and achievement; in short modern matrons 'dumb down' nursing (Dealey et al. 2007; Watson and Thompson, 2004). In response, their own ranks of nursing may seek to manage modern matrons in a way that limits their influence over HCAI.

Further, despite the rise of 'new' nursing and a renewed strategy of professionalisation of nursing detailed above, we highlight that nurses remain dominated by doctors (Burrage, 1992; Freidson, 1987; Larkin, 1988; Walby et al., 1994). In their response to successive reforms, Halpern (1992) shows how the medical profession has remained dominant over allied professions, such as nursing. In this respect, as with their relationship with organizational managers described below, nursing remains a 'managed occupation'. Even in the heyday of nursing influence following the Salmon Report (Department of Health and Social Security, 1966), distribution of power was weighted towards the medical profession (Dopson, 1996). Contemporary changes in the nursing role outlined below, where nurses are encouraged to take on some the technical tasks associated with medicine might suggest nursing is breaking away from its reliance upon doctors. However, this is less an extension of the nurse's licence and more a re-interpretation of its established terms, with nurses remaining subordinate to doctors (Dingwall and Allen, 2001). Further, the traditional matron exercised their power through doctors (Girvin, 1996), so we should not be surprised if the modern matron finds it difficult to influence doctors towards tackling HCAI.

Presenting a further challenge is that the professionalisation of nursing has been accompanied by a change of role, whereby nurses have been taken away from notions of 'serving the patients' and 'hands on care' to providing 'care management facilities for clients' (Hallam, 2000). Practice per se is comparatively devalued even though it is the raison d'être of nursing (Thompson and Watson, 2005). Traditionally nurses have been seen as bridging the gap between the patient and the doctor through their humanity and more holistic care, which mediates the impersonal nature of the doctor's interaction with the patient. Nurses 'care' for patients, whilst doctors get on with the technical task of 'curing' (Dingwall and Allen, 2001). However, this traditional role of emotional or holistic care may be incompatible with the up-skilling of nurses and nurses are handing over aspects of their caring role to healthcare assistants, whilst at the same time being drawn into technical work as medical auxiliaries (Borthwick and Galbally, 2001; Dingwall and Allen, 2001). Again, the modern matron role, which encompasses a more holistic notion of care, rather than concern with expert technical tasks, sits awkwardly with contemporary changes in the nursing profession.

Finally, with respect to the relationship of nursing with organizational management, a timely starting point to understanding the dynamics of the nursing profession, and how this might impact upon the modern matron role, is the Salmon Report (Department of Health & Social Services, 1966), the effect of which was to diminish the autocratic style of nursing management associated with traditional matrons. In the face of recruitment problems in the NHS, the Salmon Report introduced an extensive nursing hierarchy with a clear upward career pathway, which included a pathway for nurses into

management (Rivett, 2007). Its effect however, was to engender tensions between clinical and managerial hierarchy even where both were drawn from the same nursing ranks because management and nursing practice were decoupled (Savage and Scott, 2004). Despite this, the Salmon Report represented the high point of managerial involvement for nurses. Even with the introduction of more corporatist arrangements associated with 'consensus management' (Department of Health and Social Security, 1972), where nurses were given a statutory right to be included in senior management teams at local and regional levels (Ackroyd, 1996; Bolton, 2005), gains for nurses in the management sphere have been clawed back, with the thrust of new management since the 1980s focused upon the removal of the nursing profession from senior positions (Pollitt, 1990). Over the ten years following the introduction of consensus management, organizational structures and titles of nursing may have changed, but with little real power added. This meant nursing has been unprepared for the radical changes that the 1980s would bring (Girvin, 1996).

The introduction of general managers following the Griffith's Report (Department of Health and Social Security, 1983), who were held accountable for control of resources, particularly affected the clear hierarchical structure of nursing (Causer and Exworthy, 1999; Walby et al., 1994). 'New' management attacked nurse's occupational autonomy in a way that allowed greater control of the nursing labour process (Bolton, 2004). As Klein (1995: 150) highlights; 'Nurses quite clearly lost out: the effect of the Griffiths recommendations was that nurses lost both the right to be managed exclusively by a member of their own profession and their automatic representation on district management

teams, both guaranteed by the 1974 corporatist arrangements'. Nurses remained wedded to functional hierarchy and many senior nurses, engaged in functional rather than general management roles, either returned to more practice-focused roles, or left the service for education or research (Girvin, 1996). This prompted reflection by the nursing profession upon its position in managerial structures (Robinson et al., 1997; Thompson and Watson, 2005). This remains an ongoing endeavour with leadership, as well as management, entering the lexicon of the debate within nursing. In essence, whatever the lexicon, the debate is focused upon how nurses might exert more influence upon strategic decision-making (Girvin, 1996). Where modern matrons fit in with the new managerial hierarchy and the debate about the position of the nursing profession in this appears uncertain (Savage and Scott, 2004). Anecdotal evidence suggests considerable variation in the introduction of modern matrons across the NHS with some organizations renaming existing roles and amending job descriptions in line with the requirements of the modern matron, others taking the opportunity to create new posts, or redesigning senior nurse posts (Oughtibridge, 2003).

In summary, professional and managerial hierarchy and practice no longer resemble the system within which the old style matron was able to exercise authoritative power. Within the shifting terrain of nursing, which encompasses professionalisation, changing nurse roles, continued subordination to doctors and marginalisation within managerial decision-making, enactment of the modern matron role, with the authority that characterized previous incarnations of the role, may prove challenging.

Taking account of our critique of the introduction of modern matrons within the context of the NHS, characterised by professional hierarchy, we present our data along four inter-related themes – [i] What do modern matrons actually do?; [ii] The inconsistency of policy; [iii] Professional hierarchy: where is the modern matron located?; [iv] Mediating professional autonomy and hierarchy. Prior to our data presentation, we set out our research design.

Research Design

We used a qualitative approach for our study on the basis that it is acutely sensitive to the context in which leadership is enacted (Bryman, 1999; Bryman et al., 1996). We focus upon a single case study - a university teaching hospital trust in the Midlands - from which we theoretically generalise (Eisenhardt, 1989, 1991; Yin, 1994) about new roles and organizational change in public services organizations. The empirical case study is neither excellent nor a poor performer relative to other university teaching hospitals in England with respect to infection control incidents and other performance indicators: i.e. our empirical case might be viewed as typical of university teaching hospitals in England regarding its performance dimension.

Our case study encompassed 22 interviews with modern matrons and other nurses responsible for infection control in the hospital that were described as located in lower middle management positions within the hospital. There were four groups of respondents: 10 modern matrons; 6 dedicated infection control nurses; 2 mainstream senior nurses in ward areas ('ward sisters') with significant managerial responsibility; 4 senior nurses in the operating theatres department, part of whose work was to ensure standards of hygiene. All the matrons but one had been in post for over a year since the role was

introduced within the university teaching hospital. Interviews were semi-structured, focusing upon questions in the following areas: the nature of interviewees' infection control roles within the hospital (e.g. describe a typical day); the main challenges faced in enacting the infection control role; how interviewees organized others in the hospital to improve infection control; how interviewees' infection control role was supported (or limited) by the wider organization. Interviews lasted between one and one and half hours and all interviews were fully transcribed.

On a reflexive note, we suggest the topic of study may elicit interview responses concerned to 'hide' quality problems associated with the delivery of health care (e.g. would healthcare professionals admit to poor hand washing?). To mediate this effect, interviewees were assured their responses were confidential in line with ethical approval gained for the study. Readers should note written consent was obtained from all staff after they had been given information indicating the purpose of the study and information about how the data would be used. We also sought to probe responses in a sensitive manner during the interviews, where we suspected the interviewee was providing an account of their impact upon HCAI that policy-makers might regard as desirable. Finally, one aspect of respondents' accounts of change may be a tendency for self-attribution regarding their impact upon organizational change (Bryman et al., 1996). That there were four groups of respondents allowed us to assess whether any of modern matrons, infection control nurses, ward sisters or operating theatre department nurses were making excessive claims regarding their impact upon change and probe responses accordingly.

We undertook an iterative analysis process, re-reading and coding transcripts, notes and documents, generating themes, and cross-checking these through discussions between authors. Thematically related parts of the embedded analysis in each data source were grouped together. The authors discussed the coding of transcripts with each other, ensuring inter-researcher reliability of interpretation and enhancing analysis. Subsequently, the analysis agreed across the authorial team for each case was considered against the over-arching research questions. As a means of elaborating and authenticating this analysis, findings were presented to both the commissioners of and participants in the research (Yin, 2003).

Whilst we cannot make strong claims for the demographic representativeness of the participants, the interview material elicited here is of interest because of what it may disclose about the social construction of matrons' roles, what it tells us about the formulation and implementation of the tasks of infection control, and how this may relate to broader patterns or inter-relationships in organized, socially co-ordinated human activities in the health care field.

Results and discussion

Four core themes were systematically identified and sub-themes defined within these core themes.

[i] *What do modern matrons actually do?*

The new version of the matron identified in UK policy documents brought with it the traditional attributes of authority, and was positioned by policy and media response as a guardian of cleanliness and propriety. Both aspects of

the modern matron role appear to have been seen as legitimate by our interviewees.

Linked to this, when asked to describe what they did in their work roles, respondents were keen to emphasise that it is about; "making sure you take the service forward, that you are an agent for change" [#12 Modern Matron/Operating Theatres Department]. However the activities typically described by our interviewees appear relatively mundane:

> Specifically you'd be cleaning the wards, you'd be tidying the beds, you'd been managing the staff, you'd be doing everything [#10 Ward Sister/Neurosurgery Department].

That recently appointed matrons perceived 'they did everything' is interesting. The activities they describe very much includes hands on work, as well as directing others to do the work around infection control that was necessary. As we discuss later, carrying out mundane activities may have a function, notably of enhancing their visibility on the wards. However, we suggest their attempts to do 'everything' does rather counter claims that their role was a clear one, at least in policy terms.

Yet, there appears a great deal of hope invested in the modern matron as a panacea for problems of infection control in hospitals:

> Suddenly the matron was going to make everything better. And it's almost like they were harping after some era gone by. The papers have picked up that they're going to reintroduce a matron to get the hospitals clean like they used to be [#10 Ward Sister/Neurosurgery Department].

Despite this, it may be difficult for those tasked with the role of modern matron to meet aspirations:

> When they implemented the role of the matron there was a lot of media attention and publicity around what we would be able to do in relation to hygiene, infection and all of those sorts of things. However, I don't feel as if I've done everything that I can do. [#9 Modern Matron/Elective Orthopaedic Department]

In principle, the modern matron's role appears widely accepted by modern matrons and others. Interestingly, interviewees also mention the 'softer' side of the modern matron role which had been propagated in policies, namely the 'enabling' aspect of the role, which involves a lot of interpersonal interaction and liaison. The modern matron was expected to lead infection control through transcending organizational and professional boundaries and providing a bridge between the health care professionals and the patient:

> The most important aspect of my role as modern matron is to ensure that I'm effective, efficient and a role model, a good clinical lead. That encompasses lots of things about making sure that the environment and the patients are safe, they get the best possible care, but also that the patient journey is the best journey as it can possibly be … the purpose of the modern matron role is to have a link. The modern matron is the person, if you have concerns this is the person [#12 Modern Matron/Operating Theatres Department].

The interviewee above is clear about the role of the modern matron, although seems to cast the role of the modern matron more widely than hygiene and cleanliness to encompass managing the patient journey. Others, meanwhile, view the modern matron's role rather more narrowly:

> I have no problem with my role. However, other people seem to be confused about what my role is [#22 Modern Matron/Mental Health Department].

In contrasting conceptions of the modern matron role – more broadly or narrowly – we highlight that tackling HCAI might require the modern matron to attempt to exert influence upon the organizational systems that frame infection control. However, we note that jurisdictional concerns characterise health care settings. The modern matron is imposed upon existing professional hierarchy and it should come as no surprise that there may be some overlap and indeed conflict between different professional roles when the modern matron attempts to extend their domain of influence. We discuss this further in our third empirical section.

[ii] *The inconsistency of policy*

Three sub themes were identified during discussion of this core theme. The sub themes related to the difficulties experienced by senior nurses in enacting their roles and include a) cleaning, b) budgetary issues, c) targets.

Regarding the first of these difficulties, as part of the authority of the modern matrons, the original formulation of their role attributed to them the power to withhold payments to contracted cleaning companies. The matrons interviewed for our study pointed out difficulties when describing their experiences of trying to manage cleaning:

> I can talk to the domestics and say; "look guys can you just make sure that you give the side rooms a good clean out". But then their boss can come along and say; "right you've done that bit now, you need to move to another area" [#9 Modern Matron/Elective Orthopaedic Department].

Linked to their difficulty in managing cleaners on a day-to-day basis, matrons had no input into the way in which the cleaning workforce was organized:

> I think that we should have more control over the domestic services and be involved in decision making when they reduce their numbers or have sickness [#12 Modern Matron/Operating Theatres Department].

In short, cleaners at ward level, over whom modern matrons attempt to exert control efforts, respond to their line manager who works for the private subcontractor rather than the hospital. This means that modern matrons may need to manage cleaning services indirectly through the hotel services department in the hospital, since hotel services managers can more effectively hold subcontractors to account. Such 'arms length' management of cleaning services limits the impact of modern matrons upon infection control.

With respect to budgetary issues, interviewees reflected upon the conflicting demands of national policy, which they were expected to accommodate. Notably, efficiency concerns were fore-grounded in policy and this cut across attempts to improve the quality of healthcare. It seemed cleaning contracts were awarded to those private subcontractors that limited costs:

> We have to make sure that the area is absolutely, totally cleaned, but we don't seem to have the necessary cleaning staff that to do it properly. The cleaners recognise this because a lot of them that you speak to will say; "you know I wish I'd got the time and the equipment to do this properly." [#7 Senior Nurse/Operating Theatres Department]

In response to the need to provide a supportive context within which modern matrons enacted their role, we might expect modern matrons to enjoy some authority over financial and other resources. This kind of financial

authority seems particularly important for introducing and sustaining new initiatives in infection control, but, according to our interviewees, it was not granted to modern matrons. Fragmentation of the health care system seemed pervasive with budgetary responsibility decoupled from managerial responsibility for infection control:

> Policy, locally and nationally has made people responsible for things and accountable for things that they actually have no jurisdiction over. It's just bonkers really you know … We were never given the budget or the control to manage the people who cleaned our wards, so there's only so much you can do. I think our impact could be greater if the infrastructure had been sorted out to support our role. [#9 Modern Matron/Elective Orthopaedic Department]

We suggest, unless a significant budgetary responsibility is made part of the modern matron role, their impact upon HCAI proves difficult to sustain at the local level. Exacerbating competing demands around the role of the modern matron is the co-existence of targets, not just for infection control, but for patient throughput and staffing levels. The government drive for efficiency gains particularly impacted upon modern matrons. Matrons talked about the pressures that result from the conflict between professional obligations and realities of such a complex negotiated order as a hospital - where, in the end, everything revolves around saving 'time' and 'money' while still trying to save lives. On the one hand, efficiency gains were driven by increased throughput of patients:

> When you've got very high bed occupancy and you have a lot of national targets, such as waiting times, this has an impact on infection prevention and control and infections will rise. [#11 Infection Control Nurse]

On the other hand, this was accompanied by a cost-cutting regime:

> I'd like to be given a fair chance to deliver what's expected of me and that's to deliver a good quality patient service, reducing the risks to patients, including infection. However, I'm told that I can't recruit to nursing vacancies, I'm having to cut beds, I'm having to reduce staff and I don't have any input over the staff that provide that healthcare. [#9 Modern Matron/Elective Orthopaedic Department].

Both efficiency initiatives adversely impacted upon the attempts by modern matrons to control infection.

In the last statement above we note frustration that modern matrons had little control over the health care labour force and health care activity more generally within which their role was enacted. This proved a prominent theme within our analysis, which we discuss further in our next empirical section.

Finally, we highlight some frustration about one of the key responsibilities of the modern matron: the idea of the modern matron being a 'liaison' person between different groups in the hospital. Rather than being left to get on with the job of infection control, and reflecting an assertion in our first empirical section that modern matrons must do 'everything' [#10 Ward Sister, Neurosurgery Department], modern matrons appear to be performing a large number of tasks on an everyday basis. Dealing with emails, attending meetings, initiating and supervising audits, more general management represent the staple activity of the modern matron and may receive precedence over infection control related issues.

> I would do lots of HR type issues, sickness interviews, recruitment, general sort of disciplinary type, performance management kind of things. I'm very involved at the moment in meetings around workforce change. I meet regularly with my business manager, my

> divisional nurse, my finance link person. [#12 Modern
> Matron/Operating Theatres Department]

Perhaps exacerbated by the tendency of modern matrons to try and exert influence over the wider patient journey, the modern matron is pulled into a good deal of liaison activity. Whether this presents an opportunity for the modern matron to lead change is discussed further in the next empirical sections.

[iii] *Professional hierarchy – where is the modern matron located?*

The 'return of the matron' prescribed in policy suggests a structure of rigid and effective line management of personnel, with the matron as an authority figure. However, in reality, as we suggested in our previous empirical sections of the paper, modern matrons sit in a much less dominant position within the hospital than policy-makers imagine. Whilst modern matrons are likely to work within a team of modern matrons and be supported by peers, more senior nurses are positioned alongside and even above modern matrons and modern matrons work alongside, rather than above, other personnel, such as cleaning services staff, who remain outside their direct line management.

   Yet within this institutionalised division of labour, modern matrons are expected to impact upon HCAI through speaking across organizational divides that are based on differentiated groups of workers. Beside efficiency pressures discussed earlier, this also creates difficulties and confusion with regards to the issues of accountability in the modern matron role. On the one hand, modern matrons describe themselves as potentially accountable to a range of stakeholders:

> You've got lots of different people that feel that you are accountable to them. One of the main challenges of the matron role is to identify who is your boss, who are you reporting to and accountable to. There's the HR bit, there's your divisional nurse bit, there's the finance bit. There are lots of people who want a bit of you. [#12 Modern Matron/Operating Theatres Department]

As a result, the 'busy-ness' of modern matrons extends to ensuring the demands of other professional and managerial teams are met, with consequent adverse effects upon their infection control role:

> We're all so busy trying to achieve somebody else's targets that we don't focus on our own area of practice and make it the best it can be. [#22 Modern Matron/Mental Health Department]

On the other hand, it appears few healthcare staff, if any, regard themselves as accountable to the modern matron:

> Even when you put up a sign saying: "please use this hand gel before you enter this area"; you've really got to almost hit them in the face with it to get them to do it. And we know that the best users, in a recent audit here, were nurses but even then it was only 65 per cent. The doctors are about 40 per cent compliance and the visitors were sort of 30 per cent compliant the compliance to our demands is not good. [#2 Modern Matron/Ear, Nose & Throat Department]

It appears that, even around the most visible aspect of infection control, such as hand-washing, fellow health care professionals and patients appear inclined to ignore modern matron's prescriptions for cleanliness. Probing the influence of modern matrons over doctors elicited additional examples of the extent to which the former remain dominated by the latter. As the following quotes show, modern matrons can exert little influence over doctors:

We recently had a report where management carried out a check audit on one of my areas. They split the results down into nurses, professions allied to medicine, and doctors. Doctors' hand-washing was absolutely terrible, terrible, terrible. But there was nobody really who would take that on. I have spoken to our clinical director and said "Look can we get somebody to come along and chat to the doctors at the audit meeting just to raise awareness and that sort of thing?" [#9 Modern Matron/Elective Orthopaedic Department]

Concern about lack of their influence over doctors extended beyond handwashing to encompass clinical practice more generally as it impacted upon infection control:

There's nobody walking round following doctors, keeping an eye on what they're getting up to. Nurses get quite upset because nobody is watching them, testing them and making sure their standards of practice are good. I know things are changing but they can do what they like more or less you know. [#22 Modern Matron/Mental Health Department]

Further contributing towards the limited power that modern matrons enjoy, we also highlight modern matrons occupy an 'in-between' position in the managerial hierarchy of nursing, which limits their influence over their fellow nurses:

I don't manage any of the staff. What I do is work with all the wards on site, so work with the ward managers, give clinical leadership advice, offer support, offer supervision. So I work with other health care staff them but I don't line manage them. Instead staff is managed through a service manager, who is a nurse and I'm managed through the general manager, who is also a nurse. [#19 Modern Matron/Mental Health Department]

Again, in response to professional hierarchy, modern matrons have to resort to 'arms length' management of others to tackle HCAI.

In summary, modern matrons have to negotiate a role that allows them to make the impact upon infection control locally that national policy-makers envisage. In the next empirical section, we discuss how modern matrons can move forward in tackling HCAI.

[iv] *Mediating professional autonomy and hierarchy*

Having presented the themes above (i-iii) that suggest significant limits to the modern matron's role, we note our study offers a glimpse of where and how modern matrons might make a greater impact upon HCAI. The visibility of modern matrons, linked to the situated nature of modern matrons' influence over others, and finally audit mechanisms, supported modern matrons in tackling HCAI.

First, some of the matrons were positive about the 'enabling' aspect of their role, which involves a lot of interpersonal interaction with other nurses, visitors and patients. Modern matrons exerted a very visible presence in ward areas and act as a conduit for the reporting of infection control issues at a local level:

> Even when I'm working clinically people still know that I'm the matron so if they've got any problems that need dealing on a day to day basis then they'll still come to me. [#18 Modern Matron/Renal Department]

> Certainly first thing in the morning I always come to my clinical area and I make sure that I'm a very visible clinical lead. I trouble-shoot, I make sure that staffing is okay, we're covered, we've got equipment and basically any kind of thing that at the start of the day might be a problem I'm made aware of, so that's where it starts. [#12 Modern Matron/Operating Theatres Department]

In essence, modern matrons enhanced their influence by 'walking the job' in a way similar to the archetype modern matron:

> By just pacing the floor a lot more I can question things, I can ask staff more objectively on the basis of observation: "well that's not clean, why is it not clean?" [#22 Modern Matron/Mental Health Department]

Modern matrons organized themselves to focus on certain key locations within the hospital within which they exerted a very visible presence to heighten the profile of infection control:

> One of the things we did was allocate an area to each modern matron. [...]. I would regularly, every day, really go and have a look and make sure that nobody was parking a bed or an x-ray machine or anything like that that constituted obstacles to cleaning efforts and infection control. [#2 Modern Matron/Ear, Nose & Throat Department]

Second, consistent with the professional institution and enhanced visibility of the modern matron, modern matrons exerted greater influence where their activity was situated in professional practice:

> All the departments, all the staff respond to you much better if the patient has actually got an infection. So if they've got TB or got a blood borne virus then the clinical staff are fine ... So if you do any training you need to really gear it around a clinical situation and then sort of bring in the things like hand hygiene and the importance of cleanliness. [#19 Infection Control Nurse]

Modern matrons could help bring peer pressure to bear as a strong force for change with healthcare professionals engaging in the sharing of learning around best practice for infection control:

> Peer pressure around infection control has an awful lot of meaning in this environment. Staff nurses or other healthcare professionals talking to each other about what they do in their area and what you've done in yours and suggesting that, 'it's not, well it doesn't look quite right does it, why are you doing it?' [#7 Senior Nurse/Operating Theatres Department]

Through convergence with professional logic and situating their infection control activities within professional practice, modern matrons and others responsible for infection control might be able to move beyond their subordinate role to doctors:

> I stopped a doctor in the canteen a few weeks back. Now it says in the protocol you can go out of operating theatre, but only in clean scrubs. Well he had a ring of blood across his belly and I approached him and said "Do you know who I am?" "No," he said. I said "Well I'm one of the theatre sisters and you should not be out dressed like that in public areas, get back upstairs". I really got sanctimonious with him. [#16, Senior Nurse/Operating Theatres Department]

Finally, the audits carried out by the modern matrons proved to be a useful strategy in maintaining infection control procedures. Performance against infection control benchmarks was captured and monitored akin to a balanced scorecard approach, which seems increasingly prevalent and accepted in healthcare organizations:

> We have a general strategy for the management of risk. Infection control is now included. It's like a traffic system, green light for excellent performance and red for a problem. [#22 Modern Matron/Mental Health Department]

These audits have enabled the matrons to maintain a close monitoring of the standards of cleanliness and offered a 'fresh' and 'objective' perspective on the state of the hospital environment, which could then be leveraged to improve infection control:

> People do things for so long they become blind to it and so they don't realise until somebody points it out to them. The last few audits that I've done for areas in the hospital, they've scored quite highly and showed a sharp improvement. I think that's because people like me have actually been given that infection control role. Nobody was really doing it before and nobody was actually monitoring the standard of cleaning and incidence of infection. [#2 Modern Matron/Ear, Nose & Throat Department]

Rates of handwashing and even dust under beds were given as illustrations of hygiene and cleanliness indicators that were continually measured and re-measured in pursuit of improved infection control:

> We have quarterly audits within the hospital that aim to reduce cross-infection that incorporates hand hygiene. [#3 Modern Matron/Surgical Department]

> We have central audits on everything from fresh air to how many people fill in an incident form correctly. [#8 Infection Control Nurse]

Audit thus represents a particular technique for the acquisition of information that modern matrons can utilise to manage others.

Conclusion

The empirical study shows limited prospects for modern matrons to enact their role in the face of professional hierarchy. Specifically, professional hierarchy limits modern matron's jurisdiction over doctors and nurses within departments where they are expected to influence structures, processes and behaviours towards tackling HCAI. Whilst old style matrons enjoyed

significant authority at departmental level 30 or 40 years ago, their modern day equivalent appears to be positioned outside the new professional hierarchy. Doctors, largely remain outside their influence (Burrage, 1992; Dingwall and Allen, 2001; Freidson, 1987; Larkin, 1988; Walby et al., 1994). Meanwhile the 'new' nursing hierarchies and roles associated with continued professionalisation of nursing (Causer and Exworthy, 1999; Dingwall and Allen, 2001; Iley, 2004; While, 2005) do not easily accommodate a clear role for modern matrons. Modern matrons enact a 'hands on' role, which engages them in a wide range of activity. However, this appears decoupled from the technical, knowledge-intensive activities of 'new' nursing (Borthwick and Galbally, 2001; Dingwall and Allen, 2001). Whilst their visible presence in a wide range of arenas aid their attempts to tackle HCAI, overall modern matrons lack the necessary influence over other healthcare professionals, including their own ranks. Consequently, as with other studies of professional change (e.g. Kirkpatrick et al., 2004), our findings regarding the role of the modern matron in tackling HCAI, reveal the limits of management change and the difficulties of securing occupational compliance towards managerial aims. Specifically, healthcare professionals (doctors and mainstream nurses) are keen to protect their jurisdiction over the quality of healthcare (Davies, 2007).

An unanticipated outcome of our study was that policy itself appeared inconsistent in its effect upon the attempts by modern matrons to tackle HCAI. Commentators have highlighted the inconsistent effects of an economic facet of policy elsewhere (Currie et al., 2005; Newman, 2001). Our study also highlights an economic facet of policy, which sets targets for continual cost improvement, waiting lists and times. These targets exist alongside infection

control targets and may limit the influence of modern matrons. Senior nurses, who are situated with the mainstream nursing hierarchy, may focus upon policy targets beyond infection control, attainment of which may not converge with infection control targets. We suggest the plethora of targets that characterise health care activity should be brought together, perhaps with a single person responsible for attaining these. Specifically, authority and budgets must converge with a coherent set of targets (Barrett, 2003; Hewison, 2001).

That modern matrons are also awkwardly positioned in the managerial hierarchy adds to the challenge of enacting their role. Modern matrons work *alongside* existing nurse managers, rather than *within* existing nurse management hierarchies. They work to others' targets, meanwhile others are not accountable to them, and modern matrons are forced to engage in a great deal of liaison activity across organizational boundaries in pursuit of their infection control efforts. In part, their marginal position within managerial hierarchy might be due to the nursing professions' uncertain response to the introduction of general management (Bolton, 2004; Klein, 1995; Savage and Scott, 2004). In part, their marginal position might be more specific to our empirical case, where they occupy a lower middle management position. In light of variation noted regarding the position of modern matrons in professional and managerial hierarchies (Oughtibridge, 2003), modern matrons might have greater impact where they are located in senior nursing management positions.

Finally, as part of the policy drive for cost improvements, increasingly non-clinical services, such as cleaning, are outsourced to private contractors. This

fragments the 'NHS family' and modern matrons appear to have little influence over cleaning operatives at the local level. Other commentators note how aspirations for new roles that cross organizational boundaries are stymied by organizational fragmentation that accompanies outsourcing (Marchington et al., 2005).

Yet we see glimpses of modern matrons' influence over others. With respect to notions of professional autonomy and hierarchy, health care professionals may support quality improvement, including efforts to tackle HCAI in principle, but do not accept managerial leadership in this area. Modern matrons' attempts to tackle HCAI appear more effective where infection control activity is situated in professional practice. Approaches that link to peer review and pressure upon others to conform to professional 'best practice' is consistent with social control and the maintenance of professional boundaries (Freidson, 1970; Rosenthal, 1995) and therefore more likely to engender the necessary organizational change to improve quality of healthcare. We also note the target-based demands of government policy can be used to support the role of modern matrons. This requires that modern matrons integrate aspirations for improved infection control within mainstream audit mechanisms in a health care organization. The old adage, 'what gets measured gets managed' holds (Power, 1997).

Earlier we noted variation in the implementation of modern matrons (Oughtibridge, 2003) and suggested this might render our findings relatively specific to the empirical case. Except by driving a theoretical analysis through a perspective drawn from sociology of professions, we suggest modern matrons exemplify the introduction of 'hybrid' (professional/managerial) roles

associated with government policy concerned to modernise the delivery of public services. As such our findings might resonate with the challenge of introducing new roles within pre-existing but dynamic system of professions that characterises many public services organizations across the world. To re-iterate our theoretical contribution, there are four dimensions of professions that should be considered when introducing new roles. These are: the dynamics of the profession with which new roles are most closely associated; the changing role of those within this profession and its relationship with the new role; the relationship between various professions and power differentials that impact upon the new role; the relationship between the new role and organizational management.

Finally, regarding further research, we encourage comparative research across other public services domains and internationally relating to prospects for policy initiatives that introduce new roles into public services organizations. We suggest the significance of professional hierarchy may vary across other public services' domains, whilst government policy in countries outside England may emphasise targets less and/or organizationally fragment public services less, all factors that might contribute to different outcomes of policy interventions trying to reduce HCAI.

References

Abbott, A. 1988. *The system of professions: An essay on the division of expert labour.* Chicago: Chicago University Press.

Ackroyd, S. 1996. Traditional and new management in the NHS hospital service and their effects on nursing. In K. Soothill, C. and K. Kendrick, (Eds.) *Themes and perspectives in nursing.* London: Chapman and Hall.

Barrett, D. 2003. Will Modern Matrons carry on regardless? A response, *Journal of Nursing Management*, 11 (3), 144-46.

Bolton, S. 2005. Making up managers. *Work, Employment & Society*, 19, 1, 5-23.

Borthwick, C. & Galbally, R. 2001. Nursing leadership and health sector reform. *Nursing Inquiry*, 8, 2, 75-81.

Broadbent, J. & Laughlin, R. 2002. Public service professionals and the New Public Management. In K. McLaughlin, S.P. Osborne and E. Ferlie (Eds.) *New Public Management: current trends and future prospects*. Routledge: London.

Bryman, A. 1999. Leadership in organizations, in S. R. Clegg, C. Hardy & W. R. Nord (Eds.), *Managing organizations: Current issues.* London: Sage.

Bryman, A., Stephens, M. & Campo, C. 1996. The importance of context: Qualitative research and the study of leadership. *Leadership Quarterly*, 7, 353-70.

Burrage, M. 1992. Mrs. Thatcher against deep structures: The ideology, impact and ironies of her eleven year confrontation with the professions. *Working Paper 92-11*, Instiue of Government Studies, University of California in Berkeley

Causer, G. & Exworthy, M. 1999. Professional as managers across the public sector. In M. Exworthy & S. Halford (Eds.). *Professionals and the new managerialism in the public sector*. Buckingham: Open University Press

Clarke, J. & Newman, J. 1997. *The managerial state*. London: Sage.

Currie, G., Boyett, I. & Suhomlinova, O.2005. Transformational leadership in the public sector: A panacea for organisational ills? *Public Administration* 83, 265-96.

Davies, C. 2007. Rewriting nursing history again. *Nursing History Review*, 15, 11-28.

Dealey, C., Moss, H., Marshall, J. & Elcoat, C. 2007. Auditing the impact of implementing the Modern Matron role in an acute hospital trust. *Journal of Nursing Management*, 15, 22-33.

Department of Health [DoH] 2000. *The NHS Plan.* London: The Stationery Office.

Department of Health [DoH] 2001. *Implementing the NHS Plan: Modern matrons - strengthening the role of ward sisters and introducing senior sisters* (Health Service Circular 2001/010). London: Department of Health.

Department of Health [DoH] 2002. *Modern Matrons in the NHS: A Progress Report.* London: Department of Health.

Department of Health [DoH] 2004. *A Matron's Charter: An Action Plan for Cleaner Hospitals.* London: DH.

Department of Health [DoH] 2005. *Action on Health Care Associated Infections in England.* London: DoH

Department of Health & Social Security [DHSS] 1966. *Report of the Committee on Senior Nursing Structure (The Salmon Report)*. London: HMSO.

Department of Health & Social Security [DHSS] 1972. *Management Arrangements for the reorganised National, Health Service.* London: HMSO.

Department of Health & Social Security 1983. *NHS Management Inquiry (Griffiths Report).* London: HMSO.

Dingwall, R. & Allen, D. 2001. The implications of healthcare reforms for the profession of nursing. *Nursing Inquiry*, 8, 2, 64-74.

Dopson, S. 1996. Doctors' involvement in management: A challenge to established debates. In J. Leopold, I. Glover and M. Hughes (Eds.) *Beyond reason: The National Health Service and the limits of management*

Eisenhardt, K.M. 1989. Building theories from case study research. *Academy of Management Review*, 14, 4, 532-50.

Eisenhardt, K. M. 1991. Better stories and better constructs: The case for rigor and comparative logic. Academy of Management Review, 16, 3, 620-27.

Enright, M. 2005. MRSA Epidemiology & Evolution. Science Lecture, 21 April. http://www.brlsi.org/proceed05/lecture0405.htm.

Exworthy, M. & Halford, S. 1999. *Professionals and the new managerialism in the public sector*. Buckingham: Open University Press

Freidson, E. 1970. *The profession of medicine*. New York: Harper Row.

Freidson, E. 1987. The future of professions. *Journal of Dental Education*, 53, 140-144.

Freidson, E. 2001. *Professionalism: The third logic*. Cambridge; Polity Press.

Girvin, J. 1996. Leadership and nursing, part one: History and politics. *Nursing Management*, 3, 1, 10-12.

Grundmann, G., Hori, S., Winter, B., Tami, A. & Austin, D. 2002. Risk factors for the transmission of methicillin-resistant Staphylococcus aureus in an adult intensive care unit: fitting a model to the data. *Journal of Infectious Diseases* 185, 481-88.

Hallam, J. 2000. *Images of nursing*. London: Routledge.

Halpern, S. A. 1992. Dynamics of professional control: Internal coalitions and cross professional boundaries. *American Journal of Sociology*, 97, 994-1021.

Hewison, A. 2001. The modern matron: Reborn or recycled? *Journal of Nursing Management*, 9, 187-189.

Iley, K. 2004. Occupational changes in nursing: the situation of enrolled nurses. *Journal of Advanced Nursing* 45, 4, 360-370

Jasper, H. 2002. Nursing roles and nursing leadership in the New NHS – Changing hats, same heads. *Journal of Nursing Management*, 10, 63-64.

Klein, R. 1995. *The New Politics of the NHS.* 3rd Edition, Harlow: Longman.

Koteyko, N. & Nerlich, B. 2008. Modernn matrons and infection control practices: Aspirations and realities. *British Journal of Infection Control* 9, 2, 18-22.

Larkin, G. V. 1988. Medical dominance in Britain: Image and reality. *Millbank Quarterly*, 66, 2, 1-9.

Larson, M. 1979. *The rise of professionalism: A sociological analysis*. London: University of California Press.

Kirkpatrick, I., Ackroyd, S. & Walker, R. 2004. *New managerialism and public sector professionalism*. London: Palgrave

Marchington, M., Grimshaw, D., Rubery, J. & Willmott, H. 2005. *Fragmenting work: Blurring organizational boundaries and disordering hierarchies.* Oxford: Oxford University Press.

Murphy, R. 1990. Proletarianization or bureaucratization: The fall of the professional. In R. Torstendahl and M. Burrage (Eds.) *The formation of the professions: Knowledge, state and strategy*. London: Sage.

Newman, J. 2001. *Modernising governance: New Labour, policy and society*. London: Sage.

O'Connell, M.H. & Humphreys, H. 2000. Intensive care unit design and environmental factors in the acquisition of infection, *Journal of Hospital Infection* 45, 255-62.

Oughtibridge, D. 2003. The modern matron and children's nursing. *Paediatric Nursing*, 15,2, 26-28.

Pittet, D., Hugonnet, S. & Harbarth, S. 2000. Effectiveness of a hospital-wide programme to improve compliance with hand hygiene. *Lancet* 356, 1307-12.

Pollitt, C. 1990. *Managerialism and the Public Services.* Oxford: Blackwell.

Power, M. *The audit society: Rituals of verification.* 1997, Oxford: Oxford University Press.

Rampling, A., Wiseman, S. & Davis, L. 2001. Evidence that hospital hygiene is important in the control of methicillin resistant Staphylococcus aureus. *Journal of Hospital Infection* 49, 109-116.

Reed, M. 1996. Expert power and control in late modernity: An empirical review and theoretical synthesis. *Organization Studies*, 17, 4, 573-97.

Rivett, G. 2007. *National Health Service History*. www.nhshistory.net. Accessed on 15 September, 2007.

Robinson, S., Murrells, T. & Marsland, L. 1997. Constructing career pathways in nursing: some issues for research and policy. *Journal of Advanced Nursing* 25, 3, 602-14

Rognstad, M.-K., O. Aasland & V. Granum 2004. How do nursing students regard their future career? Career preferences in the post-modern society. *Nurse Education Today* 24, 7, 493-500

Rosenthal, M. 1995. *The incompetent doctor*. Maidenhead: Open University Press.

Royal College of Nursing [RCN] 2004. *Evaluation of the modern matron role in a sample of NHS trusts*. London: RCN.

Savage, J. & Scott, C. 2004. The modern matron: A hybrid role with implications for continuous quality improvement. *Journal of Nursing Management*, 12, 419-426.

Snell, J. 2001. Thoroughly modern matron. *Health Service Journal*, 111, 5774, 28-30.

Thompson, D. R. & Watson, R. 2005. Editorial: The state of nursing in the United Kingdom. *Journal of Clinical Nursing*, 14, 1039-1040

Walby, S., Greenwell, J. MacKay, L. & Soothill, K. 1994. Medicine and nursing professionals in a changing health service. London: Sage.

Watson, R. & Thompson, D.R. 2003. Will Modern Matrons carry on regardless? *Journal of Nursing Management*, 11, 67–68.

Watson, R. & Thompson, D. R. 2004. The Trojan horse of nurse education. *Nurse Education Today*, 24, 73-75.

While, A. 2005. In defence of nursing and the generic nurse. *International Journal of Nursing Studies* 42, 7, 715-716

Yin. R. *Case study research: design and methods*. 1994, Newbury Park CA: Sage.