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The Decision Making Strategies of Modern Matrons

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A thesis submitted in partial fulfillment
of the requirements of the
University of Northumbria at Newcastle
for the degree of
Professional Doctorate in Healthcare

Research undertaken in an NHS Trust in the North of England

September 2010

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Abstract

Modern Matrons are at the vanguard of both care delivery and the NHS reforms and have an important role in the modernisation of, and future delivery of healthcare. An important contextual feature of their role and a concept that has been widely embraced by the National Health Service, is that of *decentralized decision making*. Unlike clinical decision making which has been extensively studied, there is little in the healthcare literature regarding leadership and management decision making or the concept of decentralised decision making. In order to maximise the effectiveness of the Modern Matron role, it is important that we gain a thorough understanding of how they make leadership and management decisions, the reality of the term decentralized decision making for them and an insight into their abilities and needs in regards to this essential skill.

This study explores how Modern Matrons take leadership and management decisions, with a particular focus on the strategies they use and the factors that help or hinder them.

This is an interpretive case study that has adopted an inductive approach to elicit the lived experience of decision making of a group of Modern Matrons working within an acute NHS Hospital Trust. The data was generated through two sets of 1:1 semi-structured interviews. The emergent themes were presented back to the participants for comment and prioritization and to then describe in more depth what the themes meant to them. This process of co-construction facilitated an evolving understanding of the data between the researcher and the study participants.

The findings of this study clearly show the importance of the interplay between individual and organisational characteristics in regard to a Modern Matron's approach to leadership and management decision making. Specifically a Modern Matron's level and range of power bases, the authority that they hold and the credibility with which they are viewed are essential pre-cursors to the range of decision making strategies that they can then employ. These factors are then strengthened or weakened by the level of

active reflection engaged in by the Modern Matron and the structures and processes an organisation puts in place to support both the role of the Modern Matron and the establishment of a culture of empowerment and decentralised decision making

A framework of decision making is proposed that could be used to underpin a structured approach to developing and informing both a Modern Matron's and an organisation's understanding of what factors and strategies support effective decentralised decision making.

Chapter One - Introduction to The Study

Introduction

This study examines the leadership and management decision making behavior of Modern Matrons (MM) within one acute hospital trust in the north of England. The role of the MM is relatively new and was introduced in 2000 within a short time frame and a political framework that was looking in part to address public confidence in the National Health Service (NHS) (Scott et al.,2005,22). This was in conjunction with a professional drive for leadership development and a combined political and professional emphasis on de-centralised decision making. Central to the success of both of these drivers is the leadership and management decision making knowledge and skill of MMs. Whilst there have been national initiatives to foster a culture of de-centralised decision making and to develop nurses' leadership skills, none of these initiatives have explicitly addressed the theory and practice of decision making. These constituent themes set the focus of this study. This chapter provides a preliminary introduction into the key literature and emerging themes that under-pinned the development of the research question, including: the role of the MM; de-centralised decision making; decision making in healthcare and my motivation for undertaking the study. It culminates with an explanation of why this insight is required and how this study will add something new to the existing body of research.

1.1 The role of the Modern Matron

The notion of a MM first became formalised in the NHS Plan (Department of Health 2000), where the government clearly stated its intentions to introduce "a strong clinical leader with clear authority at ward level" (para 9.21). Nurses appointed to MM posts were to be:

- Respected professionals and experienced clinical managers
- People who took a pride in the NHS
- People who had a reputation for setting and delivering high standards of care

- People who had the skills to enable them to lead by example and motivate and empower others

They were to be "given authority to resolve clinical issues, such as discharge delays and environmental problems such as poor cleanliness"(para 9.21). Alongside this they would "be in control of the necessary resources to sort out the fundamentals of care, backed up by appropriate administrative support"(para 9.21). Ten key responsibilities were identified as being core to the MM role:

1. Leading by example
2. Making sure patients get quality care
3. Ensuring staffing is appropriate to patient need
4. Empowering nurses to take on a wider range of clinical tasks
5. Improving hospital cleanliness
6. Ensuring patients nutritional needs are met
7. Improving wards for patients
8. Making sure patients are treated with respect
9. Preventing hospital-acquired infection
10. Resolving problems for patients and their relatives by building closer relationships

To help facilitate the above, the government produced a Health Service Circular (HSC 2001/010 p.2) which set out "the principles to which NHS organisations should attend to when establishing matron posts." It identified a number of strategies required to introduce the role successfully. In particular, that the "personal, professional responsibility and accountability [of MMs] is matched by organisational structures and arrangements that support and enable them to exercise the authority they need to do this effectively" (HSC 2001/010 p.4). This circular recognises the importance of a robust infrastructure to enable MMs to provide strong leadership, be a positive interface between the patients and enable prompt and appropriate decision making to facilitate

high quality care. The circular does not, however, describe what some of those organisational structures and arrangements might look like. It could be argued that it was implicit given the wider healthcare context and emphasis on de-centralised decision making and empowerment. However, it might have been useful to have re-stated those arrangements that the government would have considered to be a priority.

Evaluation of the role of the MM is inevitably in its infancy due to the newness of the role itself. However, when this study began, some initial reviews had been undertaken by the Department of Health (2003; 2002) in regards to the numbers in post, the type of initiatives that have been undertaken and the initial impact of the role. The Department of Health had focussed on the positive achievements, highlighting areas of good practice, where MMs had demonstrated strong leadership and management capabilities that had made a demonstrable difference to the patient's clinical experience. Whilst this was very encouraging, it inevitably centred on the outcomes or product of MM decision making. This may reflect a political emphasis on quick, visible outcomes in regards to quantifiable issues, it did not, however, address the *how* and *why* of the decision-making processes that were chosen and undertaken to reach that outcome. This study will help to address this knowledge gap.

The key MM study that had been conducted prior to

A further indication of the importance of understanding MM decision making is highlighted in a 2004 study by Read et al (2004) evaluating the role of the MM. This is the largest study of MMs undertaken so far. They identified that the Department of Health's initial expectation had been for "in-patient modern matrons to be in charge of a group of wards on which they could 'walk the floor' on a regular basis" (p.101). However, their study identified that in some areas MMs had service wide responsibilities, sometimes across more than one site. This poses very different challenges in relation to effective leadership and management decision making and understanding how MMs address these challenges and what helps or hinders them is important to the on-going development and success of the role.

The establishment of the MM role occurred at a time when there was both a professional and political drive for decisions to be devolved down to those closest to the point of impact – known as decentralised decision making. Understanding the rhetoric and reality of that goal on MM decision making will be one outcome of this study.

1.2 Decentralised Decision Making

Decentralised decision making is a well established leadership imperative supported by multiple authors (Ruvolo 2003; Kouzes and Posner 2007; Porter-O’Grady 1996). Studies have shown that when used effectively, decentralised decision making increases: followers commitment to a decision; the quality of decisions and the decision making skill of subordinates (Yukl 2004; Porter O’Grady 1996).

It is therefore not surprising that the terminology of ‘Decentralised Decision Making’ has gained common usage in the NHS and throughout public services in recent years. It is identified as one of the four pillars of "New Labour's Third Way" approach to governing the country (Temple 2000) and is at the forefront of legislation and policy development. Whilst it is generally perceived to be a positive policy trend, some authors in the healthcare sector caution against the process and speed of facilitating decentralised decision making in the drive to modernise healthcare (Acorn et al 1997). There is a risk that with national strategy emphasising empowerment and decentralisation processes that they become 'tick box' activities with insufficient tools, processes and education to enable staff to make good quality decisions. The result, predicts Senge (1994, p.40) will be organisations that decentralise authority for a while, find that many poor and uncoordinated decisions result and then abandon decentralised decision making and re-centralise. Whilst this may be a pessimistic prediction, my experience of MMs attending the national leadership programmes were that they often expressed concerns and offered anecdotal evidence to suggest that they did not feel sufficiently prepared and informed to make or lead the decision making processes on a number of leadership and management related issues. The risk, therefore, is that decentralised decision making,

instead of being an empowering process as the NHS intends, becomes an approach where staff feel 'dumped on' and burdened. In such instances, this may be due to a lack of confidence or competence in decision making on the part of the MM or the manner and environment in which NHS organisations ask or expect staff to make leadership and management related decisions.

When discussing decentralised decision making, it is important to differentiate between clinical and leadership decision making. A key feature of MM recruitment is their clinical expertise, years of experience and as a result clinical credibility. It would therefore be reasonable to anticipate that in relation to clinical related decentralised decision making, the MMs feel both competent and confident. What has not been examined in the literature is their approach to, competence or confidence in relation to leadership and management decentralised decision making. Given that both the role of MM and the process of decentralisation is viewed by the government as being central to the implementation of NHS reforms and future healthcare delivery it would be useful to understand the MMs' perceptions of their abilities in regards to their knowledge and skill in this area.

1.3 Decision making within the healthcare sector

Gough (2002,p.ii) suggests that the NHS is characterised by "wicked problems and complicated decision-making processes which make absolute or perfect solutions intangible." This highlights effective problem solving and decision-making skills as key requirements of nurses working in the modern healthcare arena (Fraser and Greenhalgh 2001,p.801; Pearman 2000). However, there is little in the literature to suggest that nursing has a robust understanding of how these skills are learnt and used in regards to leadership and management decision making (Dowding and Thompson 2003). The nursing literature on decision-making within healthcare tends to focus on clinical related decision-making (Cullum 2002) and is generally associated with the establishment of clinical pathways and care protocols. Alongside this, the recent national focus on

leadership development in nursing (D.O.H. 2001, 1999) has included important concepts such as empowerment and healthy working relationships, recognised features of effective leadership and effective organisations (Senge 2006; Acorn et al 1997). However, the national leadership programmes, delivered through the Leadership Centre as part of the Modernisation Agency have in part been about educating nurses about the factors that support or inhibit these behaviours. Little if any attention has been given to nurses' decision making in regards to leadership and management issues and, in particular, the processes or strategies that they might use when making those decisions (Dowding and Thompson 2003,p.55, Pauker and Pauker 1999,p.195). The impact of this is that there are staff in important and influential roles in the delivery and future development of healthcare and there is limited research on how they make decisions and therefore what strategies work well or what areas of development might need addressing.

However, the need to understand how these types of decisions are made has substantially increased (Cameron and Masterton 2000). In recent years, there have been ever increasing calls for flexible working practices and new ways of working (Department of Health 2001a; 2000a; 1999; Plsek and Greenhalgh 2001,p.626). As previously highlighted, this is alongside a language of empowerment and decentralised decision-making and an increased focus on leadership (Department of Health 1999; Manthey & Miller1994). These political, structural and organisational policy and cultural issues inevitably impact upon and influence nurses in their decision-making at both a macro and micro level.

1.4 Researcher Motivation

As a healthcare professional with over 20 years experience, my interest in this proposed study stemmed from two principal areas. My full time role involved working throughout the country delivering staff development programmes across a diverse range of NHS Trusts as part of a national programme of leadership development. The programmes

focus on developing the leadership skills of nurse leaders, generally those that were already in post (Cook and Leathard 2004) and establishing a culture of empowerment in the workplace. The background to these programmes over recent years has been the emphasis at a political level on developing leadership skills alongside a call for NHS staff to be more flexible in how they delivered healthcare services. A combination of these two political drivers and my experiences of working with healthcare staff on leadership development courses and hearing their accounts of the situations they found most difficult and least competent to deal with led to my interest in one particular aspect of leadership, 'decision making,' and in particular, de-centralised decision making. Whilst the literature confirms that decision making is a critical part of effective leadership, the national leadership programmes did not appear to overtly address this issue. This is important as the concept of empowerment is in part predicated on the assumption that staff will be flexible and take on more or enhanced roles and therefore greater levels of decision making responsibility. A review of the literature highlighted confirmed my experience as a facilitator that these issues were particularly pertinent for the relatively new role of the Modern Matron.

1.5 The focus and aims of this study

MMs are at the vanguard of both care delivery and the NHS reforms. They have been described as the leaders who have the power to redesign NHS care at the front line to make it patient-centred. The NHS Trusts have been told that the role should have sufficient authority and support to get things done and make change happen" (DOH 2003,p.3), but it has been left to individual organisations as to how that should be done. With this increased authority and decision-making power in conjunction with the wider principle of decentralised decision making it is important that there is a clearer understanding of the processes and strategies MMs engage in when making these decisions and to understand the need for any training and development.

The scenarios highlighted in 'Modern Matron – Improving The Patient Experience' (Department of Health 2003) required the MM to have clinical knowledge and expertise. However, the key to the success of the initiatives were not just about the clinical decisions that they made, but also the leadership and management decisions that they took and how they were able to engage staff and the organisation with those decisions. To be effective, MMs need to be skilled decision makers, able to accept and respond to the challenges of decentralised decision making that accompany the role. However, there does not appear to be any studies focusing on this aspect of their role and as a consequence there is little real evidence to demonstrate their knowledge, ability or understanding of this essential skill.

This study intends to increase our understanding of how MMs make leadership and management related decisions, the boundaries of those decisions, the strategies they use and the factors that help or hinder them in that process. The study provides an important insight into a key attribute and expectation of the role of the MM. This then enables us to:

- Understand how they currently undertake the leadership and management decision making process
- Identify the factors that support and hinder them in their decision making
- Explore what other recognised strategies and approaches there are that might be useful
- Look at how we can use the knowledge generated to support and develop the skills of Modern Matrons in relation to leadership and management decision making.

Summary

This chapter has set the context for the study, providing a preliminary overview to the literature and 'real world' practice that has informed the research question. It gives a brief introduction into the key constituents of MMs and decision making and identified

how it will contribute to professional knowledge and practice. The thesis contains a further six chapters that describe in detail the conduct, findings and relevance of the study, culminating in a framework for MM leadership and management decision making.

Situating this research within a phenomenological paradigm has informed the writing structure that has been adopted for this study. Principally, that my reflections, as the researcher, will be recorded in italics at different points in the thesis as relevant issues arise. This is to make explicit my awareness of them and their potential influence on the data collection, analysis and discussion phases of the study. I have chosen to integrate these reflections in the main body of the thesis to facilitate clarity of understanding and a transparent approach to the conduct of the study.

In determining the research question I needed to be mindful not to assume that because I had a knowledge gap around leadership and management decision making, then so did the Modern Matrons. To mitigate this I identified within my doctoral journal a number of occasions when during direct contact with MMs on leadership programmes, they had brought up scenarios where they identified having difficulties in either deciding on what course of action to take or where on reflection they felt that they could have made either a better decision or been more confident about their decision making. In addition, once I was thinking about exploring this topic area, I began to ask MMs to explain how and why they had taken decisions in scenarios that they described during the leadership development programmes. In relation to leadership and management issues they found this quite difficult and would talk in 'general' terms and not in relation to any clear frameworks.

I was also mindful that my interest to understand more about decision making did not result in me making assumptions that the MMs also wanted to know more about it. It could be argued, however, that by volunteering for the study the MMs were demonstrating an interest in the concept of decision making which may in turn have influenced how they responded to the questions that were asked.

Chapter Two - Literature Review

2. Introduction

This chapter provides an overview of key literature relating to the role of the MM and decision making. Its purpose is to: highlight the relevance of what the literature says in relation to the focus of this study; Identify whether anyone has already examined the leadership and management decision making strategies of MMs; demonstrate how this study will fit in with and build upon existing research and so contribute something new to the profession's understanding of this concept.

During the course of the study, three separate literature reviews were undertaken:

- Jan/Feb 2005– to establish at the beginning of the study what was already known about the proposed topic and to establish whether the proposed study would contribute anything new and relevant to the understanding and delivery of healthcare.
- Summer 2008 – to identify any new literature and where relevant include in order to strengthen the study and contribute to the understanding and discussion of the findings
- Summer 2010 – to review any new literature that might be relevant to the study and ensure it is current in regards to new understandings

Two electronic databases were used Medline and ABI/INFORM GLOBAL. These were chosen because Medline is a major healthcare database and ABI/INFORM GLOBAL a major database used by the Business Schools, which is where decision making research is generally located. I also searched the library catalogues for both the University of Leeds and Northumbria University. A more detailed description of the search strategy and search terms used is described in the Appendix.

The review covers four broad areas with sub sections in each area. These sub sections arose as a result reading the initial literature and making notes on additional concepts

and relationships that were important and would contribute to an understanding (Silverman 2010) of MM decision making

Decision making is a complex subject and this is reflected in the literature review where the first area addresses the role of the MM and the three remaining areas focus on different aspects of decision making; existing decision making research in healthcare; decision making and leadership and decision making frameworks and processes from the wider decision making literature.

The table below provides an overview of the areas that will be reviewed and their relationship to each other. In particular, de-centralised decision making led to a literature review of three further areas, power empowerment and authority

Table 1: Areas contained in the literature review

Primary Topic Area	Sub Section 1	Sub Section 2
Modern Matrons		
Decision Making in Health Care	Clinical Decision Making Cognitive Continuum Theory	
Decision Making and Leadership	Transactional and Transformational De-centralised Decision Making	Power, Empowerment, Authority and Credibility
General Decision Making	Heuristics Rational & Intuitive	

2.1 Existing Research on the role of the Modern Matron

The role of the MM was, in part, a response to the concern that “nurses had insufficient authority to remedy shortcomings across services which were fundamental to patient care” (Read et al 2004). The role was proposed in the NHS Plan (Secretary of State 2000), along with a number of other initiatives, including: the introduction of ward house keepers, the establishment of Patient Forums and the Patient Advocacy and Liaison Service and the NHS Clean Hospitals programme. This plethora of initiatives have led to the suggestion that it was a somewhat piecemeal approach driven by a political agenda rather than part of a coherent strategy (Agnew 2005).

They were all part of the desire to ‘modernise the NHS’ and within that, the role of the MM “positioned nursing at the very heart of the modernisation process” (Department of Health 2003,p.2). This government focus has been sustained and in September 2007, the Prime Minister announced an on-going commitment to the role of the Modern Matron and an intention to increase the numbers to five thousand by May 2008. By July 2008, this target had been exceeded and 5,500 MMs were working in the NHS (Lipley 2008). The announcement of the role of MM generated significant debate within nursing. Some of it positive (Hewison 2001), that the focus on strengthening the role of nursing at the level of clinical care through increased authority would result in more appropriate decisions being made in a timely manner. Other reactions were more critical and sceptical, questioning the timing of its announcement and the political motivation for the use of the term ‘matron’ (Castledene 2007).

The Department of Health (2000) talked of the MM role being one that would hold increased authority and leadership in regards to decision making at a clinical level and it was anticipated that the role would be implemented across a defined clinical area such as surgery or accident and emergency. However, research suggests that the MM role is often much broader than direct leadership and management at a clinical level across a defined clinical area. As studies by both Read et al (2004) and Kemp and Morris (2003) have found, in many organisations the role of the MM encompasses a broader range of

duties and expectations across the spectrum of operational and strategic responsibilities. The consequence of this blurring of clinical and corporate responsibilities is reflected in a study by Smith (2008a) where “several matrons commented that there was no clear difference between their roles and that of senior nurses with operational management responsibilities. Smith’s conclusion was that from her research and that of Hill (2005) and Read et al (2004) “the difference between the MM roles and those of other senior managers, such as nurse directors is difficult to discern.” This justifies some of the concerns that were initially raised when the role was announced that it was not sufficiently distinct and may therefore impinge on existing nursing roles such as Senior Sister/Charge Nurse, Clinical Nurse Specialist or if they took on more corporate responsibilities, the role of general managers (Smith 2008a, Hewison 2004, Mulally 2001). This echoes a concern raised by Oughtibridge (2003) that the lack of role specificity meant that the MM was likely to find it difficult to balance the range of professional and managerial responsibilities they may be asked to take on. For those who perceive the role as having the potential to make a positive difference, the primary challenge appears to be striking this balance between the clinical and managerial demands of the role (Castledene 2007). In addition, as the MMs tread a path between the emphasis on clinical leadership balanced with corporate responsibility, Currie, Kotevko, Nerlich (2009) and Cooper (2003) caution that they risk losing their positions as technical experts and become generalists.

There is a tension in resurrecting an old role and title, that has previously been discarded and then re-introducing it as part of a policy drive to modernise the NHS (Castledene 2007). The culture and structure of the NHS has changed from when the role of Matron was first introduced. The Modern NHS espouses a culture of empowerment (Oughtibridge 2003) and the role of MM operates within a flatter hierarchy than was the case with the historical role of the Matron (Currie et al 2009, Crawford & Brown 2008).

Capitalising on the perceived positive associations that accompany the word 'matron', the Department of Health has emphasised the relationship between the role of the MM and the level of authority that they will have to make changes at ward level. However, Currie et al (2009) and Snell (2001) question whether that perception of the original Matrons having high levels of authority for their clinical area was really accurate or just a romanticised image that has been created. Alternatively, if the perception is accurate and traditional Matrons really did wield a lot of power, is that the type of power that would be welcomed in a modern NHS?

The historical stereo-type image of a dominant and authoritarian figure is in stark contrast to the language of transformational leadership, empowerment and de-centralised decision making that is the current paradigm of the NHS. The association between the title Matron and the portrayal of Matrons in the series of 'Carry On' films is at best unfortunate and at worse, undermining of nursing's efforts to establish itself as a profession both within healthcare and in the eyes of the public (Crawford & Brown 2008, Snell 2001). These concerns that the role of MM is potentially damaging to the standing of nursing as a profession is taken further by Dealey et al (2007) and Watson and Thompson (2004) who suggest that both the role and nursing has been undermined by the lack of identified formal qualifications required to be a MM. The concern being that the title is just a euphemism for getting nurses to take on more decision making responsibilities that they might not want, have the necessary competencies for or be appropriately remunerated for. These issues are compounded by an additional concern that some organisations, instead of introducing a new position of MM would simply re-badge/name existing job titles or amend existing job descriptions to fulfil the requirements laid out for the position of the MM (Malone 2002, Oughtibridge 2003, Watson & Thompson 2003). There is evidence that whilst a significant number of new posts were created, there was also a degree of altering of existing posts and calling them MMs (Mooney 2008).

The title 'MM' is an area of contention and perceived by many as 'matriarchal, culturally insensitive' (Castledene 2007) and generally inappropriate. Whilst many NHS Trusts have implemented the role using the title MM, the concern has some validity as a number of authors, when writing about the role of the MM within individual organisations raise the issue of titles and whether to use the term MM or not as an area of contention (Read et al 2004, Oughtibridge 2003, Carlowe 2002).

Whilst the focus of this study is the leadership and management decision making strategies of MMs, it is likely that either directly or indirectly, the political contextual factors that have been identified will have an influence on MM decision making'

During the two years immediately following the initial announcement of the new role of MM, further circulars were published by the Health Service. They include:

- Implementing the NHS Plan – Modern Matrons (Health Service Circular 2001/010)
- The Chief Nursing Officer's 10 Key Roles for Nurses (Dept. of Health 2002a)
- Ward Staffing Budgets (PL/CNO/2002/2, DH 2002b)
- Modern Matrons – Improving the Patient Experience (Dept of Health 2003)

These publications have a number of consistent themes that are relevant to this study.

These include:

1. Decentralised decision making - giving nurses more authority to influence decision making at a local clinical level
2. Empowering nurses to take on this increased authority and decision making power
3. Leadership, in particular different models of leadership, such as transformational and situational leadership theories.

The focus of the MM literature to date has been on three main areas; the impact of the role against the ten key responsibilities identified by the Department of Health (2002), the increased decentralised decision making authority to deliver on the responsibilities and the practicalities and implications of implementing the role within a specified organisation (Smith 2008a; Smith 2008b). The largest study of the role of the MM to date was published in 2004. It was commissioned by the Department of Health and undertaken by Read et al (2004) from the Royal College of Nursing and The University of Sheffield. Its primary purpose was ‘the evaluation of the modern matron role in a sample of ten NHS Trusts.’ The broader aims and objectives of that study which are relevant to this proposed study include:

- Using the experiences of the MMs to understand the content of the role and the challenges involved in undertaking it (*relevant to study design*)
- Identifying beneficial, educational input and clinical experience in preparing MMs for the role. (*understanding any training needs will be one outcome of this study*)
- Identifying the range of implementation models (*may influence nature of leadership and management decision making*)
- Scoping decision making within the major day-to-day responsibilities (*understanding types of decision making scenarios*)
- Obtaining examples of how organisational factors enable or preclude Modern Matrons from achieving their objectives (*relevant to identifying factors that may help or hinder MM decision making*)

The findings of the Read et al (2004) study identified nine themes that were relevant to the role of the MM. Each theme has a potential relevance to this study. The themes were:

1. *Modes of Implementation:* How the new MM posts were established including whether;

- they were new roles or re-badging of existing roles
- additional funding was allocated by the Trusts
- they wore a uniform or not and if so, what colour it was
- how they were graded and their span of responsibility
- they were line managers and who they themselves should report to

These points are important contextual information that could have an impact on MM decision making and are therefore relevant for this study

2. *Selection and recruitment:* Only 7.4% of MM appointments were external to the organisation. This is considered to be a reflection of it being the first wave of appointments to a new role. Under the identified essential and desirable attributes for recruiting to the role of MM, significant management experience and highly-developed leadership skills were listed but decision making was not identified as a specific area of skill or knowledge.
3. *Preparation for the role:* 85% of the MM surveyed had previously been employed as either G, H or I grades prior to taking up the role of MM and therefore experience, particularly in the area of leadership and management was cited as an important precursor for taking on the role. There were a number of areas identified where MM said they would like further training and development, many of these were quite topic specific, such as contract agreement and service level agreement development. Decision making was not identified as a specific topic area, but it could be argued that it would be seen as an integral part of areas such as leadership, change and performance management and carrying out investigations that were all listed as areas for development.
4. *Remit of the role:* The MMs in essence describe three models for the role. Roles that were either essentially clinical or managerial in nature or a mixed model incorporating both clinical and managerial duties. The range of the MMs varied

considerably ranging from a defined clinical in-patient area to service wide remit across in-patient, out-patient and community. Some MM had a clinical focus only while others incorporated other managerial duties or were formally combined clinical and managerial roles. The study reports that “they often find it difficult to manage all areas of their remit. Their responsibilities are at best wide-ranging, and at worst a recipe for role-overload” (p.112). This breadth of expectation places pressure on the decision making of the MM and the risk of overload illustrates the concerns identified with decentralised decision making. In addition, the requirements of decision making in regards to leadership and management issues may be quite different to those associated with clinical issues.

5. *Understanding of the role:* Due to the variation in how the role of MM has been implemented, there is a lack of standardisation in regards to role descriptions and significant variation between what they thought they should be doing and what they were actually spending their time on. Concerns were identified that MM were “being forced to give priority to organizational concerns ... which diluted their clinical role” (p.115) and also impact upon the types of decisions that the MM are having to make.
6. *Working relationships:* The study clearly identifies that “good, supportive working relationships are essential for matrons Many cited these as one of the factors that enabled them in their role” (p.119). In order to manage the demands of their roles, particularly when there is more than one site to cover, MM appear to have become more active networkers in order to influence decisions. Conversely, where the clinical demands of the role are high, MM were reported as not being as involved in decision-making processes or meetings at directorate level.
7. *Experience of the role:* For many, the role of the MM was much greater than the 10 responsibilities that were initially identified. In addition MM were perceived

to be working differently according to the clinical:managerial balance of their roles. Clinically focused MM were seen as leading by 'practical' example, with a suggestion that they should sometimes work more strategically. In contrast, those MM who had a more managerial focus were seen as demonstrating how to ensure the nursing voice was heard and influenced decision making at directorate at board level.

8. *Power and authority:* The MMs were disappointed with their level of authority reporting a need to still have to negotiate at length with middle and senior managers. However, the study suggests that in general, the "matrons tended to under estimate their own authority, in comparison with the perception of others" (p.137). This difference in perception is highlighted by one MM who described having the autonomy to make a decision but not sufficient authority to make a real change. The MMs were aware of the difference between personal and position power and generally ranked personal power as the more important. This was particularly relevant when distributing authority across the team, empowering staff and demonstrating transformational leadership behaviours.
9. *Impact of the role:* This finding is more circumspect due to the time constraints of the study and as first wave MMs, the relatively short time they had been in post. However one area that had been noted was that MM were particularly effective at making an impact when they acted as a group within a particular organisation. Because of their good overview of services and seniority, MMs were seen as 'oiling the wheels' and creating an environment where clinical staff now had increased autonomy and were able to make decisions quickly.

The Read et al (2004) study is the largest study of MM conducted so far and was an evaluation of the whole of the Modern Matron role, with a particular focus on the ten key responsibilities that were initially allocated to the role. The nine themes that have been summarised all have implications for the nature and complexity of MM decision making but do not specifically discuss the concept. This study will address this gap in our

knowledge and understanding of the role of the MM. In a follow on paper, Scott, et al (2005,p.26) make some additional recommendations from the above themes that are pertinent and address the need for this study These include:

- Selection of matrons should take account of their interpersonal communication skills and their potential as transformational leaders
- Matrons must be offered adequate preparation either before or soon after appointment

These issues are relevant because how the MMs communicate and interact with others will both influence and be a reflection of their approach to decision making. Whilst identifying the development needs around decision making could form part of the 'adequate preparation' for the role.

In addition, Scott et al (2005) highlight that their research found that management and leadership was identified by the study respondents as both a core responsibility of the role and also one aspect of the role that many of them would like help with. Decision making is a core leadership and management activity and therefore the greater understanding of their knowledge and skill in this area that will arise from this study should help to inform any programmes of development.

This study intends to identify factors that support and inhibit the MMs in their decision making. These factors have also been explored by some authors in relation to the overall role. Dealey et al (2007,p.25) identified that the "greatest support seemed to come from the divisional heads of Nursing (and from other senior nurses)" followed closely by good working relationships with clinical service leads and group managers. The factor they identified as hindering the positive impact of the role of MM was summarised as "operational pressures" in particular bed management duties, attendance at meetings, time management and lack of secretarial support. Both the supporting and hindering factors cited can be grouped under the heading of organisational influence on the role, either through local culture or systems and processes. Smith (2008a) also identified organisational support as a critical factor for her

study which in conjunction with “the title of matron gave them [nurses] access to corporate groups and to directors of nursing.” This in turn increased their level of power and authority and the opportunity to influence the decision making agenda.

This in depth review of the MM literature confirms that the focus of the proposed study, the leadership and management decision making strategies of MMs has not so far been studied. The review also suggests that such a study would be a useful development of some themes emerging from existing studies. In particular a need for more structured development to help prepare people for the leadership and management components of the role of MM, either before they are appointed or soon after.

2.2 Decision Making and Nursing

Numerous authors (Marquis & Huston 2009; Adair 2007;, Marriner-Tomey 2006; Klein 2004) identify decision making as a core leadership behaviour and, as has been discussed, the literature on MM identifies strong leadership as an essential component of taking on the role. However, although being an appropriate and effective decision maker is an important component of the role of the MM, there is no research to date on the decision making behavior of the MM. This section will examine the literature in relation to the field of health care; the field of leadership and management and then in the specialism of decision making itself to establish a depth of understanding and to identify relevant issues for this study.

2.2.1 Decision Making Research in Healthcare

Relatively little has been written in the field of nursing about the strategies nurses use when making decisions in regards to leadership and managerial issues related to their role. The primary focus has been on clinical decision making by professionals “of which

there is a substantial body of knowledge” (Harbison 2001,p.126). This difference in the volume of research may be because leadership and management decision making is often more subjective in nature and therefore maybe more difficult to study.

2.2.2 Clinical decision making

Clinical decision making is one of the key attributes of today’s clinical nurses (Gurbutt 2006; Robinson 2002) and an individual’s ability in this area is one feature of their overall ability as a nurse. It has been described as a “dynamic activity where an individual formulates one or more hypothesis and then continually reviews the relevance of those hypothesis as more information becomes available and they are able to prioritise their actions” (Robinson 2002,p.1). Benner (1984) developed Dreyfus’s (1980) Model of Skill Acquisition, in which a person’s ability to identify key pieces of information and recognise patterns in order to make good decisions forms the basis of her widely acknowledged framework within clinical nursing of Novice to Expert.

A recurring theme in the literature on clinical decision making is the role of ‘experience’ (Lauri & Salantira 1995) and the relationship between “experiential knowledge – knowledge derived from experience rather than factual knowledge and the decisions that [nurses] make” (Luker and Kenrick 1992). Whether linking knowledge to experience is a transferable principle between clinical decision making and leadership and management decision making has not been researched. Therefore this study will be able to offer some insight into this important issue.

2.2.3 Clinical Decision Tools

The development of clinical decision tools has occurred because despite decision making being “fundamental to all aspects of care – prevention, detection, treatment, survivorship and end of life – researchers and clinicians have limited knowledge of the

ways in which patients and their health care providers make critical health decisions” Nelson and Stefanek (2005). Therefore tools or instruments that can “provide order and direction” (Marquis & Huston 2009:20) and help make the decision making process more visible are seen as valuable. The use of these tools helps to minimise some of the uncertainty that is inherent within most decisions (Marriner-Tomey 2000). The tools come in the form of paper based care pathways through to sophisticated computerised decision making software with an array of tools and techniques. Examples include: Decision Grids, Decision Trees, Probability Theory, Simulations, Models and Games. However, the final decision on what to do rests with an individual person and therefore tools are still vulnerable to individual mistakes and human error (Marquis & Huston 2009). Therefore developing an individual’s knowledge and skill in the area of decision making is important and like any other skill, can be “broken down into its component parts (analysed) and learned” (Scott et al 2010,p.230).

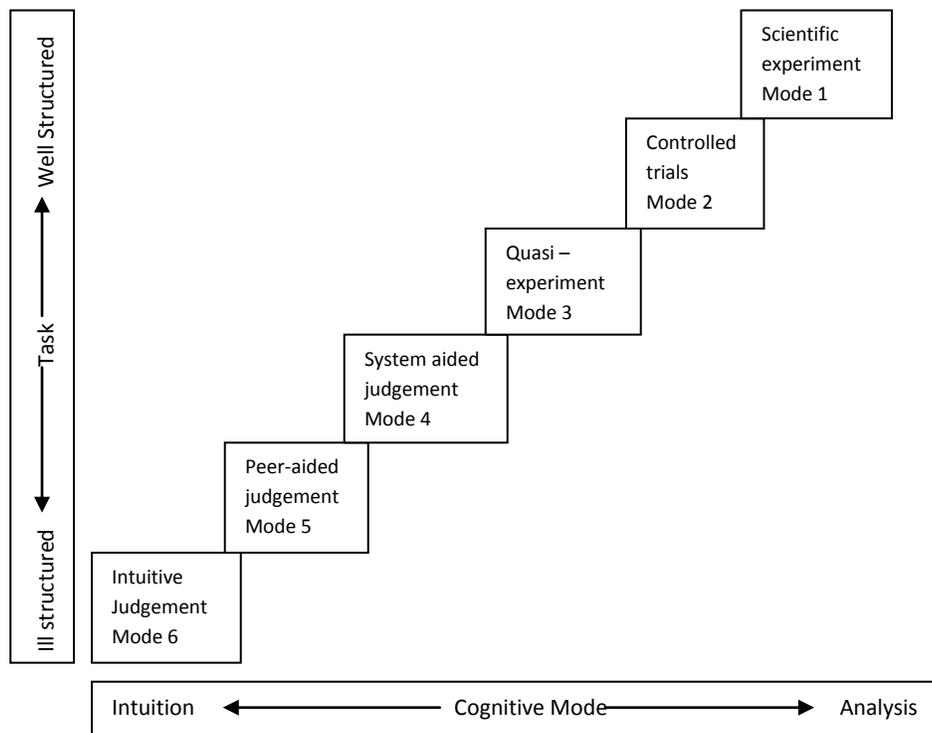
2.2.4. Cognitive Continuum Theory and Decision Making

Hammond’s (1981) Cognitive Continuum Theory is one approach that has been discussed at length in the nursing literature (Standing 2008; Cader et al 2005; Harbison 2001; Thompson 1999) as a theory that offers a useful means of describing and understanding a nurse’s approach to clinical decision making. It integrates theory with suggested actions enabling the user to critically appraise the decision making situation they are facing. Whilst the literature does not discuss it in relation to leadership and management decisions, it is worth highlighting the key features of the theory in order to explore in the Discussion chapter whether it has anything to offer in this area.

Cognitive Continuum Theory addresses the opposite features of rational (analysis) and intuitive decision making and intersects them with a continuum that describes tasks as ranging from well structured through to ill structured, whilst also taking into account the volume and relevance of the information available in relation to the decision making situation. Hammond’s (1981) work resulted in six identified ‘modes of inquiry’, a

concept that Hammond borrowed from the work of Churchman (1971). The theory being that if the level of structure was changed or the volume and quality of available information shifted, then that might influence the 'mode of inquiry' that could be applied to the decision making situation. Ham (1988) has applied Hammond's six modes of inquiry to the issue of clinical decision making in medicine, replacing the term 'mode of inquiry' with the term 'mode of practice.' These adaptations are supported by Thompson (1999) as being equally relevant to nursing practice.

Figure 1: Six Modes of Practice (After Ham 1988)



The proposition is that a more structured task results in a more analytical approach to decision making. In contrast, poorly structured tasks tend to result in decision making that is more intuition-based (Cader et al 2005). The quality and availability of information may then be a factor in moving a situation requiring a decision up or down the six 'modes of inquiry' in order to adopt the most appropriate approach. One

outcome of this study could be an appreciation of whether this model is also relevant to leadership and management decision making.

2.3 Decision Making and Leadership:

Decision making is a key feature of effective leadership, yet, the two areas have tended to be researched separately (Heller 1992). However, more recently, the separation between the two concepts has begun to be addressed with a number of authors (Marquis & Huston 2009; Marriner-Tomey 2006; Klein 2004) stating that decision making is a core leadership and management activity and including it within their writings. Adair (2007,p.viii) also identifies decision making as an essential characteristic of effective leadership, saying that “any leader who aspires to excellence obviously has a vested interest in seeing that the best decisions are taken and that problems are solved in the optimum.” MMs are identified as key leaders in the New NHS and therefore a study bringing together their leadership responsibilities and their approach to decision making is both appropriate and timely.

Despite this recognition of the pivotal relationship between leadership and decision making, Prescott’s (1980,p.viii) observation that “you have almost certainly not been trained to make effective decisions” is still relevant today. Leadership in nursing is a key professional and government target (DoH 1999) and there have been a number of initiatives to address the leadership skills of nurses. In 1999 the Department of Health published ‘Making a Difference : strengthening the nursing, midwifery and health visiting contribution to health and healthcare.’ This was a new strategy document aimed at strengthening nursing leadership at a clinical level and was followed up by the commissioning of two national leadership programmes in 1999. Leading an Empowered Organisation (LEO), run by the Centre for The Development of Nursing Policy & Practice, University of Leeds and the Royal College of Nursing’s RCN Ward Leadership Programme. These initiatives were followed in 2001 by the establishment of The NHS

Leadership Centre which, as part of the NHS Modernisation Agency, took on the role of supporting and promoting leadership.

However, none of these initiatives explicitly talked about how to be a more effective decision maker, used models of decision making or explicitly made the connection between effective leadership and effective decision making. Their emphasis and underpinning philosophy was around the principles of transformational leadership and empowerment. Clearly this subject area is relevant, as an individual's approach to decision making is likely to be informed by their personal leadership philosophy. This, in turn, is likely to be informed or influenced by any formal continuing professional development programmes on leadership that they have attended. These influences are further re-enforced by policy documents and strategic initiatives, all emphasizing the message that empowerment is good. However, whilst the need for enhanced decision making ability is inherent within the concept of empowerment, it has not been explicitly addressed as a core skill requiring professional development input. This study will highlight whether this is an omission and there is a knowledge and skill deficit to be addressed.

2.4 Leadership Theory and Decision Making

Leadership is a well researched area with a number of different theories and propositions that have emerged over the years that underpin current thinking and trends. The political and professional backdrop to the policy documents and interventions surrounding the introduction of the role of the MM are grounded in the principals of transformational leadership. Inherent within transformational leadership are the concepts of empowerment and decentralised decision making. In order to appreciate the relevance of this relationship it is necessary to look at the corresponding theory of 'transactional leadership' to see how the concepts of empowerment and decentralised decision making are demonstrated through an individual's leadership behaviours.

2.4.1 Leadership Behaviour

A leader's behaviour is the external manifestation of their attitudes and beliefs and it is how people experience that individual and subsequently respond to them (MRG 1982). A number of validated 360° leadership assessment tools, such as Leadership Effectiveness Analysis™ (Management Research Group (2003) and The 5 Practices of Exemplary Leadership (Kouzes and Posner 2007) are based on receiving feedback on a range of identified leadership behaviours. The premise is two fold:

1. If you can identify the behaviours that are demonstrated by effective leaders, then anyone could choose to work on those behaviours and improve their leadership skills.
2. If through feedback, an individual understands more about how others experience them through their behaviours, and the impact of those behaviours, then they would choose to modify some behaviours in order to be experienced differently.

How a person makes decisions would be one of those behaviours that they could choose to modify. The manner in which a leader makes decisions influences how well received those decisions are and the willingness of people to implement them. If they have a predominant style then in part it will be a reflection of their belief about the nature of leadership and how to work with people to get the best from them. The theory of transformational and transactional leadership illustrates this principle very well.

Transformational and Transactional leadership theory is demonstrated and experienced by others through an individual's behaviour. How a leader behaves has a powerful influence on how others respond to them. This raises the issue of the relationship between the leader and how they use power and influence, concepts that are also relevant to the practice of decision making. There is an inclination to use the two terms, power and influence, synonymously, however, there are some subtle differences. In leadership terms, *power* is classically considered to be the ability to exert some degree

of control over other persons, things and events, typically through the position in the hierarchy that the leader holds (Hoel et al 2010, Bass 2006, Steers et al 1996). In contrast, *influence* is related more to the notion of *personal power* and is suggestive of the leader using more persuasive strategies. The type of *power* the leader chooses, the way they use it and the impact it has on their approach to decision making is a central tenant of the theory of transactional and transformational.

2.4.2 Transactional Leadership

Transactional leadership was particularly popular following World War II when “organisations were run on the basis of goals and objectives, and contingent rewards for those who were faithful and successful performers (Sims, Lorenzi 1992,p.296). It built upon the theory of power and influence by placing the emphasis on the two-way relationship that exists between the leader and the follower. The core of transactional leadership is the power a leader has to get things done because they can offer certain things such as resources or rewards, in return for another’s commitment and good performance (Bass 2008; Crainer 1996). Alternatively they can use the threat of punishment or loss of a resource as a means of achieving a goal. In effect, there is a transaction, either explicit or implicit between the leader and the follower – if you do this for me, then I will do that for you (Northouse 2009; Bass 2008). Transactional leadership and decision making is more task orientated in its approach to getting the job done. As a result, it has begun to fade into the background during more recent years as the emphasis on leadership has become more focussed on empowerment and working with people, enabling them to make their own decisions and creating a culture where they *want* to implement the leader’s decisions. In this context, a transactional approach to (or style of) decision making is predicated on whether the decision they make and the manner in which they make it, will be sufficiently rewarding or coercive for other people to comply and implement the decision. A limitation of this theory is that it assumes that people are primarily motivated by [extrinsic] rewards the antithesis of the message of empowerment.

2.4.3 Transformational Leadership

In contrast, transformational leadership draws more on the notion of the *personal power* of the leader engaging with the intrinsic motivation of the follower. The goal is to engage people with a process that grows and transforms them as individuals (Stanley 2006). The emphasis is on commitment and inspiring individuals to want to do something rather than compliance and doing things because they have to. As previously stated, transformational leadership has become the corner stone of the NHS modernisation agenda and the dominant theoretical approach underpinning the national leadership programmes. It is therefore also likely to be influencing the approach Modern Matrons might adopt when taking leadership and management related decisions. The literature (Bass 2008) reflects a feeling of greater equality and sharing of power in transformational leadership which then affords the follower a greater freedom of choice in the decisions that they take. The issue of 'power' and the different types of power that can exist will be discussed in more detail in section 2.4

2.5 Decentralised Decision Making

Decentralised decision making has become a concept that extends across a diverse subject area from battleground technology (Dekker 2003), through to business (Malone 2004) and political (Temple 2000) paradigms. The literature spans decentralised decision making in regards to individual teams and organisations to national and global organisations such as the United Nations (Work 2001). The debates generally centre around the economic and/or social costs and benefits of centralised or de-centralised decision making. Little attention is given to the impact of decentralised decision making on the individual at a psychological level (Handy 1993). This point becomes relevant at a later stage in the literature review, when looking at the relationship between decentralised decision making and empowerment

Decentralisation has been a central theme of NHS reforms during the last two decades (Goddard and Mannion 2006). The concept has gained further prominence, especially within nursing, with publications such as the NHS Plan (Dept of Health 2000) and

Shifting the Balance of Power (Dept of health 2001). It is identified as one of the four pillars of "New Labour's Third Way" approach to governing the country (Temple 2000) and is therefore at the forefront of all relevant legislation and policy development within healthcare.

Decentralised decision making is a combination of two concepts; decentralised and decision-making, both of which can be used independently of each other. In order to clarify their combined meaning, it is important to look at the words as single entities. The table below first looks at each word separately and then identifies key points arising from that process. The Oxford Dictionary and Thesaurus (2001) identifies the following key attributes

Table 2: Defining Decentralised Decision Making

	Decentralise	Decision	Making
Dictionary Definition	Transfer (authority) from central to local government.	Conclusion or resolution reached after consideration. The action or process of deciding. The quality of being decisive	Form by putting parts together or combining them. Cause to be or come about. Force to do something
Thesaurus		Resolution, conclusion, settlement, resolve, determination, choice, option, selection	Come to, settle on, determine on, conclude. Construct, build, put together
Key Points	Is authority transferred as readily as responsibility and accountability?	Implicit is need for options and freedom to choose. Skills/competency required in order to make effective decisions	Requires knowledge of or access to wider picture in order to form. Some people may feel dumped on/forced to make decisions

These definitions of decentralisation and decision making are consistently reflected in the literature and encapsulated by Brady (2003,p.3) as "the location of decision making rights or responsibilities away from the centre". Decentralisation is in effect about 'letting go.' The challenge is to identify and put in place processes that will support activity that fosters this type of behavior. This issue was recognised and addressed in part by the implementation guidance that accompanied the introduction of the role of the MM which indicated that those MMs who have the appropriate expertise and knowledge of the local context should be given sufficient authority to take those decisions and have them implemented.

Decentralised organisational structures can only function if those leading and delivering clinical services have sufficient authority and feel empowered and supported by central management, to make significant and far reaching changes in the organisation of their own services (Senge 2006). If the process is to work, there are clear antecedents that need to be in place such as the "mutual sharing of resources and opportunities" (Rodwell 1996,p.5). This requires Modern Matrons to be able to influence upwards and outwards, demonstrating an understanding of and contributing to the strategic management and direction of services as a whole. Whilst this clearly takes the clinician's involvement in decentralised decision making beyond the direct delivery of clinical care to influencing and shaping future service delivery, it is also in line with government policy to "involve clinicians in all levels of decision making" (Dept. of Health 2001,p.23). To be successful, it requires someone to be willing to facilitate the decentralised decision making process and another person to be willing to accept it (Rodwell 1996). This requires a high level of partnership working and mutual respect and these are cultures and relationships that develop over time as opposed to overnight. The Department of Health (2001:24) recognises the importance of these factors and that "the cultural shift needed will in many ways be more crucial to the success of the [leadership] project than new management structures."

Implicit within the concept of decentralised decision making is the notion of a transfer of authority from one person or group to another to give someone else the permission to make the decision.. The challenge this poses is that authority is often equated with power and therefore what is required is a transfer or sharing of power in order for decentralisation to occur. Power, therefore becomes an essential part of the literature review.

2.6 Power

Power is a concept that has been discussed at length within both nursing and the wider literature. For the purposes of the study, this section will look briefly at the broader context of power before focusing on power in the context of leadership and organisations and how that relates to decision making. Amongst those who have reflected on and studied the concept of power, there is general agreement that it is a complex and contested concept that is of concern and relevance to everyone, but with no firm agreement on how to define or measure it (Luke 2005, Mackenzie 1979). The tension is perhaps best summed up by Luke's (2005,p.1) observation that "Power is [actually] at its most effective when least observable." This is an interesting suggestion for the analysis of the data from this study – how do you determine the relevance or otherwise of power to leadership and management decision making if, when it is working well, it is difficult to see?

The challenge for this study is that much of the 'classical' literature on power (Foucault 1980, 1995) appears to be about the domination of one group or individual over another, generally to the advantage of the former and the disadvantage of the latter. In contrast, in regards to the role of the MM, Read et al (2004) talks about power in terms of having the 'power to do something.' because they have the authority to act or to require others to act. Focussing on *power to* as opposed to *power over* opens up a wider literature base from which to discuss the concept of power, mainly the leadership and organisational development literature, including the discussions on empowerment.

2.6.1 Leadership and Power and Decision Making

MMs are expected to be leaders and whilst early examples of studies in regards to leadership, power and influence come from corporate settings, Kotter (1985,p.4) contends that the findings and principles are equally applicable to hospitals. This applicability to hospitals continues to hold value as individual NHS Trusts move towards operating in a more financially independent and corporate manner as single business entities within the overall framework of the NHS. With a predominant philosophy of transformational leadership, if a leader wants a decision implemented or a performance level achieved, they need to be able to influence their followers to achieve greater performance and their superiors and peers to make important decisions. This reflects a similar finding by Bal et al (2008,p.5) from The Centre for Creative leadership, who from their research in this area observed that “the concept of power and leadership are interconnected. Whilst an individual may exert power without being a leader, an individual cannot be a leader without having power.”

The following section will look at an extensively cited framework on power and leadership by French & Ravens (Daft 2009; Yukl 2002) which is frequently included in leadership development programmes that addresses the issue of power and how to manage it to best effect in order to be an effective decision maker. It encompasses the notion of position and personal power and provides a useful framework from which to reflect on the use of power in regards to decision making in this study

2.6.2 Types of Power: Position and Personal

French and Ravens (1959) identified five ‘bases’ or sources of social power, which they described as: reward, coercive, legitimate, referent and expert. This model has since been built upon and expanded to include two additional power bases, ‘connection power’ and ‘information power.’

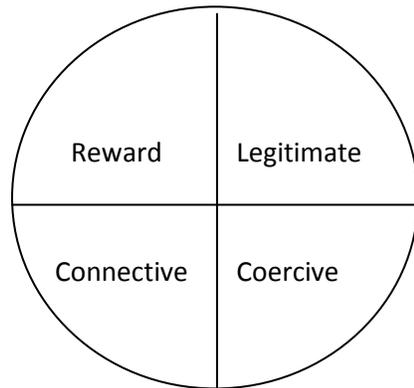
These potential sources of power have then been grouped by Bass (1960) into two broad seats of power – position and personal power. Position power, as the name implies, can be related to those sources of power that are related more to the role of the MM than to the individual incumbent of that role and encompasses legitimate, reward, coercive and connective power. As already identified, it is associated with a transactional leadership style. Generally, to have high position power, an individual needs to have a more senior role in the organisation than those around them. In contrast, Personal Power is less about the role and all about the individual person and includes referent, expertise and information power. As a result a person can be at any level in the organisation and have high personal power.

Position Power

Position power gives the holder access to what Handy (1993) describes as ‘invisible assets.’ This includes ‘information’ and ‘right of access’ to either information or people or sources of information. In regards to decision making, information is critical and therefore the more information a person can gain access to as a result of their position, the more data they can use to help inform the decision they take. *Right of access* refers more to the networks that a person can now access due to the position they hold, that are not available to others, which in turn leads to access to more information. In this study, right of access is relevant as the degree of position power will in part be a reflection of the organisation’s cultures and structures and the level of importance it has attached to the role of the Modern Matron. This in turn will indicate how much position power the organisation has given to the role, which in turn may influence the MMs in their approach to decision making and the strategies that they use.

Position Power is comprised of four components. These are illustrated in the figure below and then described in the underpinning text.

Figure 2: Position Power



Legitimate power

Stogdill (1981,p.186) describes legitimate power as being “based on norms and expectations held by group members regarding behaviours [considered] appropriate in a given role.” It is the power that is naturally associated with the position and title, of, in this case a MM and can be automatically assumed by anyone holding that position within that organisation. As a MM, it is assumed that they have the right to do certain things. In the context of this study that means the right to take certain decisions. This ‘right’ *to decide*, comes through mechanisms such as job descriptions, role requirements and invitations to attend certain meetings.

Legitimate power is important for the MM role as it gives them a level of authority, that in a naturally hierarchical system means that many people will, if they think the MM has a legitimate right to decide on a course of action, feel obligated to comply with (Nesler et al 1993). The limitation of relying too heavily on this type of power for decision making is that it can result in short termism and is synonymous with a culture of transactional leadership – good for decision making in crisis situations, but may not engage staff for the longer term.

Reward power

Reward power, or resource power as it is sometimes called, requires one person to have the control to make decisions over something, usually resources in the form of money or permission to do something that someone else wants. The risk is that it has negative connotations of bribery (Handy 1993), implying that a person can be bought. In MM terms, it is more likely to be associated with decisions to give someone study leave, pay course fees, agree off duty requests or other 'localised' issues.

Coercive power

This can be an overt statement that if you do not do x, then y will happen. Alternatively, as is often the case, it may be more subtle and implied or evident through non verbal behaviour or patterns of action (or non action) that emerge over time. French and Ravens (1959,p.158) acknowledge that it can be a fine line distinguishing between reward and coercive power as they can be seen as two sides of the same coin. "Is the withholding of a reward really equivalent to a punishment or a coercion to do something because if you don't there will be a negative consequence of some kind? Is the withdrawal of punishment equivalent to a reward?" French and Ravens (1959,p.158) go on to explain that the difference is important because the use of "reward power will increase the attraction of [the leader], coercive power will decrease this attraction." In other words, people are more likely to do something for the leader, support and implement a decision, if they perceive that there will be a reward for them, it becomes a more attractive proposition. Reward and coercion are reflective of the earlier discussed transactional approach to leadership and therefore decision making. The use of power in a coercive manner would not be considered appropriate in a modern NHS.

Connective power

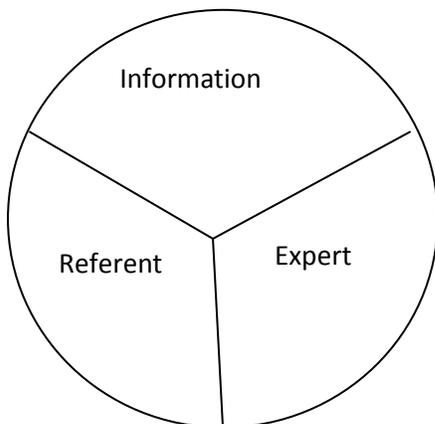
This is an addition to the original model and refers to the increased connections that come with a particular position. The more senior people that you will get to meet, the more privileged information that you will gain access to, the more people who will come

and speak to you because they want to be seen as being connected to the post you hold as they perceive it will be beneficial to them. The latter may be colloquially called ‘name dropping.’ However, all these characteristics offer the MM opportunities that they could use to help them in regards to their leadership and management decision making.

To be of value, “position power has to be ultimately underwritten by [the organisation in the form of] either physical or resource power” (Handy 1993,p.128). In other words, the role has to have some overt, measurable backing of the organisation. In theory, this should be evident with the MMs as the Health Service Circular 2001/010 – Implementing the NHS Plan – Modern Matrons made it clear that the introduction of the role required a clear level of organisational support and authority, to be evidenced through factors such as administrative resource and clear lines of accountability. It would be reasonable to expect some different facets of Position Power to be evident at different points in time within the MM’s approach to decision making.

Whereas position power comes with the territory and the job the person has, personal power is given to an individual by others. It is others’ perception of the individual that results in them having high or low personal power rather than the named position that they have within the organisation. It is generally more subtle than position power and not as easy to observe, but that can mean it is more effective Luke (2005).

Figure 3: Personal Power



The individual can earn personal power, but they cannot demand it. Its influence on decision making is therefore quite different and is generated through very different channels.

Bal et al (2008,p.8) undertook a study to test out the premise that “power extends far beyond the formal authority that comes from a title.” What they found was that “the top three most frequently leveraged sources of power were the power of:

1. information
2. expertise
3. relationships

This correlates with French and Ravens (1959) work on Personal Power, which identifies three power bases: expert, information and referent. The emphasis is slightly different between the power of relationships and referent power, but they are similar in nature.

Information power

From their 2008 study, Bal et al identified that the perception of power comes not just from the possession of information but from the way an individual controls and communicates it. This includes: being a conduit for informing others by being well connected to a diverse range of people; informing others and making information easily available to support decision making and by using the information available to ‘sell an idea’ to persuade and influence others. It is a source of power that the MM can actively increase (or decrease) depending on how they use and share their access to information.

Expert power

This power is about the individual’s own knowledge and expertise and the manner in which they use it. How the MMs’ choose to share their expert knowledge with others will be critical as to whether the expertise is viewed as powerful and beneficial by

colleagues and so strengthening their personal power base, which in turn should give them an additional avenue for engaging people with their decisions. As the ten key responsibilities of MMs include leading by example and empowering nurses to take on a wider range of clinical tasks, then having appropriate expertise and sharing it with others should be central to the decisions MMs take.

Referent power

Referent power is characterised by one person strongly identifying with another and having a desire to be associated with them or what they believe they represent or stand for (French and Ravens 1959). Stodgill (1974) cites a study by Hurwitz, Zander and Hymovitch which showed that individuals with a higher referent power rating were better liked and more accepted. The impact, in regards to decision making is that if a MM has high referent power, then it is likely to be easier for them to engage people with the decisions that they are making and people will want to be involved because they like the MM who is making the request.

The construct of personal and position power supports an interpretation of 'power' as the capacity to do something, not necessarily the actioning of that power over people or things (Kotter 1985). This interpretation of power links to the concept of empowerment – that as a leader you can strengthen your position and power base by enabling others to advance or strengthen theirs. This will be explored further in the next section.

The key issue for MM decision making is that they have access to these different sources of power. What we don't know is the extent to which they understand and use these power types to help them with the types of decisions they have to make in differing contexts and circumstances.

2.7 Empowerment and decision making

Empowerment is a term that is at risk of being under-valued through current over use (Hage & Lorenson 2005) and often misuse of the concept. It is a parallel concept to decentralised decision making that is often used within government documents and wider literature. Its origins are in the latin word 'potere' meaning 'to be able to.' In this instance, that means through the acquiring, transferring, sharing or delegation of power (Bradbury et al 2010, Rodwell 1996). Within the context of nursing, empowerment is discussed with reference to either the psychological development of the individual nurse or nursing student and the standing of the profession as a whole (Manojlovich 2011, Kuokkanen & Leino-kilpi 2000). In both instances it is about the ability to enhance and develop self worth and self esteem in order to expand horizons, increase influence and maximise potential. This in turn results in both the individual and the profession being more confident and willing to take on more challenging roles and responsibilities and higher levels of decision making.

A feeling of empowerment can be derived from 'informal' or 'personal power', such as personal networks and alliances or through a sense of feeling supported through 'formal power' related to organisational structure and culture (Laschinger et al 2009). Findings from the research on workplace empowerment conducted by Kanter (1997) and The Modern Matron study conducted by Read et al (2004) would suggest that both sources of empowerment are likely to be important for this study as it is a crucial step in the process of establishing effective decentralised decision making. Without a culture of empowerment, people are unlikely to be willing to positively engage with the principles and practices of decentralised decision making.

The role of the leader as an empowerer, is to trust staff to be able to take decisions on issues that are important (Redfern 2008). To do this, they need to use their position and influence within the organisation to create an environment with appropriate systems and processes in place that help to foster the principles of empowerment. This in turn will help people to behave like responsible adults (Manthey & Miller 1994) and inspire

and motivate them to perform at a higher level (Khaleelee and Wolf 1996). Moss Kanter (1977) identifies a number of practical strategies that leaders and organisations can take to help re-dress any power in-balances and create a more empowering environment in which leaders can then operate as empowering agents, one of these is 'decentralisation.' The others may feature in the study's findings in regards to factors that help or hinder MM decision making and include:

- Flattening organisational hierarchies
- Decentralisation
- Open communication strategies
- Sponsorship
- Peer alliances

Flattening organisational hierarchies and decentralisation are part of the same process. To effectively decentralise processes and decision making requires a reduction in the number of organisational layers. Likewise, to flatten an organisational hierarchy requires a culture of decentralisation decision making that supports the principle of decisions being taken at whichever level is most appropriate to the issue. Within this symbiotic process is the issue of authority and how that is handed over to the person now making the decision.

2.8 Authority

The transfer of authority is a key attribute of decentralisation. It is also a word that is associated with power and often used interchangeably and therefore requires some further exploration. Authority can refer to a person or organisation having official power and the right to give orders and enforce obedience. It is also associated with recognised knowledge and expertise resulting in someone being described as 'an authority on a particular subject' (The Oxford Dictionary and Thesaurus 2001).

Commensurate authority is identified within the literature as a key facet of decentralised decision making (Bass 2008; Acorn et al 1997; Simpson 1994). That is, having sufficient position power and authority to provide an individual or group with the licence or mandate to make the decisions that are required.

Levels of authority are traditionally thought of in hierarchical terms. A person who is further up in the organisational hierarchy (position power) has more authority and position power than someone lower down. This is often cultural rather than because they are the most appropriate person to make the decision (Handy 1993). However, authority can be delegated and someone with a 'lower' position in hierarchical terms can carry or be given a higher level of authority in relation to a specific task/duty. Therefore a clearer interpretation of authority is one that can relate to a specific task or decision as well as to a more general level of authority attached to a person's role or position within the organisation. In other words 'authority' can be associated with a person's expertise (personal power) as well as to their title/status (position power).

This requires managers to believe and have the confidence that the people who are doing the job generally know more about it and are therefore better placed to be the decision makers. The belief then needs to be supported by the appropriate delegation of authority to enable them to make those decisions. The aim is that individuals who are responsible and accountable for an issue have the commensurate level of decision making authority to enable them to fulfill those responsibilities (Drucker 2001; Manthey 1989). The following framework was constructed by Manthey (1989) to help people determine the level of authority that they were either delegating to someone, or receiving from another person in relation to a specific task or sphere of responsibility. The level of authority a person has provides some context for the type of decision they could make.

Figure 4: Levels of Authority

Level 3 Collect Data + recommendations PAUSE Act	Level 2 Collect Data +Make Recommendations
Level 4 Do as I would do	Level 1 Collect Data

When deciding on what level of authority to allocate someone, a manager will consider their practical competence to do the job on the one hand, but maybe also their level of credibility, that is, how they are viewed by others and whether they have sufficient position and/or personal power to manage the whole situation. The following section discusses the concept of credibility, what it is it and its relevance to decision making.

2.9 Credibility

Credibility in relation to clinical competence, was a theme that arose from the findings of the RCN study (Read et al 2004,p.149) as an important requirement for the role of Modern Matron. It was seen as adding to a person's 'personal power' and enhancing their authority. Therefore, for this study, it will be necessary to understand whether credibility, clinical or otherwise, has an influence on how the MMs make leadership and management related decisions.

Much of the literature tends to focus on credibility in regards to machinery or equipment and the reliability of an instrument to measure or do something accurately and therefore to produce credible results. In comparison, there is relatively little in relation to credibility, when applied to a person, with Kouzes and Posner (2007; 2003), Handy (1993) and Kotter (1985) being the main authors.

Credibility is in essence about 'trust' in relation to both competency to do the job and as a personal characteristic that you are trusted as a person. Its value is succinctly summarised by Kotter (1985,p.40) as "a credible track record and the [resulting] reputation it earns can help one develop and maintain good working relationships with others in a fraction of the time that is required if those power sources are absent." Therefore in a complex, people focussed environment such as the NHS strong credibility is clearly an asset. Credibility is fluid and therefore contextual. It can be strong in one area and with one group of people and missing or not yet established with another (Kouzes & Posner 2007; Handy 1993). As the remit of the MM is to extend their influence beyond the traditional role of Charge Nurse then it is possible that their perceived credibility by others may vary according to the environment in which they are operating.

The importance of credibility was recognised by the Department of Health when issuing the guidance for appointing MMs. They stated that MMs would need to be respected professionals and experienced clinical managers. In effect, people who had, over time, gained the trust and confidence of staff. Credibility is the consequence of values that are observable and experienced by others through an individual's behavior resulting in respect and loyalty for them as a person and the decisions that they take (Kouzes and Posner 2003).

Credibility is not a direct decision making strategy, but the literature would suggest that it can have a significant influence on an individual's decision making and how it is received. Kouzes and Posner (2003,p.46) describe "earning credibility as a retail activity" that is achieved through the leader being visible, accessible and making regular small

contributions. This latter point is important as they found through their research that it was the small actions, made on a regular basis that made the difference – “physical acts of shaking a hand, touching a shoulder, leaning forward to listen. By sharing personal experiences, telling their own stories and joining in dialogue, leaders become people, not just holders of positions.” In other words it is the relationships that leaders establish with others that significantly contribute to them being viewed as credible and someone whose decisions should be respected and implemented.

2.10 General Decision Making Literature

Whilst the nursing literature around decision making may be primarily restricted to clinical decision making and patient choice, there is a large body of knowledge in regards to decision-making theory and research (Bazerman 2002; Baron 1988) outside of healthcare that could potentially be applied to enhance our understanding inside healthcare. Draper (1990) contends that nursing is a ‘unique’ context and therefore caution should be exercised when applying non nursing theories. However, this approach of cross discipline review is supported by others who have proposed the value of exploring non-nursing theories to provide insight and strategies in nursing situations (Standing 2008; Cader, Campbell and Watson 2005; Mckenna 1993).)

The next section will review some key features of the theory and practice of the discipline of decision making in order to highlight relevant aspects for this study. In particular, it will look at a definition of decision making and a range of different decision making processes and approaches.

2.10.1 Definition of decision making

Decision-Making means the process of being able to put all the parts together and reach a conclusion or resolution. An integral feature of decision making is the issue of choice.

In order to make a decision, an individual or group needs to have options from which they can select. Implicit within that process is having the knowledge or access to the relevant information in order to make the decision, along with the relevant skills and competency required in order to make effective decisions.

Galotti (2002,p.1) describes decision making as “the mental activities that take place in choosing between alternatives” and that “typically these decisions are made under conditions of some uncertainty,” which is reflective of the day to day working environment of the MM. In addition, there might not be any clear criteria against which to assess the decision. All of which allows the process of decision making to be influenced by an individual’s preference (Pitz and Sachs 1984). This preference may relate to a comfort level with certain approaches to making a decision or whether one option is more acceptable, for whatever reason than another option.

So how do individuals cope? One strategy is to rely on their intuition, what feels like the right thing to do in a given situation. Another strategy would be to do what the wider decision making literature suggests they may do irrespective of how much information is accessible to them – that is to apply the more intangible approach and generally implicit strategy of using heuristics.

2.10.2 Heuristics

Heuristics are rules, or short cuts, (Pritchard 2006; Bazerman 2002) that we each use, generally at a subconscious level, that influence our judgement about a situation, which in turn influences the decisions that we subsequently make. They are a way of rapidly making sense of the situations we face and framing them so that they feel manageable. As with all short cuts, they are a means to an end and not a fail-safe rule (Facioni 2007). The value of heuristics are that they provide “time pressured managers and other professionals with a simple way of dealing with a complex world, usually producing correct or partially correct judgements” (Bazerman 2002,p.6). Whilst generally, the literature suggests that heuristics are a reasonable means of managing a complex world, Pitz and Sachs(1984,p.140) ask “is that really the case or just a response to a limitation

in human judgement/cognitive ability?” This is a valid point, maybe if more time was given to teaching people decision making strategies and competencies, then maybe there would be less reliance on heuristics. However, in general, the literature does not differentiate between those that are well educated or less well educated about decision making strategies when discussing heuristics –it is viewed as an integral part of being human that to a greater or lesser extent we rely on heuristics, some of which will be quite individual to us and some that will be in common with other people. The key is our level of self awareness of our heuristics.

2.10.3 Process of decision making

People think that they just ‘make a decision’ whereas individuals actually go through a number of stages and choices (consciously or unconsciously) just to arrive at the point of making a decision. Firstly there is how the individual arrives at the point of recognising that a decision needs to be made. In order to respond to a situation, a person must encode the information available and develop a representation or mental model for the problem (Pitz & Sachs 1984,p.147). That mental model will draw upon their experience and knowledge to date to establish the nature of the situation and whether they see it as a problem to be solved, a challenge or a routine every day scenario requiring a decision.

Judgement – The individual characteristics and factors one person brings to a situation. How they form a judgement regarding a situation will be influenced by the person’s values, beliefs and experiences and the approach(es) they use to form that judgement. This in the first instance, will influence whether in the individual’s judgement there is a decision to be made.

Options – The options generated will again be influenced by the person’s values, beliefs and experiences but also by the strategies and techniques that they use to generate those options and the context in which the decision making situation is occurring

Decisions – The action and outcome resulting from the two previous processes.

A person might use any number, variant or combination of strategies in different decision making scenarios (Pitz and Sachs 1984,p.143)

2.10.4 Rational or Intuitive decision making?

As discussed earlier in this chapter, there are two broad dimensions of decision making that are implicit within much of the nursing literature on clinical decision making, rational or intuitive driven decisions. Decisions can be made through a process of rational analysis, using a clear framework such as a Care Pathway or a computerised decision support tool. Alternatively, decisions are driven by ‘intuition,’ what the nurse believes is the right thing to do in a given situation as a result of their experience and expertise. Scott et al (2010) suggest that intuition rather than analysis is the dominant approach in clinical nursing. In using these dimensions of decision making, this study might be able to demonstrate whether that ‘dominance’ of intuitive based decision making extends to leadership and management situations. In addition, these two dimensions are proven and extensively referenced in the broader decision making literature (Bazerman 2002, Baron 1994) and therefore lend themselves to one intention of this study which is to draw upon decision making theory from a wider literature base to add value to and integrate with nursing decision making. Adair (2007) and Dreyfus and Dreyfus (1980) have been chosen as representative of rational and intuitive decision making frameworks because:

- They can be found in both the business and healthcare literature databases and therefore have a credibility in both sectors
- Their initial work has been built upon and extended demonstrating its relevance in current healthcare

- Dreyfus and Dreyfus's work has been developed by Benner (1984) and underpins her novice to expert work
- Adair is a published author on leadership as well as decision making and is on the recommended reading list for the Department of Health national leadership programmes

The general decision making literature is vast and experts within the subject generally specialize in certain areas of decision making theory and philosophy. To attempt to read this breadth of literature before undertaking the study was not practical or appropriate and to read only a selected part of the literature might result in the use of an unfamiliar or inappropriate model that could distort the analysis. Therefore the reason for any selective reading needed to be carefully considered and acknowledged within the analysis of the data. Following a discussion with the research supervision team a conscious decision was taken to read some identified generalised decision making texts, recommended by The Centre for Decision Making Research, University of Leeds. This reading combined with the review of the nursing literature on decision making identified rational and intuitive decision making as valid frameworks that were recognised in both the nursing and decision making theory literature. They used a language and illustrated issues that would be recognizable to the Modern Matrons which would help them engage with the findings and application of any new learning and insights. In addition, as a researcher new to the area of decision making research, I felt I understood the theory underpinning these frameworks and could constructively use them as reference points for the discussion of the data analysis.

As highlighted, rational and intuitive decision making are just two of a number of well tested decision making frameworks designed to enable the user to make the best decision possible in the circumstances available. However, people frequently either do not use these models or abandon them part way through (Bazerman 2002). This illustrates the crux of the issue in relation to rational and intuitive decision making. "The rational model is based on a set of assumptions that prescribe how a decision *should* be

made as opposed to the intuitive approach which describes the reality of *how* a decision is made” (Bazermann 2002,p.4). In essence, this reflects the tension between following a well researched, logical and prescriptive approach to decision making and a more descriptive approach that captures the reality of how decisions are generally made in the complex and messy environment of a work context. In a healthcare context it could be equated to the on-going challenge of getting evidence into practice.

Bazermann 2002,p.4) succinctly identifies specific factors that will be instantly recognisable to anyone working in a leadership position within the NHS. They include:

- Lack of important information on the definition of the problem
- Lack of important information on the relevant criteria for making a decision
- Time and cost constraints limit the quantity and quality of available information

In cognitive continuum theory terms the above would illustrate a lack of both task structure and relevant information that would result in a person making a more intuitive decision. Benner(1984) would review the significance of the above points in relation to the level of expertise that the decision maker holds. If the individual is an expert practitioner then they may be able to compensate for the lack of information and resource constraints as their expertise and experience may enable them to establish the one critical piece of information or to find other means of establishing important information. This may also be the case for MMs as they become more experienced and the role more established. However, if the individual lacks expertise and experience, then the above points could indicate a situation that is high risk.

2.11 Decision making frameworks and models

Decision making frameworks are accepted as an important and in many cases, essential component of clinical decision making, because adopting a “structured approach to problem solving and decision making increases critical reasoning” (Marquis & Huston

2009,p.5). The majority of recognised clinical conditions will have a ‘care or decision pathway’ to help inform decisions regarding patient care and to support the achievement of consistent, high quality decisions regarding the appropriate next clinical steps. Similarly, there are numerous policies MMs can turn to in regards to specific managerial issues such as staff performance and health and safety that provide clear information to guide decision making within their own organisation or profession. However, these can only provide direction for pre-identified situations, there are a myriad of other scenarios where there isn’t any prescriptive guidance and the decision making is more subjective.

2.11.1 Intuitive decision making framework

Intuitive decision making, also known as ‘descriptive’ decision making is something that to a greater or lesser extent we all do. The conscious use of intuition in daily decision making is seen as one of the critical skills of effective leadership. Great leaders actively call on their intuition to enhance decision making, whereas less effective leaders are viewed as relying on and putting too much emphasis on traditional [rational] approaches (Chapman & Sonnenberg 2000). Intuitive decision making, colloquially described as a ‘gut feeling’ is a recognised feature of ‘expert nurse practice’ (Aloi 2006; Benner 1984). Its value is that it enables individuals to make quick decisions in a real world environment which is often complex and messy (Klein 2004).

Dreyfus and Dreyfus (1986) describe six key aspects of Intuitive decision making:

1. Pattern Recognition
2. Similarity Recognition
3. Common Sense Understanding
4. Skilled Know How
5. Sense of Saliency
6. Deliberative Rationality

They do not suggest that an individual systematically and consciously goes through each of these steps, as with rational decision making. Instead, they suggest that some or all of these steps are evident within intuitive decision making and reflect the processes that an expert engages in when making intuitive decisions. The framework has been applied by Benner (1984) and Benner and Tanner (1987) to clinical decision making and therefore there is evidence for its use in both a leadership and clinical setting. The following table summarises the key features of this framework.

Table 3: Summary of Dreyfus and Dreyfus (1986) Intuitive Decision-Making Framework

<i>Pattern Recognition</i>	recognising patterns emerging in the form of behaviour or re-occurring problems, without working off a checklist.
<i>Similarity Recognition</i>	Draws upon previous experience to identify relevant similarities between situations, even when those situations themselves might be vague and unclear or even demonstrate marked differences.
<i>Common Sense Understanding</i>	Recognise and make sense of surrounding, contextual issues that may impact upon the presenting decision making situation. Moves from knowing what is happening to understanding what is going on.
<i>Skilled Know How</i>	Through experience and practice have the knowledge and skill to look at the whole situation and as well as knowing that something needs to happen knows how to do it (Benner & Tanner 1987). Able to convey the decision appropriately as well as make it.
<i>Sense of Salience</i>	Being able to differentiate which information and events are particularly important in relation to a specific decision making situation and then either prioritising that data or the need to obtain that data (Dreyfus & Dreyfus 1986 p,28).
<i>Deliberative Rationality</i>	Consciously taking a step back and looking at the 'whole,' in order to "think about the process and product of [your] intuitive understanding" (Dreyfus and Dreyfus 1986 p.167).

Much of the nursing literature on intuitive decision making is derived from an unpublished 1980 report by Dreyfus and Dreyfus that later provided the basis of the book, *Mind over Machine* (1986). In this text, the concept of novice to expert was applied by Benner (1984) and Benner and Tanner (1987) to clinical decision making and an individual's level of expertise in relation to a particular task or situation. This study may be able to demonstrate the transferability of the novice to expert model from nurses' clinical decision making to leadership decision making.

2.11.2 Rational decision making framework

Rational decision making processes are also sometimes referred to as normative decision making (Chapman & Sonnenberg 2000). Their common feature is that they propose a more structured approach to decision making approach that encourages the individual to follow a logical and sequential process.

John Adair (2007, 1984) has written about both leadership and decision making and following discussion with the supervision team, his framework is being used to illustrate the rational approach to decision making. However as Bazerman (2002,p.4) identifies, different authors have established similar frameworks with comparable overlapping steps. The shared intention is to provide a useful order for thinking about what an optimal decision making process might look like and to provide a coherent frame of reference to work from. The following table provides an overview of the key steps that he identifies as underpinning good decision making.

Table 4: Summary of Adair’s Rational Decision Making Framework

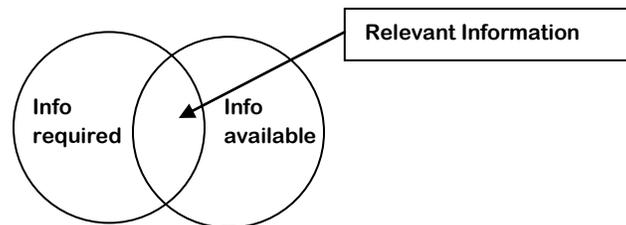
Steps	Description
<p>Step 1 Define the objective</p>	<p>Be clear about the purpose of the decision. What is trying to be achieved? What are the minimum goals that have to be achieved, along with any particular conditions that have to be satisfied (Drucker 2001, p. 255). These criteria are sometimes known as ‘boundary conditions’</p>
<p>Step 2 Collect relevant information</p>	<p>Establish what information is required in order to make the decision and whether the information is readily available. Check whether the easily available information is relevant?</p>
<p>Step 3 Generate feasible options</p>	<p>A skilled decision maker spends time generating at least three or four possibilities to have a choice of options as opposed to two alternatives (Adair 2007,p.8). Time pressures in the NHS, means there is a tendency to go with the first reasonable sounding alternative rather than spending further time generating additional options that may or may not be used</p>
<p>Step 4 Make the decision</p>	<p>Establish clarity about what criteria ‘must, should or might’ be met to enable options to be prioritised into the most or least suitable according to the criteria.</p> <p>Assess the risk and consequences of each option and then make the decision</p>
<p>Step 5 Assessing Consequences</p>	<p>Adair (2007,p.33) describes consequences as either ‘manifest’ or ‘latent.’ Manifest consequences are those that could have been reasonably predicted to have occurred as a result of the decision that was taken. In contrast, latent consequences are those that were difficult to foresee. The point in regards to decision making is that it is possible to plan for manifest consequences whereas by definition, latent consequences can only be assessed as they arise and are therefore more difficult to manage.</p>
<p>Step 6 Implement and Evaluate</p>	<p>Action the decision that has been taken and then measure and evaluate its impact in relation to the aim of the decision. This then leads to a re-assessment and a decision as to whether any further action or decisions are required.</p>

2.11.3 Commentary on Adair's decision making framework –

Two steps in Adair's model warrant more detailed discussion in regards to their relevance to the context of MM decision making. These are:

Collect relevant information

When making a decision, the MM may have information that is available but not relevant and the challenge is to differentiate between information that is surplus to requirements and may even be confusing the situation and information that is relevant and will be helpful in informing the decision to be made. Alternatively, the MM may need information that would be relevant but is not readily available. The goal is to be in a position where the person is clear about the information they require and for that information to be available or at least accessible.



Having established the information required and the information available, Adair (2007) identifies time as the next element of the process. Generally it is possible to establish quite a lot of information quite quickly. However, it often takes progressively longer to obtain relatively small amounts of information and the decision maker has to make a decision regarding the cost:benefit ration of investing more time to obtain the remaining information. The culture of the NHS is currently perceived by many as one of targets being a priority and 'time' is often in short supply. A further factor when collecting relevant information is that people "typically use heuristics in gathering and processing information" Galotti (2002,p.105). As a result, what one person considers relevant might be different to another person's assessment of the same information.

Make The Decision

When assessing risk and consequences, the NHS can be viewed as risk averse, understandably so as its business is about peoples' health and well being. However, in the main, this study is about leadership and management decisions and not immediate life and death patient related decisions and therefore there is scope for assessing risk at a more strategic leadership level. Assessment of risk can be greatly influenced by the decision maker's own tolerance threshold as to what they perceive to be risky or non risky. In addition, individual's themselves are not generally consistent in their approach to assessing risk (Bazerman 2002,p.42), therefore their assessment varies according to the context and the circumstances surrounding that context, which will include factors such as knowledge, skill, past experiences and heuristics.

Adair (2007,p.32) acknowledges, that whilst some other areas of decision making theory such as probability theory would support a structured mathematical approach using algorithms and equations to assess risk, in reality "experience plays a much larger part." Organisational theory would argue that in addition to the characteristics of the individual decision maker, the prevailing culture of an organisation and its history and experiences would also influence how risk is perceived and assessed. Therefore the location of this study may be pertinent to this step in the model.

Summary of rational and intuitive decision making

Adair (2007) recognises the importance of 'time' in regards to the 'generating feasible options' step of his model, but in regards to the model as a whole, the assumption appears to be that there is sufficient time when making a decision to work through a logical and sequential series of steps. Whilst in a clinical setting this is a potential limitation of the model as decisions sometimes need to be made very quickly, this may not be the case in relation to leadership and management related decision making. The study data should provide some insight into this.

The reality of decision making would appear to be that to be effective, an individual needs to understand the principles and processes within rational and intuitive decision making and be able to consciously choose to move up and down the spectrum according to the context and needs of the decision making situation. This issue of consciously or unconsciously using a decision making approach leads into one final model within the literature that may be of relevance to this study

2.11 Conscious Competence Learning Model

Figure 5: Conscious Competence Framework

Conscious	3. Can do it when paying attention	2. Aware of skill/lack of ability
	4. Skill becomes 'second nature'	1. Lack of awareness of skill area
Unconscious	Competence	Incompetence

This model (Howell 1986) offers a pragmatic framework with which to look at MM decision making as along with Benner's (1984) Novice to Expert work it taps into the issue of unconscious incompetence (novice) through to unconscious competence (expert). If heuristics operate at an unconscious level, it could be argued that one challenge to effective decision making is whether your heuristic is rooted in the quadrant of competence or incompetence? The Conscious Competence Model (Howell 1986) describes the stages a person goes through when learning a new skill. The Model starts at stage 1 where a person may lack awareness of the relevance of the specific skill

itself or have no insight into the fact that they do not possess this skill or ability. In order to progress and acquire the new skill, then the person needs to become consciously aware of their incompetence in this specific area (stage 2) and in order to develop the skill need to commit to learning it in order to progress to stage 3, where they are deemed consciously competent. In other words they can be relied upon to perform the skill to an adequate standard while ever they are consciously paying attention to how they are performing it. Some people in relation to a specific skill may only ever achieve stage 3, conscious competence. However, others, will, through continued practice reach a level of expertise where the skill becomes 'second nature' and the person becomes unconsciously competent, (stage 4). They no longer have to consciously think about the task in hand in order to perform it to an acceptable standard.

This model could be used as a lens to look at how the MMs make leadership and management decisions relevant to their role - their level of competence and their awareness of that level of competence. Self-awareness is generally increased through experience and feedback underpinned by honest and regular reflection. The next section will explore the role of reflection in decision making.

2.12 Reflection and decision making

Reflective Practice is a well established concept within the nursing literature (Freshwater et al 2008; Bishop & Freshwater 2004; Bulman & Schutz 2004) and generally accepted to be a good thing and something that professionals should engage in. "Leaders at all levels of an organisation need to be coached and developed" (Ruvolo & Bullis 2003) and to grow in that leadership role individuals need to experience challenging situations that result in feedback from other people and that they then take the time to reflect on and learn from (Van Velso et al 1998). Reflection, both structured and spontaneous would be an opportunity for the MMs to think about decisions that they have taken and to consider the process they engaged in. That is how they made the decision, the decision itself and the extent to which they think the decision achieved its

intended outcome. It would be reasonable to anticipate that as professional registered nurses, there would be some active reflective practice to be occurring, particularly as they are not just in a new role for them ,but also for the organisation and the profession as a whole.

Argyris and Schon (1974,p.4) believe that “all human beings - not only professional practitioners – need to become competent in taking action and simultaneously reflecting on this action in order to learn from it.” They talk about ‘theory in use’ and ‘theory of action.’ ‘Theory of action’ or ‘espoused theory’ as it is also called, is what a person articulates when you ask them what they think they should do or would do in a particular situation. In contrast, ‘theory in use’ is what comes from actually observing someone and seeing how and what they *actually* do as opposed to what they *think* they would do and highlighting the impact of this cognitive dissonance in practice (Johns 2005).

Following on from the distinction between theory in action and theory in use, two other forms of distinction arise which provide a useful framework from which to reflect on MM decision making. They are the concepts of ‘Reflection *in, on* and *before* action’ and ‘single and double loop learning.’ Reflection–in–action is something an individual does to better understand the situation that they are currently in. It is a ‘live’ and ‘in the moment’ process that allows space for re-consideration and a change of direction (Schon 1983). This process is generally stimulated by surprise, something out of the ordinary that would lead an individual to think about and reflect on what was happening and the decisions that needed to be taken. The value of reflection in action is that it allows an individual to “re-design what [they] are doing, whilst [they] are doing it”(Greenwood 1998,p.1049). In contrast, reflection-on-action happens after the event and involves a ‘cognitive post mortem’ (Greenwood 1993) where an individual takes time to review a situation that has happened and their actions within that situation. It is a retrospective process whose purpose is to generate learning that can then be used to influence future practice (Freshwater et al 2008, Boud et al 1985).

The missing component of this reflective frame of reference is, according to Greenwood (1993), a failure by Schon to recognize the value of reflection *before* action. Greenwood (1998,p.1049) describes reflection before action as “thinking through what one wants to do and how one intends to do it, before one actually does it.” The process can enable someone to identify a problem with their intended action and so create the opportunity of choice – to carry on as intended or to do something different. In the context of this study, it could be applied to a MM reviewing a decision and intended actions and potentially amending the decision which might then result in some different actions and therefore consequences.

Alongside the idea of when in the process of an action to reflect; before, during or after, Argyris and Schon (1974) have also built upon a proposition initially suggested by Ashby (1952) that learning can be either single loop or double loop in nature. Single loop learning means learning a new skill or changing an action to establish a new route to achieving the same outcome (Freshwater et al 2008). The practitioner has not reviewed the goal or intended outcome, just how to get there (Greenwood 1998). They continue to operate and understand things within the same paradigm or mental frame of reference. In contrast, double loop learning involves an understanding of the holistic context for utilising a newly learnt skill or changing a routine action that results in the practitioner questioning and reviewing the end goal. This may mean opening up to adopting new paradigms and reflecting on the norm, values and social relationships which underpin human action (Freshwater et al 2008, Greenwood 1998). Double loop learning therefore more accurately reflects the complexity of leadership and management decision making where very often it is the resulting reactions of others to a decision and the manner in which it was made and conveyed that then leads to another decision making scenario. Freshwater et al 2008,p.131) make an explicit link between this depth of reflective practice and the earlier discussion of transformational leadership in their observation that “reflection requires time, effort and ongoing commitment if one is to gain deeper insights to make lasting changes in one’s work.

Transformational leadership helps in creating an environment that facilitates caring and thoughtful interactions with others.“

Summary

This chapter has reviewed the areas of literature that it is anticipated will be relevant for this study. In particular it has examined:

- the role of the MM and how it was introduced
- clinical decision making
- leadership and decision making
- the broader decision making literature
- Reflection and decision making

During the course of this study, new studies have been conducted and papers published on the role of the MM. However, they have been small single site case studies. Whilst some acknowledge the importance of the role in regards to leadership and management behaviour, there has not been anything substantially new written about the leadership and management decision making strategies of MMs. This affirms that this findings from this study will contribute to new knowledge to the discipline of nursing.

Chapter Three – Study Design and Methods

This chapter outlines and explains the connections between the Research question and the theoretical framework used to answer it and how they, along with the data collection and analytical processes are valid and appropriate to the needs of the study.

3. Research paradigm decision

The design of a study is guided by the overall purpose and how best to generate data to facilitate an understanding and the drawing of conclusions in relation to the stated purpose. The purpose of this study was to establish, from the perspective of the Modern Matron, an insight into how they made leadership and management related decisions. Underpinning this overall aim were some specific objectives that had emerged from the initial analysis of the literature, which included identifying;

- What decision making strategies do MMs use?
- Are these strategies consistent with known decision making models in the wider literature?
- The factors that support or hinder MM in their decision making

To address these questions, an approach was needed that would enable the MMs to describe their processes of decision making and when and where they might use one process over another. This meant making their tacit knowledge explicit (Eraut 1994), possibly through the use of real work examples to enable the MMs to help make their processes more visible so that it would be possible to identify *what* was happening, *why* and *when* in order to address the study aims. This suggested an exploratory, qualitative approach which would place the MMs experience and accounts at the centre of the design and conduct of the study Simmons (1995). This placed the research within the interpretive paradigm as the study would “begin with the individuals and set out to understand their interpretation of the world around them” (Cohen et al 2000,p.22) in

regards to *how* and *why* they make the leadership and management decisions that they do. Interpretivism is quite a broad paradigm and encompasses a number of variant approaches. Therefore, to provide a coherent and credible framework in which to conduct the study, it was important to locate it in an appropriate interpretive approach. Following a review of the interpretive literature, phenomenology was identified as the most suitable approach to address the aims of the study. The following section will outline this decision in more detail and illustrate how the decision to adopt a phenomenological study subsequently informed other important aspects of the research process.

3.1 Phenomenology

In broad terms phenomenology studies conscious awareness of the world as experienced from the subjective or first person point of view and believes that to be crucial to understanding the phenomenon being studied (Annels 1996, Cormack 1996). This is its core characteristic, however, there are varying strands (Houser 2008, Schwandt 2007) that can result in it being perceived as quite a complex philosophical approach to conducting research.

Within the modern literature on phenomenology, the word interpretive is generally replaced by or subsumed within the term hermeneutic and so the term 'hermeneutic phenomenology' is more commonly used. "Phenomenology focuses on a person's lived experience and elicits commonalities and shared meanings, whereas hermeneutics refers to an interpretation of textual language" (Byrne 2001,p.970). The textual language can be existing written texts or transcriptions of interviews which are then interpreted. Therefore when put together they mean understanding the lived experience through the analysis of text.

There are a number of variations, but the two predominant strands of hermeneutic phenomenology that the literature highlights are Husserlian and Heideggerian (Koch

2006). Husserl described his phenomenology as 'transcendental' preferring to distinguish between 'facts' and 'essence' rather than the more cartesian notion of 'real' or 'unreal' (Annells 1996). He identified a value in examining every-day, taken for granted experiences and re-examining them (Koch 1995) in order to describe what they are and so bring them to conscious awareness. This would fit with MM decision making which would be seen as 'an every-day occurrence.' By focusing on the phenomena, Husserl wanted to establish a cleaner or more pure understanding, one that was not contaminated by people's assumptions, prejudices, knowledge levels or experience (Blakie 2007). He acknowledged that the individual and the context are constantly interacting and having an influence on each other. However, he believed it was also possible for an individual to transcend that influence and to put aside or bracket out any theoretical assumptions about the existence of the world, "in order to describe the essential features of concepts or experiences" (Johnson 2000,p.136). A strength of bracketing is that it can help to strengthen the validity of any interpretations by isolating the influence of the interpreter (Houser 2007, Koch 1995). However, Bauman (1978,p.121) is sceptical that it is either desirable or feasible to isolate and remove all the surrounding influences in relation to a particular phenomenon. It would certainly be very challenging to isolate the contextual influences on MM decision making. However, Husserl's acknowledgement of the influence of contextual issues on understanding and the need to manage it is an important feature of rigour in relation to qualitative research. The fundamental question is whether to bracket issues *out of* the analysis or bracket them *into* the analysis.

Heidegger, (who studied under Husserl) suggests that "the world of human beings is always one of practical involvement where things take on meaning depending on what the individual is doing (Johnson 2000; Nenon, 1997) and that understanding arises from the interaction between individuals and the wider context that they are in. Instead of bracketing things out, he suggested they needed to be recognised and included as part of a cyclical process of establishing understanding (Draucker 1999; Koch 1995). Each person bringing to the hermeneutical moment a storehouse of foreknowledge derived

from human experiences. Sometimes labelled as *baggage* or past experience, this foreknowledge provides the 'know-how' to deal with life's everyday events (Finch 2004). This is relevant to the phenomena of decision making. It is likely that when asked, MMs may well identify 'past experience' as one of the strategies they draw upon when faced with a decision to make.

Heidegger described the way he believed humans related to each other as 'being in the world' and encapsulated this within his core book 'Being and Time (1927). The concept accommodates both the past and the future and how they can influence the now in regards to a person's thinking and behavior (Conroy 2003, Burns and Grove 1993).

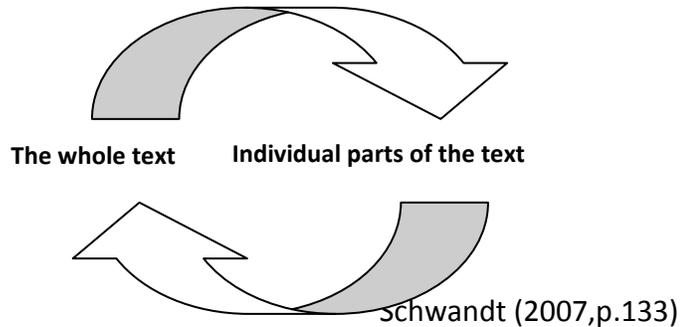
In regards to MM decision making, this is important, as faced with what may appear on the surface to be the same decision, the MM, at a particular point in time might make a different decision. This may be due to a change in the context, the nature and roles of the people present, a preceding event, something that is scheduled for later or any other number of factors. The goal of this study would be to understand from the MM's perspective: why they made a different decision; what strategies they had used to come to the different decision and what had helped or hindered them in that process? In order to elicit this data, it will be important to allow the MM freedom to talk and to identify and explain situations in their own words and time.

3.2 Hermeneutic Circle

Whilst Husserl and Heidegger both acknowledge the influence of context on understanding, a fundamental difference between them is whether to 'bracket' the contextual influences out of the inquiry process or to actively recognise and include them in it. Hekman (1983) suggests that understanding is similar in nature to a conversation in that a reciprocal relationship is the basis of their effectiveness. Therefore in hermeneutic phenomenology the role of the researcher and the influence of their experiences and biases in interpreting the data is particularly important. This

issue is addressed at both a methodological and philosophical level through Schleiermacher's 'hermeneutic circle.

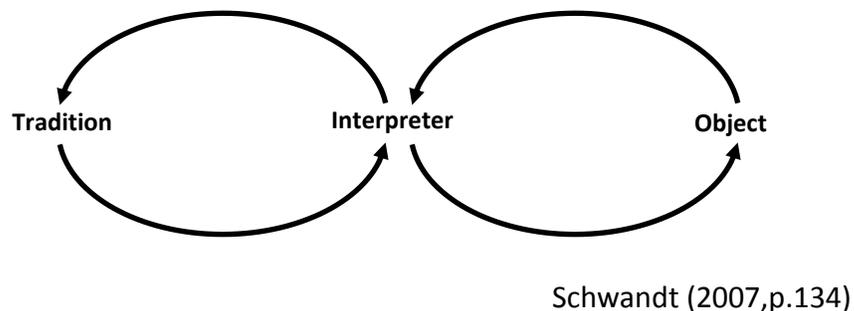
Figure 6: Hermeneutic Circle as a Method of Interpretation



The above diagram demonstrates that to establish meaning, the researcher needs to move between reading and establishing one level of understanding of the whole text to focusing on smaller, individual sections of text. The insight gained from looking at smaller sections then feeds back into re-reading and understanding the whole. This is a cyclical process designed to take account of how understanding grows and changes. Methodologically, this process is viewed as temporary and that with time, the interpreter "can come to something approximating a complete and correct understanding of the meaning of a text" (Schwandt 2007,p.133), a key goal of phenomenological research.

Ontologically, the hermeneutic circle affirms the role of the researcher in the inquiry process (Koch 1996) and in doing so, provides a framework from which to constructively manage it.

Figure 7: Hermeneutic Circle as a Philosophy



It acknowledges that “every interpretation relies on other interpretations” (Schwandt (2007,p.134) and therefore the role of the researcher and their awareness and understanding of what they bring to the inquiry process is critical. The tradition phase of the circle is to stimulate reflection of the researcher’s ‘pre-understandings,’ those biases and knowledge that the researcher (and study participant) brings with them when generating and gathering data. The concept is similar in principle to that of reflective practice in nursing. There is a recognition that to be effective, it is necessary to understand the influence of the nurse or researcher on a particular phenomenon and that where possible this should be done before, during and after the event. The hermeneutic circle demonstrates that the researcher (interpreter) is inextricably linked historically (tradition) by what has gone before and by the phenomenon (object) under examination.

Philosophically, the use of the Hermeneutic Circle as a framework to support the acknowledgement and bracketing in of researcher bias or pre-conceptions during the process of interpretation (analysis) (Benner 1994) will contribute to establishing the rigour of the study.

In this instance, the process would require me, as the researcher to reflect on *why* I had chosen to look at the decision making of modern matrons and *how* those reasons might influence any or all of the study stages. In particular the collection and analysis of data through the questions I chose to ask, the examples I decided to explore in more depth with the study participants and the filters I may carry when looking at and interpreting the data. This is addressed further in this chapter and again, when appropriate through reflexive sections written in italics to distinguish them, in each of the following chapters in the Thesis. A criticism of phenomenological research is that insufficient time and attention is given to transferring the principle of researcher reflexivity into practice (Draucker 1999).

I have not worked as a MM or in an acute hospital environment. However, I have worked as a senior clinical nurse who, in addition to a clinical role was required to take

leadership and management related decisions. which may influence the direction of the interview and therefore its content (Bulpitt and Martin 2010). In adopting a phenomenological based approach, it is issues like this that need to be openly acknowledged in order to bring transparency to the research process.

Selected methodology

Specifically, a Heideggerian hermeneutical form of phenomenology will be adopted as philosophically, the approach will facilitate an understanding of the phenomenon of decision making from the perspective of the MMs as they live and experience it. His concept that we are all 'beings' within and inseparable from the world or phenomena being studied and that we are not consciously aware of many of the things that we do reflects both the complexity of the context in which MMs are making leadership and management decisions and the frequency of their occurrence. It is a several times a day, every day activity. Therefore Heidegger's approach which not only acknowledges, but embraces the influence of context (as opposed to bracketing it out), will help me as the researcher to understand and answer the question of what factors help or hinder the MMs in their decision making. Adopting a phenomenological approach is also consistent with the only existing significant study of the role of the MM (Read et al 2004). As the sole researcher, the concept of the hermeneutic circle is consistent with Heideggerian phenomenology and provides a framework for acknowledging and managing my potential influence on the process of data generation and interpretation. The methods available to use within phenomenology are appropriate and manageable within the resources available for this study both in terms of researcher time and access to MMs, the study participants. Using this philosophical framework, the following sections will discuss the design and data collection and analysis methods for the study.

3.4 Study design

The design of a study should be consistent with its philosophical underpinnings, in this instance, Heideggerian hermeneutic phenomenology. Therefore in seeking to understand MM decision making, the approach needed to facilitate an exploration of their 'being-in-the-world' in relation to leadership and management decision making. A review of the literature resulted in a decision to frame the research as a case study within one identified organisation. This is similar to the approach adopted by Currie, Kotevko & Nerlich (2009) who also used a case study as the basis for their study into the development of the role of the MM in the NHS. Such in depth studies are useful in qualitative research (Thorpe & Holt 2008) for managing situations where there are multiple influencing factors as it is "sensitive to the context in which information is gathered" (Radley and Chamberlain 2001,p.335) and facilitates the in-depth study of a single group (Houser 2007). The approach is consistent with phenomenological and hermeneutic research because it allows for the surfacing, exploration and discussion of contributing factors (Greenwood and Lowenthal 2005), which for this study included; the political underpinnings to the introduction of the role of MM, the local organisational context and the characteristics of individual MMs .

This approach is recognised as a particularly valuable method for this type of research, where the "phenomena and the context in which it is occurring are not clear" (Yin1994,p.1). Whilst there are known models of decision making, in this proposed study, the phenomenon of leadership and management decision making has not been well researched and the nursing role of MMs that will form the sample group were newly emerged and lacking some clarity. In addition, their role and function were influenced by both the environment and context in which they were operating and politically at both a local and national level (Casey & Houghton 2010, Young 2002). By structuring the research in this way and embedding it within one particular organisation, these various contextual issues could be acknowledged and reflected upon.

To be effective, Yin (1994,p.4) states that there are 'three conditions' that should be met. The research question should be

- Explanatory in nature and involve *how and why*.
- The investigator should not have control over the events and behavior being examined
- The events being examined should be contemporary (as opposed to historical).
This study fulfils all these pre-requisites.

The following attributes should be identifiable within a typical case study – the case, the main unit of analysis and sub units of analysis (Casey & Houghton 2010).

- In this study, the 'host' organisation was '*the case.*'
- MM leadership and management decision making was the '*main unit of analysis.*'
- The leadership and decision making strategies of MM on the study site was one '*sub unit of analysis*' and the second was the factors that support or hinder the leadership and management decision making of MM.

My review of the literature began with reading the attributes of a diverse range of approaches and establishing which would be best suited to addressing the research question within the philosophical approach identified and would also facilitate a process of co-production and analysis between myself as the researcher and the study participants. By starting with the philosophical aims and principle of the research, I avoided being constrained by what might be considered to be more traditional approaches in a phenomenological study. Consequently, I identified an approach, case study) that was consistent with the aims of the study, but might be considered unusual within the literature on phenomenology.

In regards to analytical rigour, the challenges of analysing case data is similar to any other form of qualitative research (Thorpe and Holt (2008). These are the issues of:

Credibility – How representative is the interpretation of the data to the actual truth? Prolonged engagement with the study participants creating the space and opportunity for interpretations to be checked and where appropriate amended through a process of co-production.

Dependability – The extent to which a different researcher looking at the same data with the same research question would code and categorise the data in the same way. An inquiry audit detailing the research process can enable a second researcher replicate the process, code the data and enable a comparison to take place

Confirmability – An audit trail that details how a researcher has reached their conclusions. This can incorporate the inquiry audit along with a more specific decision trail identifying how and why certain decisions were made so that an independent researcher can assess whether they would have made the same, similar or different decisions.

Transferability – The extent to which the findings can be applied to other contexts or groups of people – eg: from this particular group of Modern Matrons in one NHS Trust to Modern Matrons in other NHS organisations. This is one limitation of adopting a single case study approach. However, it can be addressed by the researcher making a very detailed or ‘thick’ descriptions of the context of the study and each step of the process (Polit & Beck 2006, Guba & Lincoln 1989) to facilitate a discussion about potential transferability to a wider group of Modern Matrons.

The use of the Hermeneutic Circle and overt investigator reflexivity during the conduct of this study provides an integral framework to manage the above four areas of establishing rigour within a phenomenological based study.

3.5 Data Collection Methods

The data collection methods need to be consistent with the principles of phenomenological inquiry and enable the MMs to describe meaningful decision making experiences (Byrne 2001, Koch 1996). Therefore the methods are any that fulfill that purpose and therefore consistent with a phenomenological based study. Typically they include strategies such as: focus groups, diaries, participant observation, and interviews (Byrne 2001; Benner 1994). The following section will provide a brief overview of these potential strategies and a rationale for the one that was chosen.

Focus Groups

A focus group is described by Schwandt (2007,p.119) as an “interview or discussion that brings together a group of people to discuss a particular topic.” The rationale being that the interactions that arise from a group discussion can help participants to “explore and clarify their views in a way that would be less easily accessible in a one to one interview” (Webb & Kevern 2001,p.798). However, whilst Twinn (1998) believes that the approach reduces pressure on participants as individuals do not need to respond to every question, others observe that some people are cautious about expressing their views in front of other people and therefore may share less than if they were in a 1:1 setting (Polit and Hungler 1991). This may undermine their value as a time effective way for the researcher to gather data from a number of participants in one session (Sim 1998; Reed & Roskell 1997). The role and skill of the group moderator is particularly important in Focus Groups (Goodman & Evans 2006). Unless well facilitated, there is the potential for those with a louder voice to overly influence the direction of the discussion at the expense of quieter group members sharing different ideas or opinions (Sim 1998). Data collection can be difficult as audio recording equipment is not always as effective at recording group discussions. In addition for the group moderator to be effective they need to concentrate on the group and therefore a co-researcher is required to track who in the group is saying what (Sim 1998) in order to then cross reference back with the audio recording and attribute the audio to the right participant. Focus Groups can

be a useful approach to use in conjunction with other data collection techniques, such as generating questions or vignettes that could then form the basis of a 1:1 interview (Silverman 2010; Schwandt 2007).

This was an approach that I had previously used and was comfortable with. However, the value of discussing ideas and putting them out to scrutiny, on this occasion to a Faculty lunch-time seminar, was that I was asked a number of occasions which led to me discounting the use of Focus Groups for two reasons: successfully getting all of the study participants together in a room at the same time without a short notice cancellation and no resources for a co-researcher to provide a supplementary recoding of the focus group process and dynamics.

Reflective Diaries

“The aim of diary keeping is to capture the [participants] thoughts, feelings and emotions” (Clarke and IPohen 2006) in relation to the phenomenon being studied. One advantage of reflective diaries is that they have the potential to generate a significant amount of data with relatively little time input from the researcher. However, as Robson (1993,p.254) observes, “they [also] place a great deal of responsibility on the respondent” to record in sufficient detail and accuracy for the data to be meaningful. They could be a useful secondary data source for this study but as a primary source, the length of the entries necessary to describe their experience of decision making scenario limits their ease of use for the MMs.

Observation

Observation is one of the most frequently used data collection methods in qualitative research (Holloway 2005) and is recognised as a valuable method of obtaining data when other methods are “often inadequate for dealing with activities and behaviours of which individuals themselves may be unaware or unable to describe.” (Polit & Hungler 19,p.334). One reason for undertaking this study is the researcher’s perception that MM find it difficult to articulate how they make decisions and therefore arguably adopting

an observational method of data collection could be appropriate. Observation is generally recognised as being more time consuming than some other methods of data collection (Robson 1993), due in part to the level of immersion with the study participants that is required in order to effectively observe the phenomenon. This method therefore would require the active involvement of the researcher who would need to be present at the right time and in the right place in order to conduct the observation. This is a challenge for this study as it would not be possible to predict when an appropriate decision making scenario would occur. In addition, much of the decision making process and the strategies used are likely to be invisible to an observer as it happens at a cognitive level and is therefore difficult to observe. A further challenge of observational methods of data collection is the Hawthorn effect and the risk that study participants “may alter their behavior as a result of being observed” (Casey 2006,p.76).

1:1 semi-structured interviews.

Interviews are a means of gaining direct access to an interviewee’s experience Schwandt (2007). They are recognised as being consistent with the aims of a phenomenological study as they are an effective method of giving participants the “opportunity to describe their experiences in their own words” (Barker 1996,p.118). They allow for clarification and expansion of the data in order to understand what is being said. It is important that the “interviewer [remains] neutral in the interview process” (Scwandt 2007,p.162) as interview bias or contamination of data is an important consideration in phenomenological research. The interviewer needs to be mindful that how they construct and ask their question(s) will influence the reply. Interviewees may feel pressured into giving a particular answer or account of an experience to conform with what they think the interviewer is thinking or looking for (Barker 1996). Alternatively they may describe what they think they should have done in regards to good practice as opposed to what they actually did. Therefore an understanding and application of the hermeneutic circle will assist with the conduct of the interviews as well as the analysis of the data.

Chosen data collection method

The challenge was to find a research approach which would bring to the fore a process, leadership and management decision making, that was part of the MM everyday working lives. Having considered four different approaches to collecting the data, a semi-structured interview was chosen because it was consistent with seeking to understand a specific phenomenon and to identify *what* was happening, *why* and *when* in order to gain new insights. In addition, it was appropriate to the skills of the researcher and achievable in regards to the time and general resources available to conduct the study. It was also a method of data collection that the MMs were more likely to be familiar with and therefore more comfortable. A more detailed discussion of the actual process of interviewing and data generation is described later in this chapter.

In line with all aspects of this study, the researcher will look to maintain transparency by maintaining a Research diary. The integration of reflexive strategies into the research process is a recognised technique to help the researcher to understand the reciprocal impact of them on the research context and process and the research context and process on them (Bulpitt & Martin 2010; Freshwater and Rolfe 2001).

3.6 Data Analysis

Knowing how you intend to analyse study data is an essential precursor to collecting the data (Burnard 1991) as how the researcher collects the data will impact upon how effectively it can be analysed. Therefore it was important to establish the intended analytical approach at the design stage of the study. As with the interviewer when interviewing, it is important to manage the risk of the interpreter projecting their own world onto the text and reading something into the text that is not there (Benner 1994). Therefore, the analytical approach adopted needed to support an interpretation of the data that could be explored and developed further with the study participants in order to be an accurate interpretation of their experience of leadership and management

decision making. This informed two decisions. The first to audio record the interviews and then to transcribe them verbatim. This allows the researcher the opportunity to revisit the interview and listen again to particular sections (Silverman 2010). This is important because to arrive at a rigorous and credible understanding of the data, the researcher needs to be able to move between reading and re-reading individual sections of the text to the whole text. Schwandt (2007,p,135) uses the example of understanding poetry to illustrate the importance of a data analysis approach that will enable this movement. "To understand the meaning of the first few lines of a poem, [you] must have a grasp of the overall meaning and vice versa." Enabling the researcher to move between the whole text and individual sections of text to establish meaning is also consistent with the decision to use the Hermeneutic Circle.

I particularly like this analogy as I think it succinctly encapsulates my approach to working with and making sense of the data and clearly demonstrates the value of using the Hermeneutic Circle as a method for interpretation.

Analysis Framework

Most authors on qualitative research analysis (Silverman 2010; Robson, 1997; Polit and Hungler,1991) provide a broad description of the general process that underpins good quality analysis. These descriptions include: organizing the data; reducing it to a number of smaller units of text that are coded so that they can be re-located in the whole text. These Units are then described and interpreted to establish meaning. These activities are informed by a reading and re-reading of the data in order to exhaust the data Burnard (1991). To demonstrate validity, exemplars are used as "salient excerpts that characterize specific common themes or meanings across the data"(Crist and Tanner 2003,p.205).

Following a review of the literature, Lindseth and Norberg (2004) adaptation of Ricoeur's (1971) interpretation theory was chosen as the analysis framework for this

study. Their three step approach is consistent with the use of the Hermeneutic circle. They describe a process of:

Naïve reading – a period of time where the text is read and re-read a number of times to establish an initial understanding what it is saying and therefore grasp its meaning. It is a “first conjecture and it has to be validated or invalidated by the subsequent structural analysis” (Lindseth and Norberg 2004,p.147).

Thematic structural analysis - involves identifying individual units of meaning with the text. These can range from individual words through to one or several sentences. These units are then considered against the initial understanding from the process of ‘naïve reading and “the essential meaning of each is [established and described]in everyday words as concisely as possible” (Lindseth and Norberg 2004,p.147) to begin to establish relevant themes. This leads to the next phase of understanding the relationship between the themes and the whole text.

Comprehensive understanding (interpreted whole) – “the themes are summarized and reflected on in relation to the research question and the context of the study” (Lindseth and Norberg 2004,p.148) to begin to form an overall picture of understanding. The original text is re-read and any additional literature that may now be appropriate explored. It is also an opportunity to re-visit and reflect on how any pre-knowledge or pre-understanding may have influenced the analysis of the text and therefore the arising themes, so that these can be openly acknowledged.

This analysis framework worked well for me as it provided an approach that guided the analysis, but was not overly prescriptive allowing movement back and forth through the data as ideas emerged and understanding grew. It was consistent with the circulatory nature of the hermeneutic circle and provided the opportunity to reflect o the influence of any pre-knowledge and allowed for a process of co-construction with the MMs.

The second decision regarding the approach to the data analysis was to establish a process of co-construction and facilitate an evolving understanding of the data between the researcher and the study participants (Cader, Campbell, Watson 2009,p.1918; Paterson 2001,p.576). The initial analysis was to be presented back to the participants for them to comment or expand upon and then prioritise. This would provide the basis of a second interview with them which in turn would support a comprehensive understanding of the whole text and contributed to the co-production of the final themes.

The initial findings were presented back to the MMs in the form of a Mind Map™. *Although recognised and used in education, Mind Mapping is not a technique that is commonly used in research as part of the data analysis process. I chose to use it for a number of reasons. Unlike most written methods, Mind Mapping is both visually and numerically a non hierarchical way of presenting information. This was important as the MM were going to be asked to rank the emerging themes and I was aware that how I presented the data might influence the ranking process. Whilst ontologically, hermeneutic phenomenology acknowledges and affirms the role of the researcher in the investigation, I felt that it was still appropriate to adopt an approach that would help to contain my impact on the presentation of the initial analysis and any undue influence that might have on how the MMs later ranked the themes.*

The principle of reflecting on and acknowledging my influence as research investigator whilst also managing or containing that influence is a balance I have tried to maintain throughout the study. The interviews are deliberately semi-structured to enable me, as interviewer, to follow the participant's lead rather than direct their accounts through the questions being asked. The adoption of the hermeneutic circle and a reflexive approach throughout the study are both directed at raising my self-awareness in order to consider how I may be impacting on and influencing the research and if and when appropriate moderating my own behaviour

Mind Mapping™ is a technique that enables both a visual and written representation of the data analysis which in turn allowed the study participants to see quickly and clearly how the emerging themes related to each other (Buzan 1993,p.13). It enables an idea to be quickly and profoundly explored while simultaneously maintain a clear focus on the central theme (Buzan 1993). By using shape, colour and dimension to present information, Maps are a way of representing information in a visual format that is similar to the way the brain itself maps concepts (<http://www.open.ac.uk/infoskills-researchers/developing-mindmapping.htm> accessed 23rd. August 2010) and so improves the effectiveness of the brain to receive, hold and analyse information. In addition, using a Mind Map would enhance the opportunity for a more comprehensive understanding of the data as it provides a different entry point to the looking at the data and an alternative frame of reference for discussing it, thereby opening up different dimensions for engaging with the data.

I used a similar approach to data collection and analysis for my Masters degrees and therefore needed to be clear that I was choosing this option because it was the most appropriate for the needs of the study and not because I was familiar and maybe therefore more comfortable with it as a data analysis technique. I think I achieved this as I built in some additional rigour with the use of Lindseth and Norberg's framework and the use of Mind Maps. Mind Mapping is appropriate to this organisation as it actively promotes its use and provides training courses, it might not be suitable in a different NHS organisation.

Having determined the best approach to collecting and analyzing the data for this study, the next stage was to look at the most appropriate way to recruit firstly an organisation and then the Modern Matrons within that organisation to participate in the study. This next section will describe that process, leading into the actual recruitment to the study, ethical considerations that had to be addressed and the process of data collection.

3.7 Process and Conduct of The Study

Sampling

In research, it is not generally possible to study everything and therefore some practical decisions have to be taken about who and what is studied, where and when in order to best meet the needs of the research (Robson 1997). In this study, two sampling decisions had to be taken. The first in relation to the organisation where the study would be conducted and the second in regards to the MMs that would be recruited.

Host Organisation Sampling

Following a review of the literature and a discussion with my supervision team, a search of the NHS database was conducted, looking for an organisation with the following four characteristics:

1. Had implemented the role of the MM
2. Part of the first wave of NHS Trusts to implement the role
3. Located in the north of England
4. Star rating of three

Seeking an organisation that was part of the first wave to implement the role of the MM was a pragmatic decision to facilitate the recruitment of an appropriate organisation within the time constraints of the study (Read et al 2004). An added value might be that any early difficulties of implementing a new role would have settled down. This was important as the study was about the decision making strategies of the MM not the implementation of the role and although there may be some issues that cross over, it was important to try and minimise any confusion. The researcher is based in the North of England and therefore from a pragmatic point of view of time and cost of travelling

for initial interviews and follow up work, it was important to try and conduct the study within the North of England.

It was a deliberate decision to approach a Trust with a star rating of three as it would be an indicator of a strong, high performing organisation. Organisational culture and behaviour were likely to be an important facet of the MM decision making and therefore would feature in the data. The aim was to minimise the risk of a Trust with a poor cultural and staff developmental record having an undue influence on the data and potentially obscuring the primary purpose of the study. This was not to dismiss its importance, but to increase the likelihood that the MMs would concentrate on their own approach to decision making and be less likely to be distracted by negative influences within the organisation. The aim was that the organisational factors would still emerge but without dominating the data.

Following a review of the NHS database and then individual organisation web sites, five organisations met the criteria and their Directors of Nursing contacted.

Having created a short list of potential organisations, some additional characteristics were then addressed. The host organisation would need to have an interest in the purpose of the study. As it was part of a professional doctorate, that meant a demonstrable commitment to the professional practice and standards of their staff and a willingness to integrate any findings as appropriate into the preparation of their staff. The organisation would also need to be comfortable with the principles of phenomenology and be interested in understanding the issue of leadership and management related decision making from the perspective of the MMs. Two organisations met all the criteria. The defining characteristic of the organisation that was chosen was its commitment to investing in both staff development and the development of the organisation as a whole to achieve widespread culture change. The Director of Nursing and Head of Organisational Development both expressed a commitment to the study findings being incorporated into their staff development processes.

One issue for this study was that I, as the sole researcher was involved in each step of the sampling process, thereby raising the issue of possible bias and influence on the study data. I managed this issue by ensuring that I discussed the sampling criteria and their rationale with my supervision team. In particular the issue that the Director of Nursing and Head of Organisational Development were known to me through the national Leading an Empowered Organisation Programme

Sampling, access and recruitment for interviews

The purpose of sampling is to establish a study group that is either 'representative' of the population (quantitative research) or 'relevant' to the research question and understanding that is being sought which is indicative of qualitative research (Schwandt 2007). This study was about understanding the MM's lived experience of leadership and management decision making and therefore a purposive approach was adopted where the qualifying criteria were that the participant was a MM within the host organisation.

Silverman (2010); Robson (1997) and Polit & Hungler (1991) all acknowledge that 'real life' is likely to influence the researcher's approach to sampling in regards to issues such as time, resources and ability to travel, issues that were relevant for this study.

However, Silverman (2010,p.141) cautions that purposive sampling still requires the researcher to "think critically about the parameters of the population [they] are studying and to choose the sample case carefully on this basis."

By choosing one role in one organization I was aiming to reduce some of the variables that might have occurred if for instance participants were at a particular grade, but across different roles and as a result with diverse leadership and management responsibilities. By recruiting from an identified role, within one organisation, there was a degree of homogeneity in regards to the specific preparation that had been received for the role of Modern Matron through the two leadership programmes that they had all attended.

3.8 Research governance

The research proposal was submitted in accordance with the guidance in the Research Ethics and Governance Handbook

http://www.northumbria.ac.uk/static/5007/respdf/ethics_handbook_2.pdf (accessed on 23rd. August 2010) and passed by the Research Ethics Committee in the School of Health, Communication and Education studies. It was then submitted and passed the host organisation's local research committee and given national COREC approval. At this stage, the Trust issued an honorary contract to the researcher to enable on site visits and interviews with the MMs. Permission to approach the MMs had already been given by the Director of Nursing subject to receiving COREC approval. The Trust then required an annual written update on the progress of the research and an agreement to attend any research meetings as appropriate.

3.9 Ethical considerations

This is a phenomenological study where participants were being asked to describe their lived experience over the course of two interviews, some months apart. This posed a number of ethical issues that needed to be considered.

Informed consent – An information leaflet was written introducing myself as the researcher, the purpose of the study and the intended processes of data collection and analysis (Appendix one) and a consent form (Appendix two). The information also made it clear that a study participant could change their mind and withdraw at any stage. This is important because the nature of phenomenological research means that study participants will be re-counting personal experiences that they have had. The re-telling of these experiences may lead to feelings or insights that they had not anticipated and may be uncomfortable with and not wish to pursue. Consent therefore should always be open to on-going discussion and potentially withdrawal (Silverman 2010).

Confidentiality - is important in any research, but particularly when people are identifying personal approaches to core role related activities and possible organisational factors that may help or hinder them. Therefore all data was coded (Burns & Grove 2005; Polit & Hungler 2010) with participants being offered the choice of having their data either returned to them or destroyed at the end of the study. During the course of the study all data was stored in a locked cupboard. It was agreed that Trust management would receive no information nor have access to information regarding who did or did not participate in the study. Similarly, it was agreed when seeking access to the MMs, that the Trust Management would have no access to original participant data, audio tapes or transcripts. Any data that the Trust would view would be that which had already been agreed and validated by study participants prior to its inclusion in any documentation for wider dissemination. This was to remove the potential for participant data being used inappropriately by the organisation. Study participants could have complete trust in the confidentiality of their decision to participate in the study and that any findings would not be 'traceable' back to them. This helps to foster and support consent and confidence to talk openly and honestly during the interviews.

Voluntary participation -At all times it was made clear that participation was voluntary and not a requirement. The MMs had to actively opt in to the process by individually contacting the researcher to register their interest in participating and then signing a consent form and then attending for the one:one interviews. Consent has to be freely given with the knowledge that it can also be withdrawn in order to be valid (Silverman 2010).

Non Malificence – or avoidance of harm to study participants is an essential element of ethical research. Potentially, the study participants might become upset when recounting a decision making scenario if it had been a difficult experience for them. However, they had complete freedom of choice over what scenarios they chose to

describe. In addition, as a Registered Mental Health Nurse, I felt competent as the researcher to manage that type of situation if it arose.

The Independence of the Researcher –I was an external person to the host organisation and unknown to the study participants and therefore along with the above ethical steps put in place was able to demonstrate a credible level of independence and impartiality. However, as a phenomenological study actively using the principles of the Hermeneutic Circle, I also needed to acknowledge with them that my experience as a senior nurse and national leadership facilitator would influence on how I interpreted the data. This was part of the explanation they received for inviting them to a second interview and engaging with a process of co-construction of meaning from the data.

3.10 Sampling and recruitment of Modern Matrons

Sampling is about identifying a representative target group that meets the eligibility criteria of a particular study. This had been achieved in regards to locating the study within an organisation. The principle then had to be repeated in order to identify individual study participants. This study was about understanding the MM's lived experience of leadership and management decision making and therefore the eligibility criteria were that any potential study participant had to be employed as a Modern Matron by the host organisation. This created a potential sample size of nineteen if everyone volunteered to be involved. A question for qualitative researchers that is more difficult to answer than with quantitative research is 'how many interviews is enough? There are pragmatic considerations such as the number of researchers to read the text and the time available to undertake the analysis Silverman (2010). Polit and Hungler (p.266) suggest that in qualitative research, "small samples are usually adequate to capture a full range of themes emerging in relation to the phenomenon of interest." However, it comes down to judgement as to whether the sample size obtained is sufficient to generate the insight into the phenomenon being studied. From a perspective of rigour, Crist and Tanner (2003,p.203) offer the guidance that the "size

of the sample is considered adequate when interpretations are visible and clear and new informants reveal no new findings. ” A decision was taken to initially aim to recruit up to seven MMs to the study as that would be sample of size of just over a third of the total number of MMs and then review whether the data arising from the interviews was sufficient to address the research question.

The chair of the monthly MM meeting put the study as an agenda item and provided a 15 minute time slot for a presentation on the framework and purpose of the study. The plan was to leave information leaflets with the MMs at their meeting to reduce the risk of feeling pressured to make a decision one way or another by the group or the researcher. I anticipated that participation in the study would produce information and insight that would be directly useful to the MM (East et al 2010) as the process would enable them to construct and use their own knowledge (Reason 1994,p.328) within their everyday working practice.

In addition, all participants would be offered a 'feedback' workshop on the theory and practice of decision making and the key findings from the study. It was anticipated that these last two points, combined with the opportunity to be 'heard' would make participation in the study an attractive and not too time consuming an activity.

I attended the MM meeting and introduced the aims and objectives of the study. There were only ten people present and being mindful that with a relatively small group to recruit from, study participants' anonymity might be compromised, interested parties were asked to individually contact the researcher following the presentation at the MM meeting. The intention being that those who elected to participate in the one:one interviews would only be identifiable by their colleagues if they chose to let them know. Due to the low numbers present the Chair agreed to include the written information regarding the study in the minutes that went out, so that all of the MMs would have access to the information. Nine people confirmed that they would be happy to participate in the study. Five of those were direct from the meeting and as they chose to volunteer to participate in front of their colleagues at the initial presentation they were

clearly more identifiable than the four study participants who chose to volunteer via e-mail. It was decided to accept all nine volunteers to allow for one or two possibly dropping out of the study and bringing the numbers down to the initially proposed number of seven. All volunteer participants were asked to complete consent forms (appendix 2) and a convenient time was arranged to interview them.

3.11 Data Collection through semi-structured interviews

The one:one interviews were semi-structured in design in order to ensure the research aims were addressed whilst allowing sufficient flexibility for space for other issues to be raised by the participants. Interviews are often described as a 'conversation with a purpose,' however, that belies the level of skill that is required to facilitate the process effectively (Robson 1993; Polit and Hungler 1983). The researcher is a registered mental health nurse and experienced in the area of facilitating conversations as part of professional practice as well as in a research context. The similarity in skill sets between the two contexts is useful, but Bulpitt & Martin (2010) caution the researcher to be mindful that during a research interview they do not slip into therapeutic questioning mode.

An interpretive phenomenological study aims to understand lived experience and invites people to talk openly and honestly about their experiences (Barker 1996). Therefore, as Benner (1994,p.108) suggests, it is important that the interview context is as conducive as possible. This includes paying attention to the physical issues such as the location and layout of the room and the appropriateness of the words used to ask questions or prompt for further information and clarification. The interviews took place in a room that was on the hospital site but away from their place of work. This was to increase the ease of access for the interviews, whilst minimising the distractions of meeting in or near their clinical area. The one:one interviews (using an interview schedule that the participants received by e-mail one week prior to the interview) were scheduled to last for approximately one hour, but the room was booked for two hour slots to ensure that

there was sufficient time if the interviews lasted longer and also for ensuring all audio tapes were correctly labelled and boxed. I ensured that I arrived at least 20mins in advance of the scheduled interview time to allow sufficient time to prepare the room, seating arrangements, positioning of audio equipment to make it as unobtrusive as possible and testing of audio equipment to make sure everything was working and ready to go. There was an individual bottle of water and a glass on a small side table for each interview along with a small box of tissues, as a contingency in case someone became emotional when recounting a decision making scenario. I also ensured that I had the names and contact details of other sources of support within the organisation should they be needed. I did not expect there to be any undue emotion as the MMs would be in charge of deciding what they chose to share, however, sometimes, people can be surprised by their own reaction when re-telling or re-living a situation. In reality none of the MMs became upset. On average, the interviews lasted between 45 minutes to an hour. All interviews were audio recorded and transcribed to facilitate detailed analysis (Oppenheim 1992:67), the identification of relevant themes and allow for secondary analysis as part of the audit trail in regards to maintaining rigour.

I had initially intended to use a Computer Assisted Qualitative Data Analysis System (CAQDAS) such as Nudist or Atlas and attended a training course early on in the study. This was to support me with the analysis by providing an electronic means for me to organise the data, allocate codes and highlight and tag identified pieces of texts. However, I do not generally find computer programmes intuitive to use and therefore I found that when it came to using the software on the study data, I was not sufficiently competent to use it effectively. Therefore rather than risk compromising the study through poor use of a CAQDAS, I decided to use a more traditional index card system to organise and track the data and finally papered a wall of my study to create a large mind map of the emerging themes and data. This was an approach I had used before and did, I feel allow me to get really close to the data as I was physically handling it – writing words down, moving paper about and cutting things out. I used coloured 'post it notes' to cross reference raw data to different emerging themes. This approach worked

well, it allowed me to immerse myself in the data and get very familiar with it as I was hand writing the index cards and then putting the data back together in the form of a Mind Map to see the whole picture. A more traditional approach to the analysis was manageable with the volume of data that I had. However, for a larger study, it would be necessary to use a computer package to manage the greater volume of data.

Summary

This chapter has outlined why the study has been set in an interpretive phenomenological framework and explained the rational for using semi-structured 1:1 interviews as the primary source of data generation. The actual process of sampling and interviewing for the study has been described, leading into the analysis of the data which will be discussed in the next chapter.

Chapter Four - Data Analysis

Introduction

This chapter describes the process of analysing the data and how the study's findings emerged. The intention is to enable the reader to follow the process that was undertaken and understand how the final themes emerged from the raw data, thereby providing an audit trail.

In a phenomenological study it is important to minimise the risk of the interpreter projecting their own world onto the text and reading something into the text that is not there (Benner 1994). Therefore, the analytical approach adopted needed to support an interpretation of the data that could then be explored and developed further with the study participants in order to be an accurate interpretation of their experience of leadership and management decision making.

A two stage iterative process was used to analyse the data. As described in the previous chapter, the first stage involved the researcher immersing themselves in the data through an initial 'naïve' reading of the transcripts. Then reading and re-reading in order to really understand what was being said and to begin a 'thematic analysis.' The emerging themes were then coded, using different coloured highlighter pens within the main body of the transcripts and coloured index cards to write specific excerpts from the text that illustrated the theme, each one with a reference to be able to re-locate it in the transcripts. The excerpts and emerging themes were also written out on different coloured and shaped post-it notes and then used to create a 'moveable' mind map on the wall of my study. This enabled me to create a large, visual representation of the data which I could either stand back from and see in its entirety or focus in on individual sections as part of the process of collapsing the data into pertinent themes.

This was consistent with adopting a hermeneutic circle approach to the method of interpretation as it enabled the data to be broken down and understood as a smaller section before being easily re-assembled as required to facilitate an accurate analysis

and understanding of the data in its entirety. This process enabled a gradual reduction in the number of themes in order to arrive at the fewest number that best represented the interpretation of the data at that stage. (See appendix five for a schematic account of the analysis process).

Through a second round of one:one interviews, the emergent themes were presented back to the participating MMs for comment and prioritisation and to describe in more depth what the themes meant to them. This process of co-construction helps to establish the credibility of the study findings and facilitates an evolving understanding of the data between the researcher and the study participants (Cader et al 2009; Paterson 2001; Lincoln & Guba 1985) and maintains a commitment to the cyclical process of developing and growing an understanding of the data (Bradbury-Jones et al 2010).

As has been discussed, the principles of the Hermeneutic Circle and investigator reflexivity have been an integral part of the design and conduct of the study. This has been supported through a number of practical strategies and processes that created the opportunity for peer feedback on my approach to the analysis and interpretation of the data:

- *I have two A4 journals charting my progress through this study with notes on observations, thoughts and feedback from my own reflections, feedback from supervision and questions that I have been asked when either formally or informally discussing the study.*
- *Being a member of a Doctoral Action Learning Set at Northumbria University*
- *Presenting at an internal lunch time Phd seminar at the University of Leeds*
- *Invited to attend and discuss my research to the second cohort of Northern Leadership Academy Research Fellows*

These strategies have all been very useful. However, on reflection, I think it would have been helpful to have spent some more structured time reflecting on my experiences as a

nurse and facilitator of leadership courses in relation to each of the emerging themes to more rigorously examine how that may have influenced the data interpretation. This type of reflection is not unusual, the literature (Koch 2006, Draucker 1999) on phenomenological research would suggest that it is a challenge to recognise and capture all relevant insights and report on their influence on the data analysis process.

4.1 Data analysis - Stage One: Emergent Themes

This section shows that following numerous readings the data was coded and then gradually collapsed until from the first round of one:one interviews there were Nine emergent themes, each with a number of sub themes and key words (see table 6 below).

Table 5 –Emergent Themes

Main Theme	Contributing sub themes
<p>1. Types of decision</p>	<p>Operational – patients, staff, environment, givens/directives, promoting safety and removing danger</p> <p>Strategic – Advising and Influencing</p> <p>Clinical - Specific Clinical Interventions, Bed Moves, Clinical Standards, Ethical Issue</p> <p>People related decisions - Patients, carers, staff (within the patch), Other staff in the organisation, people external to the organisation</p>
<p>2. Time frames</p>	<p>Urgent, Planned, Opportunistic</p>
<p>3. Advising</p>	<p>Modern Matron – credibility, competence, confidence</p> <p>Senior Manager – Willingness to seek MM advice, how early involve the MM, Own level of expertise, Expectations of the Modern Matron role</p> <p>Organisational Culture – Expectations of MM role,</p>

	Support for a MM voice,
4. Influencing	<p>Modern Matron – confidence, competence, credibility, proactive, interest in strategic issues, view of MM role – operational v strategic</p> <p>Senior Manager – leadership/management style, confidence in the MM, view of the MM role overall</p> <p>Organisational Culture – Expectations of the MM role’ Acceptability of influencing upwards, Open to active participation of MM</p>
5. Supporting factors	<p>Personal credibility of the MM</p> <p>Knowledge of the organisation</p>
6. Hindering factors	<i>Senior Managers</i> – relationship between MM and the manager, occasionally individual manager not involving a MM
7. Attribute of the Modern Matron	Personality, Experience, Networks, Willingness to ask
8. Useful Training	Leading an Empowered Organisation (LEO), Flexible Thinking, Critical Incident Training, Leadership Effectiveness Analysis (LEA), Trust Preparatory Modern Matron workshops, Degree Studies, Post Graduate Diploma Studies
9. Modern Matron Decision Making Approaches/Strategies	Logical approach, knowledge expertise, Use procedures, Stop and think, Reflect on decision taken, Be willing to change decision, Phone a friend, Consider alternatives, Consider similar situations

To demonstrate the process of analysis and data collapsing that was undertaken, one of the above themes from table 5, ‘types of decisions’ is specifically focused upon. Using participant quotes to illustrate how it developed through analysis of the transcripts, this theme is discussed in more detail.

4.2 Types of decisions

Clinical related decisions - Decisions relating to a named patient. They might be about a specific clinical intervention, readiness for discharge or for moving to a different bed within the hospital. Whilst the latter could potentially be viewed as an operational decision, it has been included in clinical decision making because the MMs identified these decisions as a case by case decision, driven by the clinical need of the patient and not the operational needs of the Trust. A consistent theme of the decision making scenarios regarding clinical issues was that the MMs generally found this to be the easiest type of decision to make.

- “I mean its easy to make a clinical decision because we have got lots of clinical background” (MM9.9)
- “So clinical decisions are not hard because you know you have got to do something, you can’t just sit back” (MM 9.10)
- “Clinical decisions are easy, because you just know” (MM9.13)

Operational related decisions - Decisions relating to the day to day running of the service that involved patients, staff, the environment, implementation of national directives and local Trust decisions. Decisions often focused on safety and the removal or minimisation of a perceived danger. A number of the situations occurred when the MM was the ‘duty manager’ for the Trust and the operational issue may therefore relate to a clinical environment other than the one they were generally attached to. Other situations related to the clinical area (generally on both hospital sites) that they were responsible for.

- “I really like getting involved in incidents and complaints and really getting to the bottom of it” (MM9.16)
- “A lot of our decisions are around things like staffing issues, complaints management, bed decisions and stuff like that.” (MM5.1)
- “Risk management, I just love all that because risk management is not something that I have consciously known I’ve done in the past” (MM9.16)
- “I think there are hard decisions, particularly in this role about financial

implications and things.” (MM8.7)

- “I have day to day responsibility for the day to day management of the service on both sites. The budget is just short of 4 million pounds on each site and that is totally my responsibility to manage and take decisions” (MM8.1)

Strategic related decisions

Decisions requiring the MM to think ahead and to consider longer term issues and the broader picture when making decisions. Typically they often involve advising senior staff about the implications for clinical and professional practice and the need or desire to influence decisions regarding service developments.

- “I’ve done things about thinking how services develop and look towards the future and I think developing that thinking and foresight helps you to make the difficult decisions that you have to make now” (MM8.6)
- “We have to look at how a decision then affects how we plan for the future, how we are going to communicate with others and how we are really going to sort of learn from what has happened to then make plans to stop things happening again.” (MM6.1)
- “I think it is important to have an awareness of what is going on in the Trust. There is a lot of work going on around how the whole health service is changing. “You have to think differently from how you did.” (MM5.8)
- “Most of the strategic stuff that I get involved is because I bang on doors and say ‘I want to be involved. Please can I be involved?’” (MM 5.21)
- “You need to see things at different levels within an organisation as they influence why and how you make decisions.” (MM8.15)
- “We had meetings with the seniors, the managers, - there was myself and five other people involved in deciding on how many beds we could reduce by” (MM6.1)

People related decisions

These situations typically involve decisions that either have a clear impact on an individual or require the MM to make decisions regarding how best to approach someone who they perceive as a 'difficult person.'

- "I think hard decisions are around people and their attitudes. You know, when you have got a particularly difficult member of staff. What may have worked elsewhere doesn't necessarily work this time. Generally I think it is the people side of things that make some decisions difficult." (MM8.5)
- "But it was just about somebody, eventually, along the line making a decision and supporting staff really" (MM8.11)
- "There was a lot of the team that I knew would swim, even if I threw them in the middle of the sea, they would survive. Then there were those that I knew wouldn't. The 'one to ones' became very difficult you know, the comments of 'why are you doing this to me?' (MM6.5)
- "That was very difficult and she [member of staff] wouldn't listen to me. In the end I just had to apologise that I'd upset her, but I'd felt I'd made the right decision and that we were not going to be able to agree on it." (MM7.9)

4.3 Analysis of the emergent nine themes

Each of the emergent themes at Stage One of the analysis was determined through the same process of analytical refinement as described in section 4.2, 'types of decisions.' There are some sub themes such as credibility, competence and confidence which feature in more than one of the primary themes. These were identified as requiring further exploration and discussion during the second stage of 1:1 interviews with each of the MMs in order to establish a more in depth understanding of what these terms meant to the MMs and their relevance to leadership and management decision making. The nine emergent themes (Table 6), reflect the content of the data and include the types and the context of the leadership decisions that the MMs described. It also

highlights the range of strategies that the MMs used to help them with the different decision making scenarios they faced. However, the analysis had resulted primarily in a list of descriptive features of MM decision making. Therefore the second stage needed to contribute more depth of understanding of the MM experience of decision making and which of the features they considered to be of most importance.

This is consistent with a phenomenological approach of seeking to understand the lived experience of study participants. There was a need to identify if there were more specific factors that enabled, helped or hindered these MMs to take leadership decisions in relation to strategic, operational, clinical and people related situations and to be able to influence and advise decision making situations in the way that they described. These factors might be tangible as in specific steps or actions or more conceptual, but equally important for driving the attitude and behaviour of both individual MMs and the organisation as a whole in relation to decision making.

Could I have collapsed the data further? Possibly, in regards to the feedback on influencing and advising, but I had planned for a second interview with the MMs to facilitate a process of co-analysis and co-construction of meaning and decided to let the MMs directly comment on the emerging themes. Then, where necessary, for them to further refine them rather than me.

4.4 Data analysis – Stage Two

Each participating MM was invited to a further 1:1 meeting to discuss the emergent themes. The first stage analysis was presented back to the MMs in two ways to increase the likelihood of them absorbing and engaging with the data analysis and so maximising their input during stage two of the analysis. They each received a copy of the Stage One analysis in the form of a Mind Map™ (appendix four and discussed in the methods chapter) identifying each of the emergent themes and their related sub-themes and a written summary providing a slightly more detailed interpretation of the themes. This

approach was chosen as Mind Mapping™ is recognised as a useful method for displaying information (Buzan 1993) as:

- it is possible to present a lot of information in a structured manner on one page and show how the themes have emerged and relate to one another
- the information is presented in a non-hierarchical manner and therefore it is possible to avoid inadvertently implying something is more important by putting it first, as in a more traditional list approach
- the style of presentation is pictorial in nature and uses colour, which for many people is more easily absorbed than a more traditional text based approach.

These initial findings were used as a focus for discussion during the second interview and to enable the MMs to comment on how well the findings reflected their experience' (Cader et al 2009; Paterson, 2001). In general, they were all in agreement with the interpretation of the data and happy to validate the emergent themes. They confirmed that the lack of issues under the 'hindering factors' theme was an accurate reflection of their experience. This failure to identify 'hindering factors' will be an area for further exploration in Chapter Six. The MMs also confirmed the positive experience of the organisation culture being a significant enabler for them in regards to decision making. This will be expanded further during chapters five and six.

Their main point of clarification was that they considered 'advising and influencing' to be generally the same behaviour. It was the context that was different. The feedback suggested that 'advising' was something that MMs were more likely to do with an individual or a group that were generally at either a similar position (across disciplines) or lower in the organisational hierarchy and therefore there was a greater expectation that the MM's advice would be followed or implemented. Whereas 'influencing' was seen as happening with more senior staff or people outside of the organisation – individuals or groups who did not necessarily feel obliged to follow or implement a recommendation and had the authority to choose not to.

The MMs were then asked to be more specific in regards to what they considered to be the critical factors for them in making leadership related decisions. With all research , how you ask questions, the style, nature of content and context can all influence the response that a participant gives (Oppenheim 1992). To minimise this influence, each MM was asked the same question. “Please identify up to ten key words/themes on the ‘Mind Map’ that you believe are most relevant for you in making leadership and management related decisions.” They were given a maximum number to encourage them to discriminate and prioritise those words that they considered to be most relevant to their decision making. The words circled then informed the questions during the second 1:1 interview where each MM was invited to describe what they understood the words to mean.

It could be argued that the presentation of the data in the following table looks quantitative in style as it records frequency. However, the primary intention was to inform the questions for the second round of 1:1 interviews. Each MM was asked about the words they had circled in order to seek a greater understanding of their individual experience of and approach to decision making and what they perceive to be the important factors that help them.

Table 6: Summary of themes circled by Modern Matrons

Modern Matron									
Word/Theme Circled	1	2	3	4	5	6	7	8	9
Credibility of the M. Matron	√	√	√	√	√	√	√	√	√
Reflection	√	√	√	√	√	√	√	√	√
Organisational Culture	√	√	√	√	√	√	√	√	√
Authority to make decisions	√	√	√		√	√	√	√	√
Modern Matron Competence	√	√	√		√	√	√	√	
Networks			√	√	√	√		√	
Senior Managers leadership style	√		√	√		√			√
Confidence	√	√			√	√			√
S. Manager confidence in MM	√	√		√		√		√	
Leading an Empowered Org (LEO)	√		√			√	√		
Consider similar situations		√						√	√

Critical Incident Training					√		√	√	
Willingness to ask			√	√					√
Personality of MM		√		√			√		
Knowledge of organisation					√		√		√
Operational	√			√				√	
Time							√		√
Logical approach		√							
Be willing to change a decision				√					
Phone a friend					√				

The above table provides some very useful data in regards to providing a consistent approach to establishing the areas for further questioning during the second interview. I had to be careful not to conflate frequency with importance. Therefore, although there are three themes: credibility of the modern matron; reflection and organisational culture that were identified by all of the Modern Matrons. This table does not indicate if any one of those themes was of significantly more importance than the other two. What it does indicate is that there is a consensus that they are relevant to decision making and that as they were identified by all of the MM, they will be discussed more frequently during the 1:1 interviews than those themes that were only identified by two MMs. It is the analysis of their descriptions in the second interview that informs the level of importance.

No-one circled less than 10 themes – although there was the option to circle less, implicit in the question was that they would identify ten. This could have been addressed by giving a minimum and maximum number of themes to identify. The instructions could have read, ‘to circle between five and ten themes.’

Whilst table 6 demonstrates that there was some variation between the MMs, there was also a significant level of consensus. Three themes were circled by all of the MMs - *credibility of the Modern Matron,* *‘reflection’* and *‘organisational culture’*.

These were followed by *‘authority to make decisions’* which eight of the nine matrons circled and *‘modern matron competence’* which was highlighted by seven MMs. A further four themes were identified by five MMs including: *networks, senior manager’s*

leadership style, confidence and senior managers confidence in MMs. The organizational development course, *Leading an Empowered Organisation* was identified by four people and the remaining ten themes were identified by three or less of the participating MMs. These latter themes, that were only ticked a few times eg: logical approach, be willing to change a decision and phone a friend appear to be idiosyncratic decision making strategies that only some MMs use or consider to be important. Table 7 reflects both the individual MM data whilst also providing a summary picture of which themes were cited more frequently and were therefore maybe of greater importance.

Second interviews

Whilst some interpretation of the relative importance of different themes could be inferred from the frequency with which they were cited in table 7, to be consistent with understanding the data from the perspective of the MMs, it was necessary to engage in further discussion in order to co-create the meaning.

During the second round of 1:1 interviews, the MMs were asked to be more specific about the ten themes that they had circled on their mind maps and to explain from their perspective the meaning of those words. Field notes were taken to capture the key words that the MMs were using to describe their choices.

To illustrate this process, included is a copy of the completed Mind Map and accompanying field notes (typed up for ease of reading) that were taken for Modern Matron 1. The other eight sets of mind maps and field notes are in Appendix Five.

MMO

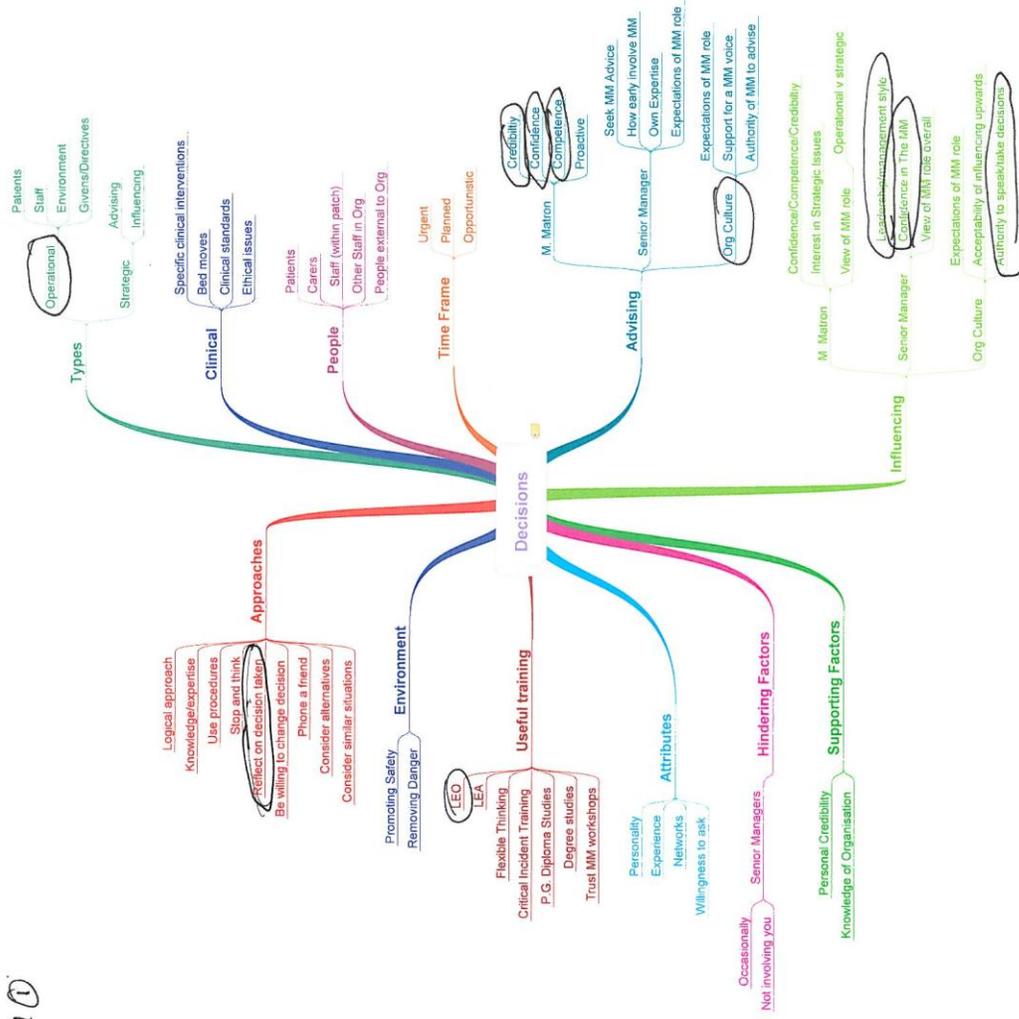


Figure 8: Mind Map from Modern Matron one

Table 7: A selection of notes from second interview with Modern Matron one

Word/Phrase circled	Field notes of description
Credibility	I've worked here a long time. I know many of the consultants and senior managers when they were juniors. People know me, how I work, that I am good at my job. I can do the job and feel that I am trusted to do the job.
Reflect on decisions	Of course its important. Its how we learn from our mistakes. I should maybe do it more often. Its about stopping and thinking and being more honest with yourself.
Organisational culture	Strong ethos of staff involvement and people being accountable for decisions. LEO is a big thing. Everyone but everyone has to go on LEO. Its good, I like the culture. I'm glad its spreading to the other site, will help join us up better.
Authority to advise/take a decision	Freedom to get on and do as I think as an experienced professional nurse needs to be done. It has boundaries, usually financial ones. Means more responsibility, but so long as you know what you are doing that's OK.
Modern Matron competence	Means being capable, knowing what we have to do and being able to do it. Having confidence in your abilities.

The field notes from the second round of interviews provide additional depth and insight into the relevance of the various terms identified by the MMs from the Mind Maps. Below is a summary of the field note descriptors for the twenty terms.

Table 8: 'Summary of theme descriptors'

Theme	Descriptor
<i>Credibility of The Modern Matron</i>	<i>I can do the job and feel I am trusted to do the job. We know what we are doing. Earned it though lots of years of experience. People ask us our opinion. Managers will listen to us. Gives us power and authority which is useful in tricky situations. About trust</i>

<i>Reflection</i>	<i>Stopping and thinking about what I am doing. Thinking could I/should I have made the decision differently? Taking time out to press the 'pause' button. Part of being a professional nurse. Means being honest with yourself and asking for feedback from others and then accepting it.</i>
<i>Organisational culture</i>	<i>Empowerment, everyone but everyone has to go on LEO, No blame culture, Expected to get on with it. Its generally a nice atmosphere and people get on which makes it easier to make decisions and work through things that might be difficult. Devolved decision making. Encouraging staff to fulfill their potential. About trust and respect and everyone doing their bit.</i>
<i>Authority to make decisions</i>	<i>Can get on with the job, Backed up by line manager/organisation. Frustrating if you need it but haven't got it as it can slow things down. Helps make me more credible as it says I am trusted to do the job</i>
<i>Modern Matron competence</i>	<i>Expertise, experience, competence to do the job, Have got the knowledge and skills. Have a lot of years of experience. Know what to do when, who to call. About being 'fit for purpose'. Competence gives you credibility which gives you authority</i>
<i>Networks</i>	<i>People I can ask formally or informally for advice or information. Useful for making contact with people. Helps me to know what is happening. Can use them to indirectly make something happen or get some information somewhere. Helps me stay in touch with the bigger picture</i>
<i>Senior manager leadership Style</i>	<i>Can make work of MM easier or harder. About how much/little they are willing to let go of/devolve to the MM. About how much authority they will let go of. Need to understand work with their style to get the best out of them</i>
<i>Modern Matron confidence</i>	<i>About trusting your abilities and inspiring trust in others. Need to have confidence your manager will support you. Confidence grows with experience and a supportive org. Part of being competent – knowledge and skills is not enough, need confidence to use them. About believing in yourself</i>
<i>Leading an Empowered Organisation (LEO)</i>	<i>Leo is good – provides a solid foundation for both individual staff and wider org behavior. Core staff development course that everyone goes on. Bout empowerment and trust and being accountable. Provided some techniques and strategies that as a MM I could use with staff to get the best out of them.</i>

Senior manager confidence in Modern Matron	<i>Someone having confidence in you feels very motivating. More likely to be asked your opinion early on. High trust adds to your credibility with other staff. Low confidence from manager would feel very under-mining</i>
Consider similar situations	<i>Very few situations are unique. Need to think laterally. Just helps me as a strategy when I am not sure. Looking for similar principles can help provide some ideas as to how best to make the decision.</i>
Critical incident training	<i>The structure and systematic approach are really useful. Doesn't tell you what to do, but provides clear guidance. You can use the framework when making other types of complex decisions. Gave me confidence to tackle bigger or more contentious issues</i>
Willingness to ask	<i>Goes back to networks, having people you can ask for help/advice. You can get another perspective, help get clarity on what you should be doing. Need to know when to ask. There is a lot of credibility in admitting you don't know and asking for help. Can be easier sometimes to ask networks rather than immediate colleagues.</i>
Personality of the Modern Matron	<i>Personality can't help but influence decision making – it's a reflection of who you are and so impacts on how people presents issues to you etc etc.. I know I am more direct than some – others give a lot more explanation. My natural decision is to make a decision and move on</i>
Knowledge of the organisation	<i>I know peoples' personalities, foibles, maybe things that they are passionate about and so make decisions accordingly to get the best out of them. Sometimes it is easier to make decisions when you have been in an organisation a while, you know its history, custom and practice and the unwritten rules that apply.</i>
Operational	<i>Everyday things requiring decisions that are fairly easy to take as it is about drawing down on experience as a clinician. You know the ins and outs and likely consequences of operational decisions. The Modern Matron role means that generally we have the authority to take operational decisions. Operational decisions are easier.</i>
Logical approach	<i>Putting in a step by step process that makes sense to everyone.</i>
Time	<i>How much time you have influences the nature and quality of the decision. Time influences how much information you can get to make a rounded/informed decision. Need to be able to assess when to give a situation more time and when to give a quick response and deal with the issue.</i>

Be willing to change a decision	<i>Sometimes you get more information – or you stop and think and realise things weren't quite so straight forward. People respect you if you admit that maybe you got it wrong and you want to change your decision.</i>
Phone a friend	<i>Having people other than your manager who you can ring for advice/information re a decision. It isn't possible to always be confident and competent to make a decision – having a network of friends is really helpful</i>

4.5 Outcomes of Stage One and Stage Two Data Analysis

The on-going process of content analysis and refinement of the data was continued with the additional data collected during the second stage of analysis using Lindseth & Norberg's framework. The data from stage two had more boundaries as it was directly related to the twenty themes that emerged from the stage one analysis. A similar process of data immersion was adopted by reading and re-reading the data several times to begin to identify the themes that were pivotal to MMs' leadership and management decision making. The original transcript data was then re-visited and re-read to establish whether the themes emerging from stage two were consistent with and could be traced back and connected to the more in-depth first round of interviews. This process of distillation resulted in six themes:

- Theme 1 - Approaches to Decision Making
- Theme 2 - Credibility
- Theme 3 - Power
- Theme 4 - Authority
- Theme 5 - Organisational Culture
- Theme 6 - Reflection

These themes are all well supported within the study transcripts, some overtly and others, such as 'power' and 'reflection' at a more subtle level initially. Unlike a number of other themes, these six all grew in importance through the co-creation process with the MMs and the second round of interviews.

In order to stay connected to the original transcript data which is where the MMs actually described the decision making scenarios that they chose to highlight, it was important to cross reference the themes back with the raw data. This is particularly true for 'power' to ensure that it was present in the original data, even if its significance was only established during stage two of the analysis. This process is illustrated in Appendix 7

4.6 Final six themes from the analysis

Below are the final six themes resulting from stage one and two analysis with a short descriptor for each one.

Theme 1 - Approaches to decision making captures the numerous small themes that emerged during stage one analysis such as phone a friend and adopt a logical approach that reflect individual MM approaches to decision making. Whilst these small themes were all cited by three or less people in table 6, they are fundamental to the research question of 'what are the decision making strategies of MMs?'

Theme 2 – Credibility was, following the stage one analysis, a component of three other themes, advising, influencing and supporting factors. Its relevance was cemented during the second stage of analysis when all nine of the MMs identified 'credibility' as one of their ten priority word. The field notes that were then taken during the second interview re-enforced the importance of 'trust' in relation to the role of credibility in decision making. They also demonstrated that there is an inter-relationship between credibility, authority and power which will be discussed later.

Theme 3 - Authority to make decisions was identified by eight of the nine MMs during the process of identifying the ten most relevant words and phrases in relation to decision making (table 6). During the second round of interviews, the manner in which the MMs defined the term included reference to organizational culture, competence in the role and confidence of the senior manager in the MM to be able to do the job and take appropriate decisions.

Theme 4 - Power grew in importance during the co-creation process with the MMs. It was not a specific theme that was identified during the stage one data analysis and therefore it was not available as a theme for validation or prioritisation during the stage two analysis. However, whilst taking field notes during the second round of interviews, the term 'power' arose on a number of occasions in relation to the MM's description of authority, credibility and organizational culture. Whilst there is a connection with these themes, it is sufficiently distinct to be addressed separately. On re-reading the literature and the original interview transcripts, the concept of 'power' is relevant and has a presence in the data. It appears to be a by-product or outcome of the previous themes and therefore less tangible and initially more difficult to identify, yet the literature would suggest very important.

Theme 5 - Organisational Culture was initially identified as a sub-theme within advising and influencing and itself had further sub themes of 'expectations of the Modern Matron', 'support for a Modern Matron voice', 'authority of a Modern Matron to advise' 'acceptability of influencing upwards' and 'authority to speak/take decisions.' Its importance was re-enforced during the stage one validation process and second stage of analysis when all nine of the MMs chose 'organisational culture' as one of their ten priority words that were important for decision making.

Theme 6 - Reflection was a theme that was highlighted by each of the MMs during the process of validating the stage one data analysis and the second round of interviews. During stage one data analysis, *reflection* was a sub theme of *Approaches to Decision Making*. However, the level of importance accorded to it by the MMs during the second

stage of data collection and analysis and the supporting evidence from the original transcripts elevated it to the level of a primary theme.

Chapter Five – Findings

Introduction

This study addresses two research questions. The first is, 'What are the decision making strategies of MMs in relation to leadership and management issues?' Theme 1, Decision Making Approaches, which emerged from the data links directly to this. The second research question is, 'What are the influencing factors that help or hinder that process?' Five themes emerged from the analysis and help to provide a context for the MMs' use of specific decision making approaches. These were:

- Credibility
- Authority
- Power
- Organisational Context
- Reflection.

This chapter presents the findings in two parts, addressing each of the research questions in turn. Each of the emerging themes is examined, drawing upon the study data, using participant quotes as appropriate, to illustrate the relevant theme in the context of the role of the MM. This is against a backdrop of relevant cross-referencing to the literature review. Whilst the themes are presented individually within this chapter, they are not unrelated or distinct. In many instances, one section of data transcription can illustrate two, three or more of the emergent themes.

5.1 Question One - The Decision Making Approaches of Modern Matrons?

This section presents the findings under the following broad headings:

- Heuristics
- Specific Decision Making Approaches
- Decision Making Frameworks

The analysis highlighted two main areas within the data, related to the theme of decision making approaches. The first of these is aligned with the literature definition of the concept of heuristics, those underlying principles and values that guided and informed the MMs' beliefs and therefore their approaches to different decision making scenarios. The second area relates to the specific decision making approaches or strategies that the MMs recognised they used and often consciously applied when faced with decision making scenarios. These findings are then considered in the context of recognised steps within established decision making frameworks.

5.1.1 Heuristics

Heuristics are an integral facet of how people manage the myriad of decisions that they are faced with every day (Bazermann 2002). They generally operate at a subconscious or implicit level, influencing the manner in which a person sees, hears, experiences and therefore responds to the situations that they face.

This was clear in a number of the interviews where the MMs expressed strong personal beliefs that then influenced aspects of their decision making. These included:

- Essence of good nursing
- Patient care, ethics and safety
- Nature of leadership and management

Essence of good nursing:

There were a number of heuristics expressed that were clearly grounded in the MMs' extensive experience of working as senior Registered Nurses. They reflected their beliefs about core values that then drove their decision making when managing staff in relation to direct patient care and also in regard to the management of a nursing team so as to optimize best practice.

I have always been driven by patient care, that's been my force throughout (MM 5:15)

I have always taught every nurse that you treat every single patient as if it were one of your own, that's my goalpost. (MM 1:13)

One of the first things I wanted to do after I had got to know them a little bit better was 'off duty' because I am a great believer that once you get the off duty right, it helps everything else (MM 2:1)

I very much feel that getting quality care for your patients, you do it through your staff and you do it through training. Happy staff, you get that through good off duty, [team] being comfortable in their job, getting training opportunities and just having a happy Unit where people are spoken to with respect." (MM 2:14)

"I suppose I have the old fashioned belief system that a nurse's uniform is about being professional, about giving out those standards to people. You know, what you see is what you get. And if somebody [a nurse] can't get themselves up and dressed properly and looking smart in the morning, then you know, the care that they give may well be in the same vein" (MM 4:24)

"When somebody throws something at me, the first thing that goes through my head is 'is that right for the patient'" (MM 5:9)

Patient care, ethics and safety

When discussing a specific incident in which the police had been called to remove someone, the MM concerned was very clear on two different heuristics as to why she had followed the process that she had. The first heuristic was that staff safety was paramount an issue that she repeated in a number of ways

“From a staff safety point of view” (MM 1.2)

“Potentially I could have put staff in a dangerous position if I hadn’t [called the police]” (MM 1:3)

“We’ve fought it and we were really proactive in making sure change came about it was getting over the patient safety aspect” (MM 5:8)

The second heuristic relates to ethics and the nursing code of conduct in relation to decisions, such as what can and should be divulged regarding a patient’s care. As a result, despite being under pressure by a hospital visitor to explain her actions in having a patient removed by the police, the MM’s belief in the importance of confidentiality meant that she absorbed the criticism and angry comments that she was receiving.

“So I explained to this lady that for ethical reasons I couldn’t discuss the case with her. To which she said she would make a complaint to the Trust” (MM 1.2)

Another MM was driven by the importance of ‘patient safety’ when trying to persuade a group of the need for a change in process.

Nature of leadership and management

Heuristics can also lead to ‘knee-jerk’ or reactive decision making. One MM4 described a scenario involving uniforms. *“One of my biggest issues and they know it is, because they quoted me, saying ‘we know what you are like with uniforms, but can we ...?’ My initial reaction was ‘no’. Then I looked into it further* In this instance, the MM recognised

that her strong beliefs about uniforms and how and where they should be worn might be clouding her ability to make a considered judgement regarding the situation that had been brought to her attention.

In contrast, a different MM described a different and more transformational leadership style where she felt strongly that in her practice and sphere of responsibility, *“People are spoken to with respect and they are not shouted at and nobody puts anybody down Its having that ethos on the Unit that you treat people with respect”* (MM2.14)

The impact of a strong belief about the ‘right way’ to lead people and make decisions is captured by one MM who said *“You know I would just love to go in sometimes and say ‘this is what we are doing and don’t argue with me because we are doing it, end of story.’ But, you can’t, you have got to sit down and you have got to negotiate with them and you have got to ask them their views. You have got to get their input because if you just tell them they are just not going to do it.”* (MM8.12). Whilst on occasions, this Matron clearly found it frustrating to involve people in decisions that she felt it would be quicker for her to just make and implement. She also expresses a belief about the importance of shared decision making for the successful implementation of decisions that is strong enough to over-ride the occasional frustration.

5.2 Specific decision making approaches

The MMs generally required some prompting during the first interview to provide explanatory detail on how and why they took the decisions they did in the situations they chose to describe. These prompts took the form of phrases such as “tell me a bit more about how you made that decision” and “why were you comfortable that was the right decision?” The additional depth these prompts elicited provide some insight into the range of strategies that the MMs recognized they used.

No individual MM listed all of the strategies and some only identified one strategy as being the one thing that they consciously do when faced with a difficult decision making

situation. The following is a list of strategies that emerged when the MMs were describing decision making scenarios during the first round of interviews.

Table 9: Range of strategies identified by individual MMs

Strategy	Modern Matrons	Strategy	Modern Matrons
Adopt a logical approach	1,6,7	Using knowledge and expertise	1,2,3,7,9
Use existing procedures	1 & 4	Stop and Think	3,5,7,8,9
Reflect on decision taken	2,7	Be willing to change decision	8
Phone a friend	3,7,8,9	Consider Alternatives	1,7,8
Consider similar situations	1,2		

Below are some excerpts from the transcripts that illustrate and support these different decision making approaches that have been highlighted. They are a mixture of direct use of the terminology, naming or identifying a particular approach and short descriptive scenarios that illustrate the approach in action.

5.2.1 Adopt a Logical Approach

Some of the MMs make reference to consciously thinking a situation through and taking a more step by step approach

“I would try and follow things through quite logically ... I think a logical progression, making notes and just getting things so that you haven’t missed anything (MM.7:4)

“You have got to detach yourself and you have got to be logical.” (MM 6.7)

There is reference to training that the MMs all received in how to conduct investigations which has undoubtedly influenced some of the Modern Matrons in their thinking and approach and on occasions fostered a more logical and rational approach.

“I’ve gone on an Investigation Course for Leaders within the organisation. So that makes you kind of think not to dive in and think ‘ah this is it’ and to think in a logical manner from the time of arrival and look at it as a whole picture, almost process mapping really” (MM 7:4)

“The Advanced Investigations Course helped me enormously” (MM 1:13)

5.2.2 Using Knowledge and Experience

There are some general reflections on the impact of experience on how the MMs approach decision making situations.

“I suppose because of your experience that you have got, that you have been a nurse for a long number of years, you have got the judgement.” (MM2.6)

“You can call on past experiences ... I do look back to situations that I have been involved in and how I felt and I have just called on my past experience.” (MM3.12)

“I suppose that’s maybe experience and not jumping to conclusions and looking at the whole picture as opposed to maybe just the facts that you are initially presented with” (MM 7:3)

“ I think because I knew it had worked before and I was familiar with it and I knew all the ins and outs and the downfalls because I have got experience of it over the years” (MM 2.:4)

“I think my knowledge of the hospital, staff and patients and which wards do what.” (MM 1.4)

“A clinical decision is easy, because you just know.” (MM9.13)

5.2.3. Use Existing Procedures

There was a mixed reference to the role of policies and procedures in decision making ranging from an acceptance that they were there and had to be abided by to whether they were a help or a hinderance to the MMs.

“At the end of the day, we do have a Trust policy and people can’t just go native and do their own thing.” (MM4.24)

“We have got a zero tolerance [policy] that is used to protect staff. That internal agreement that we will contact police and act on patients being violent sort of helped me make the decision.” (MM 1.3)

In this instance, the objective was two - fold; to keep staff safe and to ensure that organisational guidelines were followed.

In another situation, the MM recognizes that some of the decisions that she finds more difficult to make are those relating to policy targets. In particular, four hour waits in A & E, where she feels that some clinical decisions are being driven by meeting the target first and the patient’s clinical need second.

“Targets can be frustrating What I struggle with sometimes is the fact that our decision making is driven by targets and sometimes it can be unsafe.” (MM 1.6)

5.2.4 Stop and Think (about the wider picture)

The importance of pressing the ‘pause’ button to allow more information to be gathered and to provide the MM with the ‘space’ to stand back, reflect and look at the bigger picture is a common theme for a number of the MMs.

“Very often I find because I am driving between sites, that time when I am sat in the car on my own, I can think about things.”(MM 3.3)

“I’d say now, that since I have been in this role, I have changed how I make decisions. I used to be very reactive as in ‘why are we doing this?’ You know somebody would tell me something or a decision to be made and I could feel myself getting wound up and it would be ‘right, I’ve made my decision and that’s what we are doing.’ Whereas I tend to look at things more widely now. I tend to think things through a bit more and then I will usually have a more structured decision.” (MM 5:28)

“Well you have to weigh up everything. You have to look at what the decision is that you are going to be making and why you need to make that decision.” (MM8.5)

“I unthread it, I talk it through. I actually have people dotted around the place, two Sisters in particular who I get a lot from because they make me stop and think before I open my mouth sometimes.” (MM9.11)

“I spoke to the staff and kind of looked at the whole scenario and I still wasn’t getting any answers whatsoever so I took the investigation a little further It just didn’t seem to add up. So I went back and thought about it more and realized there were CCTV cameras covering that area, so watched them The lady had not been run over by a trolley, she had actually tripped and fallen herself..” “I suppose maybe that is experience, and not jumping to conclusions and looking at the whole picture as opposed to maybe just the facts that you are initially presented with.” (MM7.3)

5.2.5 Reflect on decision taken

This was an approach that featured strongly during the data analysis, particularly during the second stage.

“I think you just do it without thinking about it sometimes. But, if there are difficult ones to make, I like to mull things over I will go away and think about it and you are

thinking ‘have I done the right thing?’ ... was that the right thing to do and go away and think about it. I know if I am uncomfortable with something it really churns me up” (MM2.22)

“I do think I reflect, really learn, so that maybe if I could do things better, or if it has been a good way of dealing with things then to use those strategies again.” (MM7.4)

5.2.6 Be willing to change a decision

The following scenario is an account of a scenario that had happened a few years ago that had clearly resonated and remained with the MM as an important principle – that having made a decision it is important to remain open to the possibility of changing it.

“She came to me and said ‘can we trial them’ and I said ‘no’. It wasn’t until I saw the look on her face as she walked away and never said anything else to me, that I thought ‘well I shouldn’t have done that, I should have asked.’ I think at the back of my mind I was very new in post and there was perhaps a little bit of ‘why didn’t I think of that one?’ I let it go a week or two and then I said to her ‘you know what you said to me before, why don’t you cost it all up and show me its going to make a difference.’ And we are still using them today actually.” (MM8.15)

In this one scenario, the MM has also used a range of other strategies, including: knowledge and experience and taking time to reflect on the decision that was made. This demonstrates both the interconnectedness of the strategies and that decision making can involve the use of multiple strategies.

5.2.7 Phone a Friend

This approach demonstrates the importance of networks and knowing a range of people who can be approached when advice, support or confirmation is required to support an individual in their decision making.

“So I talk it through. I actually have people dotted around the place and two Sisters in particular, who I get a lot from because they make me stop and think before I open my mouth sometimes” (MM9.11)

“I enlisted the help of a friend” (MM 3.6)

I do like to ask other peoples’ opinion. I think you should do, especially if the decision is far reaching.” (MM7.9)

“I rely on the other Modern Matrons quite a lot [with decision making]. I rely on them a lot for their help

5.2.8 Consider Options

This strategy has evolved during the study from the initial term ‘consider alternatives’ to ‘consider options.’ This is a more accurate reflection of the transcript data where the MMs describe identifying a few different solutions and is consistent with the literature where Adair (2007:28) emphasises the importance of the word ‘options’ as opposed to ‘alternatives.’ “An alternative is literally one of two courses open. Decision-makers who lack skill tend to jump far too quickly to the either-or alternatives. They do not give enough time and mental energy to generating at least three or four possibilities”

“I usually try to think about a problem and usually can come up with two or three scenarios of which way I can go with it”. (MM 1:3)

“I would have a look at the problem, think of a few solutions and pick the best one.” (MM8.5)

One MM reflected on one particular decision that she had found difficult and that whilst she was comfortable that she had made the right decision, she has not anticipated the outcome that arose from her decision. This is a good example of Adair’s (2007,p.3) concept of ‘latent consequences’ – an unexpected outcome or impact of a particular decision.

“You live with the decision, but I think it’s the outcome of it that you don’t always anticipate.” (MM7.8)

5.2.9 Consider Similar Situations

There was a recognition within the interviews, that one strategy the MMs used was to consider (or possibly reflect) on situations they had previously experienced that were similar in nature in order to help them decide on an appropriate course of action.

“I knew it had worked at [the other organisation] and I was familiar with it I have got experience of it over the years.” (MM2.4)

“I think that you are always going to come across a problem that you have not encountered before. But I think you tend to rely on things that may have been a similar experience or somebody else’s experience that they have shared with you – you think – hang on a minute, ‘I can remember what they did with this’” (MM 1.26)

In summary, a total of nine decision making strategies were identified during the interviews with the MMs as techniques they use to help them when making leadership and management related decisions. However, these strategies were not overtly linked to a model or framework. Instead they appear to have been stand alone approaches according to individual MM preference and experience.

5.3 Decision Making Frameworks

Whilst the MMs might not have made any explicit reference to knowing about or consciously using a recognised decision making model or framework, both the decision making strategies they identified and the decision making scenarios they chose to describe clearly illustrate approaches that would be viewed as indicative of either a

intuitive or rational approach to decision making. The findings are also significant in regards to intuitive and rational decision making steps that the MMs did not describe using.

The following table displays these findings, illustrating the connections (or lack of them) between the MMs decision making strategies and those associated with either an intuitive or rational model of decision making.

In the left hand column, only two of the six stages, 'similarity recognition' and 'skilled know how' within Dreyfus and Dreyfus's Intuitive model of decision making correlates with strategies, 'consider similar situations' and 'using knowledge and expertise' described by the MMs.

In the right hand column only one of the six steps, 'generate feasible options,' identified by Adair's Rational model of decision making correlates with the strategy, 'consider alternatives' described by the MMs.

There are a further six strategies described by the MM that can be seen as leaning towards (shown by the direction of the arrow) a rational or intuitive approach but not sufficiently close that the findings can be linked to a specific step within either approach.

A rational and intuitive decision making framework were used as one means of making sense of, presenting and discussing the emerging themes and not as a frame for informing the interview questions and generation of the data. The study was looking to establish an insight into MM decision making, not test out known decision making frameworks.

Table 10: Mapping out Decision Making Strategies

Intuitive Decision Making Steps	Strategies identified by the Modern Matrons	Rational Decision Making Stages
<i>Similarity Recognition</i>	<i>Consider similar situations</i>	
<i>Skilled Know How</i>	<i>Using knowledge and expertise</i>	
	<i>Consider alternatives</i>	<i>Generate feasible options</i>
	Stop and think	⇒
	Adopt a logical approach	⇒
	Use existing procedures	⇒
	Reflect on decision taken	⇐
	Be willing to change a decision	⇐
	Phone a friend	⇐
Pattern Recognition	None	Define the objective
Common Sense Understanding	None	Collect relevant information
Sense of Saliency	None	Assessing the risk
Deliberative rationality	None	Assessing the consequences
	None	Implementing and evaluating

The following section will look at those steps within the intuitive and rational models that are distinct from the strategies identified by the MMs. It will identify where there is evidence within the data to demonstrate that the MMs are using these strategies in practice, even if they do not themselves recognise or overtly identify that they are during an interview situation.

Intuitive decision making steps – (Dreyfus and Dreyfus 1986)

Pattern recognition	quote from Modern Matron transcripts
Spotting patterns emerging in the form of behavior or re-occurring problems	<i>"We knew that this was a pattern of escalation with her behavior" (MM1.2)</i>

Common sense understanding	quote from Modern Matron transcripts
Dreyfus and Dreyfus (1985) suggest that there are some things that are just obvious and that the decision making is about common sense not any particular expert knowledge or senior position within an organisation.	<i>"If the corridor is dirty you would get someone to clean it anyway. Which you would do, or I would like to think that you would do anyway, because that is just common sense. You don't need a Matron's title to be able to tell you to ask somebody if there is litter on the floor to pick it up and that type of thing". (MM 2:7)</i>

Sense of salience	quote from Modern Matron transcripts
This is about knowing what information and events (salient features) are particularly important in helping to make a good decision. It is associated with knowledge and expertise and knowing what is the right thing to do.	<i>"I think to some extent it is your gut feeling as well, that what you are doing is right." (MM 2.18)</i> <i>"When I heard that, alarm bells rang. I knew the best approach would be to go and talk to them, another phone call wasn't going to sort it." (MM.7.32)</i>

Deliberative rationality	quote from Modern Matron transcripts
Is associated with expert practice when a person intuitively recognises that	<i>I spoke to the staff and kind of looked at the whole scenario and I still wasn't getting any answer it just</i>

<p>they need to step back and look at the situation in a more structured and rational manner</p>	<p><i>didn't seem to add up (MM7.3)</i></p> <p>Went back herself to examine the area and get more detail and facts and uncovered the cause of the accident which was very different to the initial claims. As a result the Modern Matron reflected</p> <p><i>I suppose maybe that is experience and not jumping to conclusions and looking at the whole picture as opposed to maybe just the facts that you are initially presented with.</i></p>
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Rational decision making steps – (Adair1984)

Define the objective	quote from Modern Matron transcripts
<p>Being clear about the purpose of the decision and what is trying to be achieved in making the decision</p>	<p>There were no specific examples within the study data that illustrated whether the Modern Matrons specifically spent some time being clear about defining the objective or purpose of the decision to be made.</p> <p>There were examples of the Modern Matrons saying ‘<i>I knew what had to be done</i>’ and therefore inferring that they had defined the objective, but no clear scenario that would illustrate them either spending time defining the objective or recognizing that time should be spent doing that. One Modern Matron did address the importance of the other end of the process and that was ensuring that there was a clarity of communication re the outcome of the decision.</p> <p><i>“Its about making sure that people clearly understand why you have made the decision and being clear about how you communicate that decision-making process to other people so that they understand. (MM7.9)</i></p>

Collect relevant information	quote from Modern Matron transcripts
<p>Determining what information is <i>available</i> and what information is <i>required</i> in order to make a</p>	<p>There was a common theme of gathering information to help inform the decision making process</p> <p><i>“In most things you need to stand back and get your facts</i></p>

decision	<p><i>before you react.” (MM 5:22)</i></p> <p><i>“You’ve got to make hard and fast decisions, unpopular decisions, I think part of it is trying to get the full picture before you do sort of react.” (mm 5:23)</i></p> <p><i>“So I think a lot of it is knowing what is going on and knowing about why situations have occurred. If there are things underlying to it that can influence your decisions on why the situation has arisen. (MM 5:28)</i></p> <p><i>“Lack of information is always the biggest judgement call, which way you go and you just sometimes have to make that decision and then live with it, don’t you.” (MM 4:5)</i></p> <p><i>“So it was investigating really, trying to get to the bottom of what had gone on and what had happened ... I went off on a kind of fact finding mission really, to find out what had happened I think a logical progression and making notes and just getting things so that you haven’t missed anything.” (MM7.1-2).</i></p>
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Assessing risk	quote from Modern Matron transcripts
Assessing the context and surrounding circumstances such as knowledge, skill and past experiences	<p><i>“A lot of it I think is about knowing the staff that you have got and knowing what those areas are like so you are minimising your risk by doing that.” (MM 5:7)</i></p> <p><i>“From a staff safety point of view” (MM 1.2)</i></p> <p><i>“I based my decision on the fact the patient was known to be violent and aggressive we knew that this was a pattern of escalation with her behaviour! (MM 1.2)</i></p>

Whilst the first quote is about minimising risk, the second is directed more towards minimising risk by promoting safety. The focus on promoting safety as opposed to avoiding or minimising risk may be attributable to the code of conduct and the

principles of ‘benificence’ and ‘non-maleficence’ The third quote relates more specifically to an individual patient and connects the value of collecting information in order to recognize a pattern of behavior that can then be risk assessed.

Assessing consequences	quote from Modern Matron transcripts
Assessing the likely impact/result of making the decision	<p><i>I always try to work it through, well work it back to what was the worse possible outcome. You know if I am working through my solutions, and I don't want it then I don't go down that track.”(MM 4:4)</i></p> <p><i>“I think what helped was thinking things through about what the consequences would have been.” (MM 1.2)</i></p> <p><i>“We have got to look at how that decision then affects how we plan for the future, how we are going to communicate with others, [before we implement it]” (MM 5.1)</i></p> <p><i>“I usually try to think of the consequence of each scenario and what would be the best outcome for everybody.” (MM 1.3)</i></p> <p><i>“Looking at what the outcome is going to be” (MM9.12)</i></p>

Consequences can come in two forms ‘intended,’ those consequences that were planned to happen from taking the decision and ‘unintended’ which applies to those unforeseen and possibly undesirable consequences that can arise from a decision. If potentially undesirable consequences can be identified upfront, then it gives the MM an opportunity to choose to take a different decision.

Implement and evaluate	quote from Modern Matron transcripts
The need to action a decision that has been taken and to then measure and evaluate its impact.	<p><i>Implementing a decision out of hours</i> - <i>“Sometimes wards refuse to take patients and you go up and negotiate but ultimately, you say ‘at the end of the day, I’m sorry, there is nothing else I can do, you’ve got to do it.” (MM 2.21)</i></p> <p><i>“I think it is about a process of implementation and I always say we will try it out and if you don’t like it, we’ll look at it again.” (MM 1.24)</i></p>

In the first quote, the MM is clear that she has a decision to be made that needs to be implemented and that after a certain period of discussion, there are occasions when she insists that the decision is implemented. What she doesn't then say is whether she evaluates the quality of the decision she took and the manner in which she took it and implemented it.

The second quote describes a different approach, where the MM is happy to take a 'trial' approach, also known as 'piloting' to the implementation of some decisions as a method of gaining people's support to try something and to genuinely 'test out' the new procedure to see if it does work as intended.

5.4 Summary of Findings in relation to:

Question one – what are the decision making strategies of Modern Matrons?

This section has identified the Findings from the study in relation to question one, 'the decision making strategies of Modern Matrons.' This included identifying examples of how individual heuristics have influenced the MMs in their decision making and describing the range of strategies that the MM's use to help them in decision making situations. Within the two decision making frameworks (intuitive and rational), that are being used as reference points for this study there are a total of eleven defined steps. Even though the MMs may not have consciously identified and articulated it, there is evidence to demonstrate that between them, the MMs have used nine of the eleven steps in the decision making scenarios that they have described. The two recognised steps that did not emerge from the analysis of the data were:

- Defining the objective
- Evaluating the decision

The relevance of their omission will be discussed in the next chapter.

Question Two- What are the influencing factors that help or hinder Modern Matrons in their decision making?

This second section of the Findings chapter will address, the remaining five themes that emerged from the analysis and identify relevant supporting study data as appropriate :

1. Credibility
2. Authority
3. Power
4. Organisational Culture
5. Reflection

5.5 Credibility –

Credibility has emerged as a strong and important theme from the study data. Sometimes the MMs use the actual word, other times they describe the facets of credibility.

“I think the Matrons are very credible. I know that the Management Team that sits in the divisional office will take notice of me and consider that I am the expert in this clinical area.” (MM 1:22)

“So I think it has been my knowledge of what needs to be done which has helped me [engage people] with the decision making process.” (MM 3:3)

“I am still willing to work alongside with nursing staff and I am still experiencing all their problems and difficulties in the day to day work.” (MM 1.19)

“I think my advantage is that I have got quite a bit of credibility with the Directors)” (MM 3.8)

“Leading is not always easy, because one lot want to go one way and some want to go that way. So you have to prove yourself as a person and clinically. First and foremost, I think you have to be credible clinically.” (MM8.11)

“When I first went to the other site, I got pretty much of a shock. I couldn’t believe how bolchy everyone was. I had to go softly softly and let people see how I worked and let them get to know me. On this site, I would have just given the hard word, but that was due to the fact that everybody here knows me and respects me. (MM 1.6)

One MM describes very eloquently how it wasn’t her knowledge, but her approach that had earned her a significant level of credibility with one member of staff

“If I don’t know, I am open and honest and up front about it and say ‘well this is out of my area, you will have to bear with me while I find out what to do’ and that is how I have got through.” (MM 3.7)

The same MM then describes some feedback she received on her philosophy and approach.

“A nurse recently said ‘I always remember when you had not been here long, we were in a MDT meeting and you were asked a question and you said ‘I don’t know the answer to that but I will find out.’ I thought Matrons knew absolutely everything. It made me feel a whole lot better because I don’t know lots of things. But it also made me recognise that it wasn’t a sin to say that you don’t know something. She said, ‘I learnt such a lot from that” (MM 3.31)

Credibility is the consequence of behaviours that are observable and experienced by others. Generally it is earned through successes, but on occasions, it can also be earned by how an individual addresses a mistake that they have made. The following scenario occurred some years before the interviews, but had clearly resonated for the MM both at the time and still some years later on. She re-counted it as an important learning experience for her in regards to how easy it is to lose credibility with someone but that with the right course of action, it is possible to repair the damage and in the process actually strengthen credibility.

“She came to me and said ‘can we trial them’ and I said ‘no’. It wasn’t until I saw the look on her face as she walked away and never said anything else to me, that I thought ‘well I shouldn’t have done that, I should have asked.’ I think at the back of my mind I was very new in post and there was perhaps a little bit of ‘why didn’t I think of that one?’ I let it go a week or two and then I said to her ‘you know what you said to me before, why don’t you cost it all up and show me its going to make a difference.’ And we are still using them today actuallywe also have a great working relationship” (MM8.15)

5.6 Authority

As identified within the literature review, there is often a vagueness about how much authority a person has to do something and it is very often not clearly defined, leading to an individual having either too much or too little in relation to a specific task, neither of which is conducive to good quality decision making. This section will illustrate the value of a clear understanding of authority and the potential impact of an imbalance of authority with responsibility and accountability.

Overall, the MMs were quite content with the level of authority that they had for decision making. Sometimes they cited specific areas such as:

“The budget is mine to play with as I want” (MM 1:14).

Generally speaking the MMs had operational authority for their budgets and how they were spent, but needed to seek further authority for more strategic related spending.

"I think it is quite easy to influence upwards so long as there are no £ signs" (MM 1.22)

"I would say from a nursing point of view, that I have got the authority to implement most things, often in conjunction with finance people. If it is a decision about how the future is going to look, then it is usually a group discussion with clinicians." (MM 1.7)

"No, I didn't have to check with anyone, because there was no budgetary impact, I just did it. It was with the ethos of flexible working that people talk about. I probably talked to my senior nurse about what I was going to do, but I didn't go and say 'can I have permission to do this?'" (MM 2.4)

Another MM was quite clear that she and her fellow MMs, had 'out of hours' authority to take a decision and then inform others without having to first seek permission.

"Out of hours, usually if there is a problem, more often than not, I think most of us make the decision and deal with it and then just ring the on-call Manager up to say 'this is what's happened, this is what I have done, but I just thought you needed to know" (MM 9:9)

"Absolutely I feel supported in HR decisions, I feel that I am at a stage where I am just ringing to inform people what I have done, just to let them know" (MM 1.25)

As described in the literature review, authority is not a constant. A person's level of authority is likely to vary according to the task in hand and who else they are working with in relation to a particular task. One MM reported that generally speaking she felt that she had '*loads of authority*' (MM3.18). However, there were also occasions for the

same MM when she had felt compromised in her decision making and as a result began to take measures to 'cover her back'

"Its been frustrating, because I have known what's needed to be done, so I have let the Deputy Directors know. I have kept people informed every step of the way what I have been doing. I have informed them of risk and everything if these things aren't done. What I have actually done, I have kept copies of every single e-mail that I have sent and received so that when people turn round and say 'oh no', I didn't know about this. Well actually you did, because on such and such a date. So it's really been for my own safety."
(MM3:3)

The consequence was that the experience left the MM feeling cross and frustrated

"I have known with the staffing that what I have been doing is right and the challenge has been that everybody else's lack of planning if you like just suddenly became my emergency Its put me under a lot of stress and I've felt a bit resentful about that stress, because if people had listened." (MM3:4)

This episode highlights the importance of 'authority' in relation to decision making. From Drucker's perspective (2001;61) it illustrates that responsibility and authority are two sides of the same coin and that to be an effective decision maker you cannot have one without the balance of the other.

The importance of an equitable balance between Responsibility, Accountability and Authority was re-enforced by those MMs that referred to their responsibility in relation to cleanliness. They were generally fairly dismissive of the Department of Health's statement (Dept of Health 2000, para 9.12) that MMs were "to be given authority to resolve clinical issues such as ... poor cleanliness." Within the host organisation, most

hospital cleaning was contracted out, therefore in reality, the MM's authority to address issues of concern were limited. They could negotiate at ward level and achieve things through good personal relationships and personal power, but they did not feel able to influence the cleaning contracts and were not involved in the setting up of the contract. The feeling is best summarised by the following extract.

"It was done as if someone could just suddenly, magically, because they were there and walking around and inspecting it. It doesn't quite work like that" I think things were put in the job description but without any real sort of They might have given people in words the authority, but not real tools of the trade or any guidance or any way of being able to actually do something about it Its not easy trying to influence other people that you don't have any direct control or jurisdiction over." (MM7:13-14

5.7 Power

This section explores five different sources of power that the MMs made reference to during their interviews. Although they often did not explicitly use the word 'power' they did recognise the value and additional power that certain activities and connections gave them, which in turn often helped them with decision making situations. In particular this section will look at concept of power in relation to the areas of expertise, relationships and networks, information, position and personal power and empowerment.

5.7.1 The power of expertise

Bazerman (2002:152) identifies experience and expertise as being useful tools for improving decision making and this is echoed by the experience of the MMs.

"I suppose because of the experience that you have got, that you have been a nurse for a long number of years an you have got the judgement to be able to do it." (MM 2.6)

“So I think it has been my knowledge of what needs to be done which has helped me with the decision making process.” (MM 3:3)

“I know that the Management Team that sits in the divisional office will take notice of me and consider that I am the expert in this clinical area.” (MM 1:22)

The MMs’ recognise that it is their clinical expertise that leverages power for their decisions to be respected and influence operational and strategic decision making.

5.7.2 Relationship and network power

The MMs make extensive reference to the value of their working relationships through their networks and contacts and the access to additional advice and information that these gave them.

I have relied heavily on M’s experience and spoken to J and they have just been brilliant and given me contacts of other people (3:6)

“If you have set up good networks when you arrive somewhere new, that helps you with decision making because you can go to the right people for advice” (MM 7:16)

“I spent my time getting to know the staff, getting to know the department and looking at changes.” (MM 1:10)

These MMs have recognised the value of relationships and networks and have actively sought to expand their networks to help them make decisions by increasing their access to advice, information and support.

“I’ve had lots of experience in the Trust and I know a lot of people sometimes I just

feel like I've got an advantage because I know all of them." (MM 3:23)

"If I don't know, then I always do know some body who can help me make those decisions." (MM 3:7)

"I have got all of the Deputy Directors mobile phone numbers in my phone and I know that I can ring one of them up and talk things through. I have even got the Chief Exec's phone number ... we have got this e-mail relationship and it will be 'Hi J'" (MM 3:23)

In addition to the value and power of relationships in terms of accessing support and information, the MMs make several references to the importance of 'knowing people' when making decisions in order to help them know how to approach an issue with someone and that their approach might be different from one person to another. That 'inside' knowledge helps to give them an edge in regards to achieving the outcome they are looking for.

"I know most of their personalities and their characteristics really well" (MM1:18)

"If I am struggling, I know who to go to ...(MM3:). "It's important to build up your relationships with staff so your staff know you are there, so they do tell you what is going on so you can be there and see what is happening for yourself. I think you need to be out there and also important to really keep yourself updated on what is going on and what is changing." (MM 5:22)

"It's where you go, a lot of it is about knowing whose cage to rattle really, to get a response" (MM 5:34)

However, there is also a recognition of the importance of using this sort of power appropriately

"I make sure I go through my chain of command if I need to. I play the game, I wouldn't dream of using that [experience] to actually miss out stages in the process for communicating with people" (MM 4:7)

5.7.3 The power of information

This is about more than just holding or having access to information. It is about the role that the MM plays in the movement of information. In some instances they are part of a hub and spoke model where information is disseminated out from a central, usually more senior source within the organisation and the MM acts a conduit, moving the information on to other groups and people.

"Things get cascaded down to me and I cascade information out to them" (MM 2:12)

"I get things off the intranet and because I work with a multi-disciplinary team, I will pass that on to the therapists and the therapists will do the same in return, they will pass information on to me." (MM 3:22)

"People tell me things and that info can be very useful, sometimes when you want to know how best to get someone to say 'yes' (MM9.32)

At other times, the MM will use information, facts or data to influence a person or group to support their idea or back their decision. The intention is to use information to persuade or influence someone to do something.

5.7.4 Position power and personal power

Position Power reflects how the role of MM is perceived within the organisation, whilst Personal power relates to the individual within the role of the MM. This is demonstrated

in part by the findings that have already been presented, but also in part by the authority that MMs have to make decisions. Within the transcripts, it is difficult on occasions to separate position power from personal power. This is because in the main, the data is a reflection of the MMs' individual experiences and perceptions and therefore a combination of general observations and specific experience.

"In regards to management and position power, I probably feel I have more of it now as a Modern Matron than as a senior nurse" (MM 4:9)

"I think I have had quite a lot of freedom really about deciding where and what I will do in my job and I suppose it is for me to decide what is important and what is not important." (MM 1.20)

There was also a recognition though, that power comes with responsibility and that decision making had to be congruent with Trust policy and strategic direction. It did not mean power to do what you like.

"At the end of the day, we do have a Trust policy and people can't just go native and do their own thing" (MM 4:24)

5.7.5 Empowerment

Whilst much of the MM interviews centred on their experience of decision making in relation to the influencing factors that they found helpful, time was also given over to describing how they have chosen to foster decision making ability in others.

"I explained it to the senior sisters and we wrote some guidelines. I explained it to all the staff ... I had an opportunity to discuss it with them and let them know what was happening. So we did all that before we implemented it." (MM 2.4)

"I was trying to educate staff with it rather than it just be 'this is what we are going to do from such and such a date.'" (MM 2.4)

"I feel my role is supporting them [senior sisters], helping them with difficult decisions that they have got to make on a day today basis and being a sounding point for them"
(MM 2.12)

True empowerment is about more than just delegating responsibility, authority and accountability, it is about doing all of these things in a supportive manner that fosters confidence and trust.

"So part of my role over the last year has been to teach them about understanding it [the budget] and also stepping back and letting them do it, but me supporting them and helping them and discussing things really. And to some extent, if all goes pear-shaped, we all go down together" (MM 2.11)

Generally, the MMs are developing other people's decision making skills because they believe it is the right thing to do. However, on occasions, the behaviour was being driven more by a 'needs must', because they didn't feel they could do it all as opposed to I want to let go and hand this responsibility and authority over to you.

"I do have a tendency to be a bit of a control freak, but this role has challenged that because you can't do it [alone] you have got to do it through other people." (MM 4:31)

"The main thing was getting the senior staff on board and empowering them to be able to do it." (MM 2.5)

"I have definitely been empowered and I am supported, really supported" (MM 3.18)

Empowerment was also described in the context of relationships and the satisfaction that can be gained from seeing someone else achieving and knowing that your actions have contributed to that person's growth and development.

"I take a great deal of pride in seeing how the staff on that site have developed. I am really proud of [her], because when I picked up that Unit, the Sister before me had apparently ruled with a rod of iron and nobody could make a decision, nobody had an option. Amanda was this very timid E grade who tried to be invisible. She has just become an F grade and is blossoming" (MM 3.30)

5.8 Organisational culture

The host Trust has, since 1998, invested in a programme of organisational development that is grounded in the principles of establishing a culture of empowerment. All staff are expected to attend the programme, clinical and non clinical staff, and as a result all of the MMs have participated in the three day programme. The influence of that three day programme is reflected in this section on organisational culture which includes sections on local culture and empowerment.

The following quote encapsulates the prevailing culture of the host organisation and is an important facet of the Modern Matron approach to decision making. It demonstrates the 'trust' the MM has in the organisation that if she genuinely makes a mistake and acknowledges and learns from it that she will be respected for it rather than punished.

"I mean everybody makes the wrong decisions sometimes, don't they? But I know I can hold my hand up and say 'I did that wrong and I'm sorry and nobody is going to bite my head off, because we don't deliberately harm people by making a wrong decision?" (MM 9:9) -

As demonstrated by the array of quotes below, this positive experience of the organisational culture was a consistent theme across all of the MMs.

“The culture is that we are progressive and we are decentralised” (MM 1.6)

“There is always one of them [senior managers] that you can go to for help” (MM 8:18)

“As an organisation, its very good about offering organisational development and things.” (MM 7:6)

“They are a very open culture within the division. Your opinion is sought and you know, you feel you can put your spanner in the works and put your bit in with regards to whatever.” (MM 4:13)

“I certainly think our divisional office is open and you can go in anytime and just say ‘can I run this by you?’ Yes an open door policy, definitely and certainly with the Matrons.” (MM 1.26)

In a different context one of the Modern Matrons talks about how she values the freedom to make her own decisions and how she feels that she has the authority to act on things that she assesses as requiring action.

“Its nice being somewhere I can make decisions for myself and that I am not dictated to. I think as well, that’s very much the culture that I work in, in that in a sense it comes from the top.” (MM 2:24)

5.8.1 Impact of local culture

The Trust is comprised of two hospitals located in neighbouring towns, and a number of years prior to this study they had been two separate organisations until they joined together as one large NHS Trust. Hospital A had been engaged with establishing the principles of empowerment and de-centralisation for some time whilst it was a newer concept for Hospital B. This raised some interesting issues for those MMs who had been

working as senior nurses in Hospital A but were now working across the two sites with a responsibility for a clinical specialty across the whole service.

“the two sites are very very different” (MM 4:11)

“That was hard for me, because I wasn’t used to it. I was used to making a decision and doing it. If it was in my remit, make the decision and do it. Whereas there, you might think about making a decision, but had to check first and if they didn’t like it, then ‘no, full stop’” (MM 2.11)

“When I first went to the other site, I got pretty much of a shock. I couldn’t believe how bolchy everyone was (MM 1:6)

However, the MMs also recognised that the difference between the two local cultures is dissipating as the organisation settles down into becoming one Trust as opposed to two hospitals in two different towns.

“Between the two sites, the culture on the shop floor was very different and I think that is changing now because we are doing a lot of cross site working” (MM 1.16)

At a micro culture level, there was the occasional example of a senior manager who might not in the view of the MM involve them early enough in some decision making situations and as a result a decision would be made that they had to try and implement, that they did not feel was workable

“So straight away, you are thinking well it’s a system that can’t work. Its all very well these people coming up with these ideas, but they are not working with them. It would have been a lot easier if they had involved me early on” (MM 5:4)

“You know, its put me under a lot of stress and I’ve felt a bit resentful about that stress because I thought I didn’t need to be under that stress. Because if people had listened [to what I was saying, it could have been avoided] (MM3.4)

However, these occasions were minimal and the data overall presents a positive picture of local culture already being either very good and empowering or moving in that direction. This data also highlights the interaction between the personal characteristics and attributes of the individual MMs with the environment and local culture of the organisations that they are operating in. The individual can influence and have an impact on the organisational culture just as the organisation can have an impact on the individual's decision making.

5.9 Reflection

Introduction

This theme is important because of the apparent contradiction between the relative lack of evidence for it occurring in any structured manner within the study transcripts and the emphasis given to it by the MMs during the second round of 1:1 interviews. On a number of occasions, the MMs described how sometimes they stop and reflect on decisions that they are about to take or have already taken.

"I do reflect when I have got decisions to make ... I do look back at situations that I have been involved in and how I felt and I have just called on my past experiences and how I would feel as that person." (MM3.12)

"If there are difficult ones to make, I like to 'mull things over' if I can and talk to people. Or, if I do make a decision then I will go away and think about it and you are thinking 'have I done the right thing?' 'could I have done it any better?' I know if I am uncomfortable with something it churns me up really, you are thinking about it all the time and thinking 'could I have done it better, or would it have been better if I had done this or that or the other?'" (MM.2:22)

"In relation to HR issues, I think the Matrons have shared their experiences amongst

each other and learned from it.” (MM 1.26)

“I do reflect when I have got decisions to make” (MM 3.12)

“I try not to be knee-jerk. I do try and think about things and I will say ‘I can’t make these decisions like that and you have just got to give me time to think about it.” (MM 3.13)

“Sometimes, I think you need to be able to reflect on what you are doing. Its nice to be able to have time to think about why you are making decisions and perhaps as well not just looking at it from your own point of view, but looking at it from other people’s points of view.” (MM 2.23)

The common feature of the above excerpts is that the reflection is ‘ad hoc,’ there does not appear to be any structured time for reflection about their decision making, either with their peer group or a line manager. This is epitomised by the following account by a MM regarding what she had felt to be a valuable lesson regarding decision making, that she learnt from her line manager –

“Go away and make your decisions, you will make mistakes and when you do, we will talk about it.”(MM. 1:22)

Whilst the MM concerned viewed this as positive advice and understood it to mean that unless told otherwise, she had the authority to get on and make the decisions that she felt were necessary for her job. It also re-enforces the lack of attention to any structured reflection. There are two issues here, the first is that reflective practice can help reduce and avoid mistakes by enabling insight to be gained *before* they occur (Greenwood 1998), and so providing an individual with the opportunity to make different decisions or take different actions. Secondly, there is much to be learnt from reflecting on decisions that have worked out well, as well as those that have not.

One MM provided an example that she was aware of the value of ‘reflection in action’ when she described that

“Some of it is about stepping back, getting all sides of it before I take any action.” (MM 4:4)

The data collection framework for this study required the MMs to engage in a process of reflection in order to identify decision making scenarios that they could recount and talk through in some detail. Three of the MMs acknowledged that initially they had found it quite a difficult task as they had not previously thought in any depth about how they make decisions and the factors that influence, help or hinder that decision making process.

“This is quite difficult, I haven’t really thought about how I make decisions before today, I just do it.”

“I think you just take decisions without thinking about it” (M 2.22)

Amongst the approaches to decision making identified by the MMs “having time to reflect” was identified as a strategy. However, the identification of it as important did not appear to be backed up by any formal or structured time given to the activity. This will be explored further in the Discussion chapter.

Due to their level of experience and the exposure to a range of organisational development programmes a number of the MMs demonstrated that through reflection over the years, they had gained a level of self awareness and recognised that some of their own personal attributes influenced the strategies they used when making decisions. Factors such as their own personality, their willingness to ask questions or ask for help, their experience and their networks

“One of my tendencies is I can be impulsive and jump to conclusions.” (MM 4:4)

This MM is aware of this side to her personality and is therefore in a better position to manage it and reflects a general recognition by the MMs that over time, they had learnt to modify some of their behaviours in order to increase their effectiveness in the workplace.

Summary

This chapter has illustrated the key findings from this study through the use of relevant participant quotes to underpin and provide explanatory context for the final themes.

5.10 The key findings are

- The MMs use a number of recognised rational and intuitive decision making steps, but more through experience and often at a sub conscious level than through any specific knowledge and application of decision making frameworks
- A key factor of MM decision making is the interplay and relationship between Credibility, Authority and Power and the MMs’ understanding and use of those concepts to help them both make and have implemented, good quality decisions.
- These MMs do not routinely reflect, in any structured manner on the quality or effectiveness of their decisions and initially found it quite difficult to describe leadership/management decision making scenarios
- Authority to take decisions and the clarity of that level of authority is important in regards to both MMs confidence and their ability to take decisions
- Organisational culture of empowerment facilitates MM in feeling confident to use their expertise to take decisions and effect change

In the next chapter, the findings will be explored and discussed in detail in order to identify their relevance for MM decision making and to inform how the learning from this study can be applied in practice.

Chapter Six – Discussion

6.0 Overview

This chapter integrates and discusses the findings in relation to the MM practice of leadership and management decision making within the context of a de-centralised NHS. The discussion culminates in a framework for decision making that has been developed from the study and which could support MMs to improve both their knowledge and skill in this important aspect of effective leadership and management. Whilst there are specific models (Adair 1984; Dreyfus and Dreyfus 1980) within the decision making literature that propose 'steps' to support good quality decision making these are insufficient to address the decision making processes of MM in this study. The Decision Making Framework that has been developed combines a knowledge of the 'processes' of decision making with an understanding of the individual's psychological process of decision making and importantly the structural features of the organizational context in which the decision making is occurring. This holistic view enables healthcare professionals to understand the wider perspective of effective decision making as well as the mechanics of actual decision making steps.

Introduction

This study set out to address two questions:

1. What are the decision making strategies of MMs?
2. What factors help or hinder MMs in relation to leadership and management related decision making

These questions emerged against a backdrop of the Department of Health (REF) promoting a philosophy of decentralized decision making with the expectation that staff would engage with and take on the additional associated responsibilities. MMs were chosen as the focus of this study because increased decision making was seen as a key

feature of this new role and therefore an important component of its successful implementation. The study's findings have provided a useful insight and increased understanding relative to both research questions whilst also identifying areas for further exploration.

Overall, the study has demonstrated that the MMs who participated have a limited knowledge of decision making theory and frameworks and generally apply a range of idiosyncratic strategies often as a 'stand alone' approach, influenced by their individual heuristics, which they may or may not be aware of. Through an examination of the study's data in relation to Cognitive Continuum Theory and The Conscious Competence Model an integrated model has been developed that captures the inter-relationship between the two and provides a more succinct frame of reference for a MM to assess the most appropriate decision making model to adopt in a given scenario. However, in relation to leadership and management related decision making, what has emerged is that simply knowing and applying a suitable decision making strategy alone is not sufficient. Alongside subject expertise and the knowledge and use of decision making models, senior clinicians and managers need to understand and be able to cultivate and to use flexibly a range of other enabling factors. The study results show that these factors include: credibility, power, authority, organisational culture and reflection, leading to greater level of self awareness.

This chapter discusses each of the above areas in more depth, within the context of developing a framework for effective MM leadership and management decision making.

6.1 Decision making approaches

What are the decision making strategies of MM? This was the first of the research questions and this chapter begins by building upon, and exploring in more detail, the implications of the three broad headings that were identified in the Findings chapter.

- The role of Heuristics
- The decision making strategies of Modern Matrons in this study
- Application of known clinical decision making frameworks

6.1.1 Role of Heuristics

In order to illustrate and then examine the influence of heuristics on leadership and management decision making, the following scenario has been highlighted involving MM 4 and the wearing of non traditional uniforms.

This scenario illustrates how :

- A strong heuristic can have a significant impact on both *how* someone takes a decision and the actual decision itself
- The lack of a structured decision making framework can allow heuristics to have a stronger influence than the decision maker may realise
- The lack of a framework resulted in some important steps being missed which could have supported the MM in both her decision making and in dealing with a situation that on a personal level she found challenging.

“One of my biggest issues and they know it is, because they quoted me, saying ‘we know what you are like with uniforms, but can we ...?’ My initial reaction was ‘no’. Then I looked into it further. If I let them do that [wear a cooler non-traditional uniform in hot weather], they were not allowed to go off the ward in them, go down to the dining

room, no whatever. My 'win' was that if I allowed them to do that, then all the jewellery came off, so that was my negotiation.

I went off for two weeks and came back to a meeting to find a staff nurse there not wearing the proper uniform. So I pulled them up about it after the meeting and said 'look not acceptable, you heard what I was saying.' The two staff nurses who were on duty, one of them was very challenging, saying 'I don't care, I am wearing it, it's too hot. I don't care what the chief exec says, they want to come up here.' I said, 'look, I don't care, these are the agreements, if they are breached, then it spoils the agreement for everybody.'

I had to really. It was difficult and it felt uncomfortable, because I really had to stand my ground because I knew if I lost, I may as well throw in the towel. There was something about putting boundaries down and how far they could push it, and they were certainly pushing it. So I think we won that battle actually and came out of it okay" (MM.4. See appendix for full scenario)

It appears to be the MM's heuristics regarding uniform style and the nature of her role as a leader and a manager that was driving her decision making in the above scenario. There is some recognition that it was the 'belief' rather than the facts of the situation that was guiding her decision making. In this instance, the Modern Matron did, on reflection, change her mind and amend her initial decision. *"my initial reaction was 'no'. Then I looked into it further.."* This "looking into it further" then surfaces a second, equally strong heuristic which is about her perception of her role as the 'boss' and the staff that report to her and how she needs to act in order to be credible. This seems to be about the importance of the power of a leader and the authority that position carries and that if she was going to give ground on the issue of uniforms then she had a right to request something in return *"my win was that if I allowed them to do that, then all the jewellery came off, so that was my negotiation."* This results in a transactional approach to dealing with the situation and therefore the decisions that she takes. *"If I let them do that [wear a cooler non traditional uniform in hot weather], they were not allowed to go*

off the ward in them, go down the dining room, no whatever. My 'win' was that if I allowed them to do that, then all the jewellery came off, so that was my negotiation. The MM's belief was that staff needed to see that she was getting something in return, there had to be a 'trade off.'

On further discussion the MM said that she felt that it was such an important issue that she was giving ground on that there needed to be a 'win-win,' ie: that she also gained something significant that she had been wanting the staff to agree to. It is debatable whether this was really a win-win or just a compromise/trade off. A win-win in the true sense means finding a new solution that meets everyone's needs without involving a sense of loss or of giving ground that is associated with compromising (Covey 1989). This appears to be the case here, ie: a blanket 'no jewellery at work policy'. The Matron saw it as a deal, 'you want this,' "uniform flexibility", well you can have it within some clear parameters, but in return what I want is, "no jewellery." This would be described in the literature as a transactional approach to leadership and decision making, where followers do things for the leader because of they have the position power to make things happen or to stop them from happening - if you do this for me, then I will do that for you type approach.

This transactional style was then repeated two weeks later when a nurse was seen off the ward in the wrong uniform. The MM responded by re-iterating the rules in an e-mail to everyone saying that, the criteria for the flexible wearing of uniforms was clear and that if the 'deal' was breached again, then there would be no flexibility.

The importance of being 'seen to be in charge' and decisions being made on the terms of the MM are re-enforced by the combatative language that the MM went on to use when re-counting the scenario – *"I had to stand my ground, because I knew if I lost I might as well throw in the towel. There was something about putting boundaries down so I think we won that battle actually and came out of it o.k."*

However, the Matron also says *"I had to really. It was difficult and I really had to stand my ground."* This 'difficulty' may be a reflection at a sub-conscious level of the

dissonance between her approach in the scenario she was describing, which reflects a more transactional approach to leadership and the transformational leadership approach put forward by the Trust and by the MM elsewhere during her interview. When asked whether on reflection she would have done anything differently, the only thought raised was whether she should have sent an e-mail first and then had the conversation or the other way round.

This would suggest that the importance of the manager showing they are in control and not wanting to be externally directed is a strong heuristic for this individual as even on reflection, she is only considering minor re-sequencing of actions, as opposed to whether there were alternative, viable courses of action open to her.

This scenario demonstrates the impact of a strong heuristic and how, without the moderating influence of a clear decision making framework and some structured reflection, the heuristic can dominate and influence the course and direction of the decision. Even when as in this instance it is counter to the espoused culture of the organisation. The knowledge and application of a recognised decision making model may have made a difference in this scenario. As a minimum, it would have prompted the MM to ask some clearly defined questions to help inform her decision making. Using the steps in a decision making model may have reduced the impact of her heuristics as they would have prompted her to reflect and consider what the core objective was, as presented by the staff and to then assess whether she was ready to move on to the next step in the decision making process.

The table below provides a scenario of how the use of a decision making framework might have impacted upon the uniform scenario. Using Adair's (1984) rational decision making framework, the right hand column reflects the MM's self report of her actions. The middle 'staff team' column highlights the staff objective as reported by the Matron, followed in italics, by a selection of possible different actions had this particular framework been applied to the decision making process.

Table 11: Application of a rational decision making framework to Uniform scenario

	Staff Team	Modern Matron
Define The Objective	'Too hot,' propose wearing cooler non traditional uniforms	Against non traditional uniforms. If concedes want something in return
Collect Relevant Information	<i>Could have provided data re actual temperature, time peaks, incidents of sickness etc</i>	Did not appear to have collected any relevant info
Generate Feasible options	<i>In addition to non standard uniforms, might have suggested – use of fans, opening windows, mobile air conditioning units</i>	Only appears to have identified one option – a 'deal' involving no wearing of jewellery and wearing of non traditional uniform ONLY on the ward
Assess Risk and Consequences	<i>Might have asked for a health and safety risk assessment for staff and patients of being in an environment that they felt was too hot</i>	If criteria of 'deal' not followed, then might be revoked
Implement and Evaluate	<i>Could have measured impact of chosen measures on ward temperature and the health and well being of staff and patients</i>	Implemented strictly, when criteria broken, MM threatened to abandon agreement. Evaluation centred on criteria being maintained not on alleviation of the problem of over heating
	<i>This column is supposition of the impact of using a model and what else could have happened and how the staff team could have been engaged</i>	

Whilst the knowledge and use of a decision making model may have altered the MM's approach to this decision situation and possibly the decisions she took, it would not necessarily have resulted in any learning and increased insight into her own thinking and behaviour and how that influenced this decision making scenario. Therefore, whilst useful in helping an individual to deal with a particular situation, frameworks on their own are of limited value unless combined with other concepts such as professional reflection and a supportive organisational context and culture.

6.1.2 Decision making strategies

Chapter four indicated that there is evidence from the data to suggest that MMs implicitly use some of the recognised processes or steps of known decision making models, for example, pattern and similarity recognition or collecting relevant information and generating feasible options. These are all recognisable within the literature as identifiable decision making steps within the broad spectrum of rational and intuitive based decision making frameworks. However, the MMs did not report having learnt about any specific leadership and management decision making models, either through direct attendance on a course or through assimilation from others. It is, therefore, more likely that whilst the language may be different, there are some commonalities between decision making processes for clinical issues and leadership and management issues. The Nursing Process describes a simple framework of Assess, Plan, Implement and Evaluate and many clinical pathways incorporate similar processes such as 'collect relevant information' and 'assess risk and consequences' but under different headings.

During the initial interviews, the MMs identified that they found it easier to make *clinical decisions*. Significantly, MMs appear to be transferring their knowledge and expertise of clinical decision making to leadership and management related decision making but without developing additional knowledge and skills of relevant decision making models and theory. This is significant because there is no evidence within the

literature to demonstrate whether this is an effective strategy and a conscious decision or just a means of 'plugging the gap' due to a lack of continuing professional development introducing Modern Matrons to decision making models that are suitable for leadership and management related situations. To explore this point further, there are three elements of rational decision making approaches which in relation to the study data warrant further discussion. These include:

Defining The Objective

There were no clear examples within the study data that illustrated the MMs spending time to be clear about defining the objective or purpose of a decision making situation. In contrast, in reference to clinical decision making, there was a greater clarity that the focus was the patient and their well being and this objective informed the information being asked for and then assessed. This difference may be a reflection of the general complexity of leadership and management related decisions or that (except in critical incident reviews) the process the MMs follow is more idiosyncratic than structured and predictable. It does, however, raise some interesting questions about the MMs willingness or ability to spend time defining leadership and management decision making objectives. An important difference from clinical decision making might be a reduced level of expertise in non-clinical activity or that leadership and management decisions often require the use of negotiating and influencing skills to arrive at a shared objective with other individuals. In addition, the MMs " level of authority" (Manthey 1989) and "circle of influence" (Covey 1989) is also different between the two aspects of decision making. Clinically, the decisions the MMs describe are within their "circle of influence", that is they have full authority to make the decision, request people to implement it and then also, if appropriate to request a process of active reflection afterwards. Whilst this may be done in a transformational leadership style, it is still clearly within the MM's remit. However, in leadership and management situations, decisions often do not have an immediate impact on patients. Instead, the decision

being taken by the MM is often part of a much longer chain of information-gathering and decision making. Therefore it can become more difficult to get the information required to define the objective since it may be a more senior person in another department who holds the information. In addition, the greater the number of people involved in the information gathering chain, the more difficult it becomes to establish or maintain clarity regarding the objective of the decision as it may require a shared agreement about the objective of a decision.

Evaluating a decision

A final step in rational decision making is to evaluate the decision that has been implemented. This appears to be the consistent missing piece from all of the decision making scenarios that the MMs describe. There is reference to them loosely reflecting individually as to their perception of the success or otherwise of a decision, but not in any considered or structured manner. The impact of this is explored further in the discussion around the role of Reflection and Decision Making in section 6.6. The apparent lack of attention to evaluation raises some interesting questions about how the MMs know whether the decisions they took were appropriate or implemented effectively if they do not evaluate them, either formally or informally. Clearly it would not be reasonable to evaluate all decisions, but those that they chose to describe in their interviews were generally either unusual situations or ones that had caused them some stress. Yet, in only three of the twenty scenarios did two different MMs describe having spent time reflecting whether the decision they had taken was the correct one. This reinforces the previous point that if there is a failure at the outset of a required decision to define the objective, then that lack of clarity may make it difficult to start considering how to evaluate the decision.

Assessing risk and consequences

This step is only identified on a few occasions in the data. The MMs talk about the importance of assessing risk as well as thinking through what the outcomes or consequences of their decision making might be. It is not possible, however, from the

study data to assess *how* they do this. There is no evidence in regards to leadership and management decisions that the MMs use any particular risk assessment frameworks or approaches. There is, however, evidence of them recognising a pattern of behaviour and then considering the risks associated with that pattern. This appears to be a more intuitive assessment of risk and consequence as it comes from observation and experience rather than being prompted by a conscious decision or utilisation of a framework to look at the potential risks and consequences of a situation and the decision to be taken. MM 1 states in the incident involving the police that part of her decision to call the police was that *'this was a pattern of escalation with her behaviour.'* The implication being that the risks and potentially negative consequences were likely to increase unless a decision was taken to remove person concerned.

As discussed in section 5.4 of the Findings chapter, this scenario demonstrates the use of steps from both rational and intuitive decision making frameworks. In addition, this scenario gives rise to three further questions in relation to how MMs assess risk and consequences.

1. Where do Modern Matrons begin when assessing risk?
2. Is it risk to themselves or others?
3. If it is risk to others, do they differentiate between staff, patients and members of the public and if so, how?

The Nursing and Midwifery professional code of conduct (Nursing and Midwifery Council 2008) requires nurses to "make the care of people their first concern." In this scenario, the Modern Matron followed this guidance and first confirmed that the patient had been deemed medically fit for discharge by both the physician and the psychiatrist. The focus of her assessment of risk and consequences then appears to have been primarily on the safety of staff (the patient had a history of aggressive behaviour towards staff and had previously attacked nurses with a pair of scissors) as well as ensuring that the Trust's policy of a 'zero tolerance' of violence towards staff was upheld. In addition, as part of the decision making in relation to staff, the MM

considered the consequences of not having the patient removed and whether it would have been damaging to staff morale if they had felt they had been put in a dangerous position and not supported by the organisation.

Significantly less attention appears to have been given to assessing the risks and consequences in relation to the visitor who had initiated the incident by bringing the (ex) patient back into the ward and insisting that she was seen and being very angry about what she perceived to be a lack of care. This could have included the distress to the visitor, the potential damage to the public image and perception of the organisation and the risk of the visitor making a public complaint. This apparent lack of consideration of risk and consequences in relation to the visitor, may be because the issue of 'safety,' which had clearly provided a frame of reference for the MM's assessment of risk first in relation to the patient's clinical health and then in regards to the protection of staff, was not seen as so relevant in relation to the visitor.

What this scenario indicates is that within the transcripts, the evidence in regard to the Matron's assessment of risk and consequences was strongest in relation to clinical risk and more general health and safety issues. Their approach appears to be more influenced by experience, expertise and relevant management policies, such as 'zero tolerance' than by an explicit use of any frameworks. Once again 'assessment of risk and consequences' is an area of expertise that benefits from considered and active reflection, and this is explored in more detail later in this chapter.

6.1.3 Application of known clinical decision making frameworks

As identified within the literature review, there are three broad approaches regarding decision making. The first is that good quality decisions need to be made in a clear, logical and rational manner that follows a series of identifiable and sequential steps, (Adair 1984). The second is that it is possible to make good quality decisions from a point of 'knowing' something is the right thing to do due to the decision maker's own

knowledge and expertise and that the process may not be transparent and defineable into clearly defined steps, (Dreyfus and Dreyfus 1985). The third perspective would be that decision making is more situational Hersey, Blanchard and Johnson (1996) and that the approach or model used, should reflect the context and needs of the individual situation in conjunction with the experience and expertise of the decision maker. For this study, that would require the MMs to be able to accurately assess which model of decision making to use alongside an awareness of their competence in relation to different decision making scenarios. Information from this study suggests that two of the decision making frameworks reviewed within the literature chapter could be relevant in assisting the MMs with this type of assessment as well as appraising what they are actually doing. These two frameworks are Cognitive Continuum Theory and the Conscious Competence Model.

6.1.4 Cognitive Continuum Theory

During the literature review, Cognitive Continuum Theory was highlighted as a well used and referenced decision making framework within the clinical decision making literature (Cader, Campbell and Watson 2005; Standing 2008). Its focus is on exploring when it might be more appropriate to adopt either an approach that is a) more rational or b) intuitive in nature in a given situation. Two determining factors are how structured or conversely, poorly -structured the situation is that is requiring a decision and secondly, the volume and nature of the information available to the decision maker. In effect the model proposes that decision making is highly situational and that the approach adopted will be determined by the needs of the individual situation. As identified in the literature review, this study provides an opportunity to raise the question '*can the model be applied to leadership and management related decision making situations and retain its value as a tool to support decision making?*'

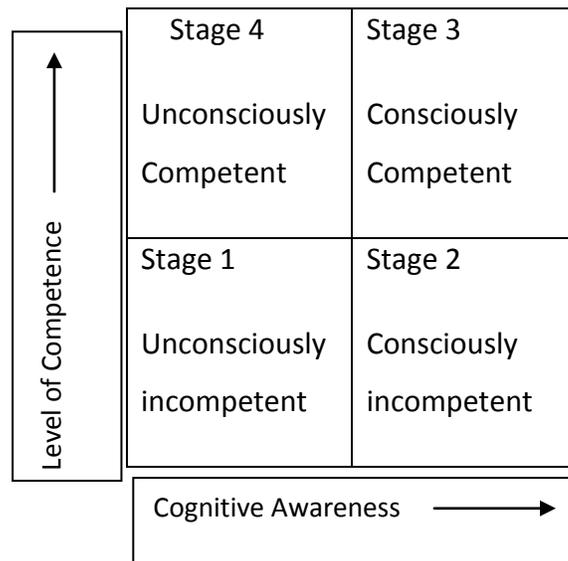
If, as Cognitive Continuum Theory suggests, poorly-structured tasks have properties that induce intuition and generally require a need to be resolved quickly, then it could be

argued that the theory is only relevant in part to leadership and management decision making as most of the scenarios described by the MMs were not of a nature that required an immediate response. An important aspect of Cognitive Continuum Theory for this study, is that it introduces the concept that decisions do not have to be made in either a rational or intuitive manner, but that within the idea of a continuum or spectrum of behaviours, there could be an inter-play and varying application of both, determined by the degree of structure associated with the decision making task in hand as well as the volume and nature of the information available to underpin the decision. This may account for the mix of idiosyncratic strategies that the MMs used – they would vary their style and approach according to their perception of the individual decision making situation facing them. If so, this approach is not one that they have consciously been taught, but may have adopted vicariously through experience of clinical situations.

6.1.5 Clinical expertise and leadership and management decision making – Conscious Competence Model

Each of the MM's make reference to the value of their clinical experience and expertise when making decisions and an essential requirement of the role is to provide clinical leadership. It is therefore reasonable to assume that in many areas of clinical practice and clinical decision making a MM would be considered to be an expert (Benner 1984). This is also sometimes referred to as unconsciously competent. However, as identified in Chapter two, does that level of competence extend to leadership and management related decision making? The Conscious Competence Model (Howell 1986) offers a useful frame of reference for assessing this. It has four stages of competence that intersect with an individual's level of cognitive awareness of their competence.

Figure 9: Conscious Competence Model



The MMs initially found it quite difficult to describe how they made leadership and management decisions. Using this model, that would suggest a low level of cognitive awareness. Both stage four and the intuitive end of the spectrum in Cognitive Continuum Theory are closely aligned with Benner’s (1984) ‘expert’ mode – able to make decisions without either consciously thinking about them or requiring clear explicit steps, because of an inherent expertise in relation to one or more skills and or situations

In regards to leadership and management issues, a MM’s level of expertise may vary, depending on the issue at hand. They would be expected to recognise the importance of good leadership and management skills and therefore automatically at Stage Two of the Conscious Competence Model. However, it would depend on the specific situation at hand as to how competent they would feel in managing it and taking the relevant decisions at the appropriate time. In general, for the positions they hold, they ought to be at least consciously competent (stage three) in regards to most decision making scenarios and be able to recognise those where they feel consciously incompetent and act accordingly.

It is possible that on occasions it is the MM's unconscious competence and 'intuitive' expertise that leads them to deciding that a particular decision making situation requires them to adopt a more analytical approach and so they deliberately insert a more structured and rational approach that one might more usually associate with someone who has level one or two competence.

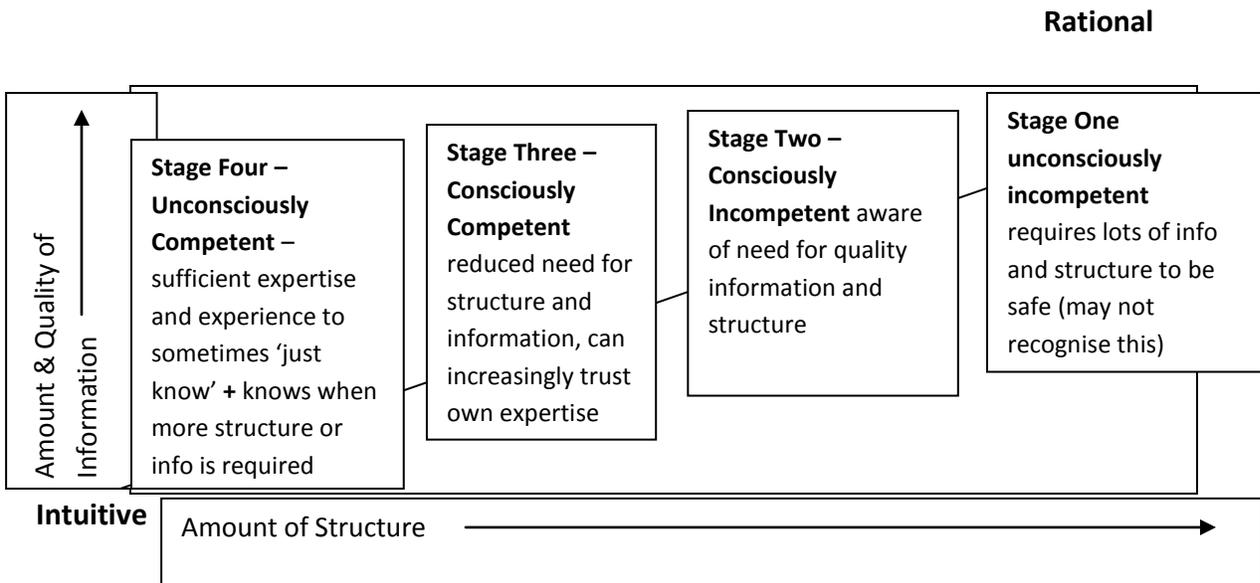
During the 1:1 interviews, a number of the MMs commented that they initially found it difficult to identify and describe leadership and management related decision making scenarios. This could indicate:

- The MMs are experts and have an unconscious competence in this area and therefore do not consciously think about what it is that they are doing. This is unlikely, because as has already been discussed, there does not appear to be any conscious awareness of having learnt about models and frameworks to support their leadership and management decision making.
- How they make decisions is not something that they have given much thought to before.

This latter point is more likely as along with a lack of knowledge of relevant decision making frameworks, there was no evidence to demonstrate that the MMs created any space for structured reflection. This point will be discussed further in section 6.6.

Therefore, in the context of this study, the findings would suggest that an integration of these two models would provide a useful frame of reference for the MMs. In any given decision making scenario, it would prompt them to; recognise their level of competence, assess the degree of structure present and the volume and quality of the information that was available. This in turn would help inform or support them as to whether they needed to adopt a more rational or intuitive model of decision making. The integration of the two models, cognitive continuum theory and the conscious competence model is shown in figure 10.

Figure 10: Integrating Cognitive Continuum Theory and Conscious Competence Model



A person who is unconsciously incompetent (stage one) in regards to a specific task or situation has a low level of cognitive awareness and a low level of skill. Therefore they ‘don’t know what they don’t know’ which is potentially a high risk situation. In these circumstances, the individual needs to have both a high level of structure to work within and a corresponding amount of good quality information to guide and support them in their decision making. If their skill level then increases alongside an increase in their cognitive awareness of their abilities then they can begin to make decisions in a less structured environment and require lower volumes and less detailed information. An individual at stage four, who is unconsciously competent can operate anywhere along the continuum. In general they can make decisions with relatively small amounts of information (compared to a person who is unconsciously incompetent) and have a low need for structure and processes to support their decision making. However, because of their expertise, they are also able to recognise or ‘know’ when to seek out more information or put in a clearer structure so someone else can follow and understand the decision they made.

The following scenario about an elderly lady whose fall was not observed by anyone illustrates the potential value of an integrated framework as a point of reference and guidance in regards to the type of decision making approach to adopt.

“The lady herself was absolutely adamant that she had been run over by a porter ... I spoke to the staff and kind of looked at the whole scenario and I still wasn’t getting any answers whatsoever ... so I took the investigation a little further it just didn’t seem to add up. So I went back and thought about it more and realised that there were CCTV cameras covering that area, so watched them. The old lady had not been run over by a trolley, she had actually tripped and fallen by herself I suppose maybe that is experience and not jumping to conclusions and looking at the whole picture as opposed to maybe just the facts that you are initially presented with.” (MM 7.3 – see appendices for full scenario)

The MM is a clinical expert who regularly works at Stage Four – unconscious competence, requiring relatively low levels of structure and information in order to make good quality clinical decisions. In relation to this scenario, the situation was being treated as a critical incident. The Matron had attended a critical incident training course and so had a clear process and structure to implement in order to conduct the investigation, to then make a rational assessment of the situation. However, it was her intuitive feeling “that things just didn’t seem to add up” that pushed her to look for better quality information and discover the CCTV images that then provided the answer as to what had actually happened.

Summary

The study findings would suggest that the output of the MMs leadership and management decision making was due more to their clinical expertise and transferable principles which they had, to a large extent, sub-consciously applied to the wider leadership and management decision making responsibilities they now have. With the exception of the critical incident training that they had all received (which was about a clear process for conducting an investigation), there was no reference to any other frameworks or models of decision making that they used or had experienced. There were references to the prevailing organisational culture of decentralised decision making and empowerment and these will be discussed later. During the course of the data collection none of the MMs said that they wished they understood more about decision making theory or that they had a better knowledge of relevant models that they could use. However, it would seem reasonable to assume that such knowledge and understanding would be useful and initial indications from the feedback workshop that was held for the MMs was positive. A basic understanding of some of the generic principles of decision making would give the Modern Matrons more options. It would allow them either to choose to use their usual style or to recognise the circumstances that might suggest an alternative model or framework that would be useful. This thesis has drawn upon a combination of rational and intuitive decision making theory alongside cognitive continuum theory and the conscious competence model to provide a spectrum of decision making frameworks that could be usefully applied to management and leadership decision making in a healthcare setting.

6.2 Factors that help or hinder Modern Matrons leadership and management decision making

The second of the research questions addressed by this study, 'what factors help or hinder MM decision making' has identified five connected factors that are relevant to MM decision making. These factors are each discussed in turn and then related to the previous section in a final commentary on MM decision making

1. Credibility
2. Power
3. Authority
4. Organisational Context
5. Reflection

6.2 Credibility

This section discusses what is meant by 'credibility' and why the MMs see it as an important facet of their leadership decision making.

Credibility emerged strongly from the data, both in terms of the MMs using the actual term 'credibility' and from the Stage One analysis where all nine chose 'credibility' as one of their ten priority requirements for effective decision making. This recognition of its value to the role of the MM, reflects the findings from the RCN study Scott et al (2005) where clinical credibility was recognised as adding to 'personal power' and enhancing the Modern Matrons' authority.

Credibility therefore, is an important contributor to the power base of the MM and their ability not just to make decisions but to have those decisions respected and implemented. It is not however, something that automatically comes with the position,

it is something that is established over time through demonstrable actions. The transition from a Charge Nurse with responsibility for a clinical area to MM with a leadership and expert advisor role for a designated clinical service, along with additional corporate responsibilities is a significant one. Whilst the clinical credibility that has been established at Charge Nurse level is an essential component of being a MM, there is still a need to establish leadership and management credibility at both a wider operational level and strategically. This issue of “contextual credibility” (Handy 1993,p.142) was a real issue that emerged from the data for those MMs who, prior to taking up their post had worked on one site and now were covering two hospital sites in two different towns. They described discovering that they were having to lead and make decisions in different ways according to which site they were on and the extent of their credibility on that particular site.

Credibility is associated with doing things well, but, MMs are fallible and errors of judgement will occur. It is how the MM addresses the error that will determine whether it damages their credibility. The findings would suggest that some of the MMs already recognise the importance of at least some of Kouzes and Posner’s (2003,p.204) notion of recovering credibility through the six A’s of leadership accountability: accept, admit, apologise, act, amend and attend. There is however, no reference by the MM to having formally learnt about the attributes of credibility recovery. Any actions taken would appear to be through experience or their individual personality and approach to situations rather than a conscious awareness that there are recognised steps that can be taken to both strengthen and recover credibility. The role of organisational culture is also important in developing and or recovering credibility as by engaging with the suggested 6 A’s the MMs are making themselves potentially vulnerable. They need to have confidence that the organisation will see such a display of potential vulnerability as a strength to be applauded and supported.

Kouzes and Posner (2003,p.51) conclude that credibility is a combination of respect and loyalty and is “earned primarily when leaders demonstrate by their actions that they

believe in the inherent self-worth of others. The consequence of failing to demonstrate this is a lack of credibility and people not having confidence in the leader. Kouzes and Posner (2003,p.51) go on to say that “these [attributes] are earned by appreciating others, affirming others and developing others ... acting in ways that shows trust in them.” This is in effect a philosophy of leadership or being, demonstrated through observable behaviours and will be discussed further under empowerment and organisational context.

Summary

Credibility is not a direct decision making strategy, but it is an important facet of being able to take good quality decisions that others will sign up to and implement. Kouzes and Posner (1993,p.46) describe “earning credibility as a retail activity” that is achieved through the leader being visible and accessible and making regular small contributions through their day to day achievements and behaviours with others. Therefore as a longer term strategy for being able to make and implement decisions, establishing and increasing credibility is an important strategy for the MM to develop.

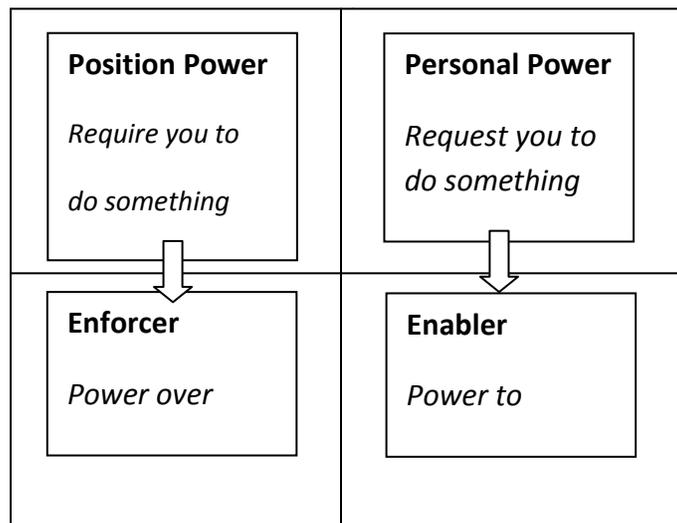
6.3 Power

Power is a complex phenomenon with a diverse and extensive literature base. In relation to this study, power is important in regard to the MMs’ understanding of the different types of power that exist and how to positively develop and use a diverse range of power sources in order to be an effective decision maker. This section discusses power in relation to: position and personal power, power of relationships and networks, power and conflict and empowerment.

6.3.1 Position and Personal Power

Position Power is hierarchical, about a legitimate right and authority to require another person to do something. The power is attached to a particular role and a person has it because they hold that position. It is conferred through organisational behaviour, such as; a paper to the Board regarding the establishment of the position, role, grade and pay; who the MMs report to; the type of meetings they attend; the information that they are privy to; how often their opinion is sought by senior staff and the level of visible influence they have on the running of the organisation. Position Power enables an individual, within pre-determined boundaries, to say 'yes' or 'no' to requests or to authorise spending. Personal Power is more reflective of an individual's own power base and their ability to make things happen because of who they are as opposed to the position they hold. The table below summarises the key facets

Figure 11: Position and Personal Power



The MMs in this study have the potential for both power bases to co-exist. The role is graded as a senior position in the host Trust and in addition to their role as clinical leaders for a particular speciality, they carry a significant level of managerial

responsibility for the operational running of the service out of hours, generally being the first point of contact.

The strength of their 'position power' may vary a little between Directorates due to the degree of additional responsibility and authority individual Directorate Heads may be willing to give, but at a corporate level the role is supported. It is likely that the 'personal power' base of individual MMs varies from one to the other and will reflect, in part, the different levels of credibility that they have established with staff who report to them, their peers and senior Trust managers. It is clear that some of the MMs are aware of the level of position and personal power they have in certain situations and environments and with particular people and how in turn that makes it easier for them to make decisions. It is less clear if they appreciate the value of using one style over another. In Scenario 1 in this chapter, MM 3's decision making process was rooted in her 'position power.' In order to implement the decision that she had made, she *required* the staff 'to remove the jewellery' as part of the deal and she *enforced* the terms of the agreement regarding 'no wearing of non-traditional uniforms off the ward.' Had the MM's 'personal power' base been stronger, it is likely that she could have *requested* staff to remove the jewellery and worked with them to *enable* staff to keep to the terms of the decision.

To be effective decision makers, MMs need to be able to understand, develop and use both types of power. The challenge is in getting the balance right for the task in hand. The balance and value of the Modern Matron having and being able to use both position and personal power is encapsulated by the following transcript quote.

"I have got all of the Deputy Directors mobile phone numbers in my phone and I know that I can ring one of them up and talk things through. I have even got the Chief Exec's phone number ... we have got this e-mail relationship and it will be 'Hi J'" (MM 3:23)

This example demonstrates how important relationships and networks are to strengthening both the personal power of the individual MM and the position power of the role as a whole. If a MM has the telephone number of the Chief Executive and would feel able to ring them up to talk and issue through – suggests two factors:

- The role of MM is sufficiently important in this Trust that it is O.K. for them to contact the chief executive direct (position power)
- The MM is sufficiently respected that senior managers within the organisation have given them their mobile number (personal power)

6.3.2 Power of relationships and networking

The value of strong, productive relationships and networks was clearly evident in the study data. There were three main facets:

1. relationships and networks that gave the MMs access to people with more position power and authority who could sanction, legitimise or authorise a decision or course of action (see above example)
2. Relationships and networks where the MM could 'ring up' or 'pop in' to informally ask someone's advice or run an idea or intended course of action passed someone before implementing it.
3. Knowing people and what their priorities are and what they are interested in to help you know how best to approach them regarding a particular issue or decision.

The importance of these three facets are re-enforced by Kotter (1985,p.39), who suggests that to perform well in a leadership position today means understanding the diverse and interdependent milieu that surrounds the job. This means knowing who *all* of the relevant parties are, their different perspectives ... what they want, how they look at the world, This information along with a sensitivity to its importance, is key to good quality decision making. The findings of this study would suggest that at least some of the MMs know this. The key is to bring that knowledge to the fore so that it becomes a conscious competence that can be shared and used to help prepare staff for the challenges of decentralised decision making.

Relationship power can also contribute to a person's credibility. Kouzes and Posner (2007) identified that "by sharing personal experiences, telling their own stories and joining in dialogue, leaders become people, not just holders of positions." In other words it is the relationships that leaders establish with others that significantly contribute to them being viewed as credible and someone whose decisions should be respected and implemented

Kouzes and Posner (2003) identify five characteristics that support and maintain the power associated with good working relationships, often across a wide geographical area that helps an individual to make and implement decisions:

1. Respect
2. Admiration
3. Perceived Need
4. Obligation and Friendship
5. All derived from a Good Track Record and a Good Reputation

The MM experience was that they were working across two hospital sites, several miles apart and that with the site that was new to them, they were having to work both harder and with more thought to establish the above characteristics that they had become accustomed to having with staff on the initial site that they had worked on. A useful strategy for a couple of the MMs was that some of the consultants now working on the second site had worked as junior doctors with the MMs some years previously on the first site. Therefore the MMs had an established track record and reputation with them and some staff were happy to take their lead from the "credible relationship" (Kotter 1985,p.40) that had previously been established. This type of scenario where value is transferred from one relationship to another is a valuable way of shortening the time required to gain the benefits of being viewed as a credible decision maker. The MMs in this study all had several years experience within the host organisation and therefore had had the opportunity to establish numerous credible relationships that

they could draw upon to help them with the challenges they faced when taking on the role of MM.

The importance of good relationships and strong networks is emphasised by a study undertaken for The Centre for Creative Leadership by Bal et al (2008) which consistently identified relationships as not just an important power base that leaders currently used but also the most important one in regards to the area they felt that they should spend more time developing. This fell into three main areas:

1. Find the time and energy to invest more in existing relationships by keeping in touch with people and spending more time with people
2. Identifying a specific person with whom to establish a better relationship, including boss, peers, customers
3. Recognising the need to repair damaged or neglected relationships

Establishing and increasing a power base therefore, requires an investment of time and energy and MMs would benefit from more insight into understanding how to do that and the benefits that might accrue from that extra investment.

6.3.4 Power and conflict (or power over)

Whilst power and conflict are significant themes within the literature on power (Blalock 1989; Giddens and Held 1982), the issue of power in relation to overt/covert conflict did not emerge as a strong theme from the data analysis. This does not mean it does not exist. However, in regards to the scenarios that the MMs chose to illustrate their decision making, they did not generally describe or infer the presence of conflict. Where they identify dissatisfaction, it is more likely to be couched in regards to the concept of 'authority' and having a lack of authority to take a decision or implement a course of action. This will be discussed further in section 6.4.

Whilst the MMs have not themselves identified or referred to situations of conflict, it is possible that within a few of the scenarios described where a MM has over ruled a senior clinician or called the police to have a person removed, some of the other 'players' may have felt that conflict was present or that they were being disadvantaged due to an imbalance of power. However, in the context of the study and how and why the MMs took the decisions that they did, then the issue of 'power' is relevant in regards to the MMs' authority to take a decision resulting in a specific course of action. Analysis of the data suggests that in relation to the situation where the police were called, the MM's decision was influenced by two main issues –clinical need (or lack of it) and staff safety which were in turn linked to the nursing Professional Code of Conduct and Organisational Policy. This could be interpreted as 'power to' protect staff, maybe other patients and the organisation. Alternatively, it could be viewed as 'power over' what happened to the individual who was removed by the police and 'power over' the member of the public whose request was turned down. In both cases, there was conflict between the individual and the MM and on each occasion, the MM exercised her 'position power' and *required* the individuals to leave and with one, *enforced* that through the use of the police.

6.3.5 Empowerment

In contrast to power in terms of conflict and exercising power over people, empowerment is about being able to share, transfer or give away power through behaviours such as delegation (Bradbury Jones et al 2010, Rodwell 1996). In view of the organisation's stated strategy of 'empowerment, decentralised decision making and a commitment to the principles of a Learning Organisation', it could probably have been predicted that 'empowerment' would feature in some form within the study data and findings. As a result, it seems to be a behaviour that many of the MMs are comfortable with and consciously integrate into their actions. MM 3 talked about her pride at

watching a staff nurse blossoming and developing the confidence to share ideas and make decisions. Whilst MM 1 says:

“A strategy I use a lot is to ask staff to let them come up with a plan, see if they can actually come up with a better plan or a way that it could work differently” (MM 1.21)

Kouzes and Posner (1993) recognise this as a key principle of empowerment. They suggest that

“if you are genuinely interested in what other people have to say, ask their opinion, especially before giving your own. Asking what others think facilitates participation in whatever decision will ultimately be determined, increases support for the decision and reduces the risk that it might be undermined by either inadequate consideration or unexpected opposition. Another benefit is that asking other people for their ideas and listening to their suggestions enhances their self worth”

which in turn, helps to foster a sense of empowerment. That the MMs both feel empowered and actively endeavour to support empowerment for others would suggest that the organisation has been reasonably successful in its aim of establishing a culture that fosters empowerment.

Summary

MMs need to understand the role of power in leadership and management decision making. They need to be clear about their own ‘power base’ when operating in different contexts and with different people and to be able to consciously move between ‘power bases’ as appropriate and to understand what they can do to increase their power base.

In a study of 260 people attending a Centre for Creative Leadership Programme (Bal et al 2008), only 29% “believed that their organisations teach their leaders how to effectively leverage their full power.” Whilst this study did not ask that question, the

findings would suggest that there is a lot that the host organisation could do to educate the MMs about the complexity of power and the essential role, when correctly developed and used that power has in helping them to be effective decision makers.

6.4 Authority

Just as there is a synergy between credibility and power, so there is between authority and power, particularly position power. As a result, there is a tendency to use the two terms of authority and power interchangeably. This study has highlighted four distinctions that are important in regards to MM decision making.

1. Authority tends to be more task and context specific and results in a perception of power that tends to be more diffuse and generalised. The MMs are given a higher level of authority when making decisions in regards to hospital wide operational issues during the hours of 5pm to 9am (out of hours) than they do during the day. Similarly there is a clear understanding of the limits of their authority in relation to money. They can spend up to a specified limit, over that figure, they have to get permission from someone with a higher level of authority.
2. Authority has a greater significance when combined with the concepts of responsibility and accountability. As will be discussed, it was a lack of commensurate authority to levels of responsibility and accountability that caused tension for one MM.
3. Authority infers legitimacy. A legitimate right to do something either because of the position that an individual holds or because of their personal knowledge and expertise that gives what is sometimes referred to as a 'natural authority.'
4. Power is the outcome or consequence of having and exercising authority. Power comes from having authority

Unlike the term 'credibility' that featured quite regularly within the 1:1 interviews, the actual words 'authority' and 'power' featured less frequently with the MMs more likely to use phrases that described those concepts than the actual words themselves. This might reflect a level of discomfort with the terminology as the term 'power' is often viewed negatively and inferring 'power over' people, not a concept that sits comfortably within the NHS.

The authority related to position power is different to the authority related to personal power. The former comes with the role and enables the holder to sign off finance up to a certain level or to be able to recruit to a post or suspend someone from a role. Authority that relates to personal power is more variable. Sometimes described as 'natural authority' it means that people will listen to you and do as you say because of who you are and the expertise and track record you have, in other words, your established credibility with them. Authority is important and the higher the level of authority, the more freedom an individual has to act. However, what enables an individual to make an impact with that authority and to have their decisions implemented promptly and willingly is the credibility standing that the authority holder has. In the following excerpt, the MM's level of authority to implement a course of action is the same on both sites, it is her credibility levels that are different and as a result, make it easier and quicker to implement a decision on one of the sites.

"When I first went to the other site, I got pretty much of a shock. I couldn't believe how bolshy everyone was. I had to go softly softly and let people see how I worked and let them get to know me. On this site, I would have just given the word, but that was due to the fact that everybody here knows me and respects me. (MM 1.6)

6.4.1 Authority, responsibility and accountability

As previously mentioned, Authority does not sit as an entity on its own, and there was one scenario where there was a lack of clarity regarding a person's level of authority.

This combined with an imbalance with what the MM perceived to be the levels of responsibility and accountability she was carrying, resulted in a situation which she reported finding difficult and stressful.

This is illustrated in the following scenario where MM 3 reported that she felt very comfortable in the area of authority, stating *“I have loads of authority”* (MM3.18). However, she also described one situation when the balance between responsibility, authority and accountability had not been right and as a result she had felt compromised in her decision making.

“Its been frustrating, because I have known what’s needed to be done, so I have let the Deputy Directors know. I have kept people informed every step of the way what I have been doing. I have informed them of risk and everything if these things aren’t done. What I have actually done, I have kept copies of every single e-mail that I have sent and received so that when people turn round and say ‘oh no’, I didn’t know about this. Well actually you did, because on such and such a date. So it’s really been for my own safety.”
(MM3:3)

This quote illustrates on a number of levels the problems that can arise when there is both a lack of clarity re the level of authority an individual has in regards to a specific task combined with a lack of balance between the levels of responsibility, authority and accountability. The MM was clear that she was responsible and accountable for the development of a new service which amongst other things, involved liaising with architects for building alterations and recruiting new staff in order to open the service by the date set. She felt comfortable that she knew what needed to be done by when. However, she did not always have a sufficient level of authority to authorise certain things to happen and had to seek permission from other more senior staff, with a higher level of authority. This might have been appropriate, but the MM’s perspective was that they did not always act promptly and therefore in her eyes, important time frames were not being met which jeopardised the service opening on the scheduled date.

The consequence was a MM who was quite clear that she had been delegated the responsibility and accountability to establish the new service by a particular date, becoming concerned that she would be *held* accountable and concerned that might be in a punitive manner. An element of distrust crept in to her dealings with senior managers and she began to 'cover her back'

"so that when people turn round 'oh no' I didn't know about this. Well, actually you did because on such and such a date. So its really been for my own safety." (MM3:3)

This scenario demonstrates the importance of not just a clarity re levels of authority, but an appropriate balance with the requirements of responsibility and accountability. It also clearly shows, the impact on an individual's behaviour, which if repeated too many times, would have a negative impact on the morale and performance of the MM and undermine the credibility with which she viewed senior managers. The opposite of what the organisation would want to happen.

6.4.2 Authority and the trust leadership and empowerment programme

The primary leadership development programme invested in by the Trust is *Leading an Empowered Organisation* (Manthey & Miller 1994) and it has a specific section on 'authority' and the importance of being clear how much authority one has when accepting responsibility for a task and therefore for making the decisions associated with that task. Similarly, when allocating a task and delegating responsibility, the programme states that it is equally important to be clear both for yourself as a leader and for the person you are delegating to that the level of authority for decision making is both clear and commensurate to the task responsibility and accountability.

However, the MMs did not refer to or demonstrate through their scenarios that they actively used or consciously thought about the model of authority endorsed by the Trust, not even in the occasional situations where there was some dissatisfaction. This would suggest that despite an organisational commitment to the Programme, this

simple framework had not moved from the classroom to being applied in the workplace. There are numerous frameworks within the three day Programme, many of which have considerably more time spent on them than is allocated to this section on levels of authority. As a result, it would appear that this section does not make the same impact, either individually or organisationally and the learning is not retained and applied in the workplace. In their discussion of West's (1966) work on teaching, Freshwater and Bishop (2004,p.104) succinctly summarise some of the challenges of teaching professionals, two of which are relevant to this issue of the MMs appearing to forget about the model of authority that they had all been introduced to - "not all that is taught is learned" and "of that which is learned, much is quickly forgotten."

Summary

It is clear from the data that the MMs feel supported by senior managers and that in general they have the level of authority they need to make decisions, implement them and have them supported. There is clarity that the one area where their authority is sometimes restricted is in regards to financial issues when they would be expected to seek approval before making a decision that had significant financial resource commitments attached to it. Interestingly this clarity has not been applied more generally to authority levels, even though they had all attended the LEO programme. This might be because it is a 3 day programme covering a wide range of strategies and techniques and unless the authority section is re- enforced outside of the programme, it could be lost amongst other content. If the authority section was actively followed up on by the organisation through workshops, supervision, demonstrating it in practice, then the MMs might proactively address the importance of maintaining a balance between levels of authority, responsibility and accountability, both when they are accepting decision making responsibility and when they are delegating it to staff.

6.5 Organisational Context

The environment in which the MMs work and the study was conducted is clearly relevant to the research findings. There are a number of features of the host organisation that can be identified as factors that in this study have generally assisted the MMs in their decision making. These factors include organisational performance, structure, a culture of empowerment and the staff development strategy.

6.5.2 Host Organisation

The Trust is recognised as a high performing NHS organisation. At the beginning of the study it was a 3 star Trust and has since progressed to become a Foundation Trust. It is also a 'demonstrator site' for the Department of Health and has won a number of awards for different aspects of its performance.

It was a deliberate decision to base the study in a strong organisation because the goal was to investigate, from the perspective of MMs, how they made decisions. Whilst finding out about organisational factors that hinder decision making was important, it was not the primary goal. The concern of basing the study in an organisation that was not recognised as being a high performer was that the data could become overly dominated by negative organisational factors at the expense of understanding and being able to identify the MMs decision making strategies.

6.5.3 Organisational structure and culture

Because of the history of the organisation being two organisations split over two large hospitals in two different towns, this study has been able to identify, in part, the impact of two different organisational cultures on the decision making strategies used by MMs. One organisation (organisation 1) had established a philosophy of staff empowerment

as a key organisational driver some time before the merger. The other site, organisation 2, did not have a stated commitment to establishing a culture of empowerment.

The majority (seven out of nine) of the MMs who participated in the study originally worked in organisation 1 and approximately 75% of all of the MMs appointed had also originally worked in organisation 1. The observations from the MMs regarding the challenges they faced when they first gained responsibility for the second site, originally part of organisation 2 suggests that organisational context and culture is very important to MM decision making and that a commitment to the principles of empowerment helps. It means that supportive words are translated into supportive processes and procedures, such as access for all staff to transformational based leadership programmes or forums for accessing and talking to members of the Trust Board.

The host organisation continued the commitment of Organisation 1 to empowerment and made a significant investment in leadership development. Over time, this involved taking the whole integrated organisation, clinicians and support service staff through the three day programme, Leading an Empowered Organisation. This programme was the bedrock of the organisation's strategy of establishing a culture of empowerment and decentralised decision making within Senge's (1994) concept of a 'learning organisation' (Host Organisation's Trust strategy document Feb, 2002). Therefore it was also important to the scope of the role of the Modern Matron and how that role was viewed within the organisation. Barriere et al (2002) clearly identify "the importance of aligning the internal structures and processes of an organisation to match the characteristics and demands of the external environment", highlighting the vulnerabilities that can arise in an organisation when internal mechanisms are not aligned or compatible with the external environment." This is an important point and relates back to why the Department of Health (2000) issued guidance regarding the implementation of the role of the MM and the need for relevant supporting organisational structures In this instance, there is alignment. The organisation's commitment to staff empowerment and decentralised decision making is consistent

with the direction being set by the Department of Health. The Leading an Empowered Organisation Programme that is the centre piece of the organisation's strategy was also part of the national leadership strategy for Nurses and Allied Health Professionals. In addition, the MMs have two lines of reporting and accountability; managerially to the Head of the Directorate that they are attached to and professionally to the Director of Nursing. This is important as it underlines the importance of both the managerial and professional leadership accountability of the role and the decision making responsibilities that go with it. The value of this organisational commitment to empowerment is further supported by Lachinger and Finegan (2005) who, in a meta analysis of studies of nurse empowerment, explicitly link structural empowerment, to a number of factors, one of which is the level of nurse participation in organisational decision making. This provides further evidence that the host organisation is achieving its commitment to being an organisation that supports decentralised decision making and empowerment. Not only are these nurses experiencing that philosophy in their roles as MMs, as most of them were working in the organisation prior to becoming Modern Matrons, they have experienced and worked within the culture for some time.

As discussed in section 6.2, 'trust' is an important component of credibility for the MMs. However, it is equally important for the organisation to demonstrate it as part of establishing its own credibility. One way of doing so is to ensure its philosophy and structures are aligned, as outlined above. The result, suggests Mishra and Morrissey (1990) is a genuine culture of empowerment and decentralised decision making which results in greater worker involvement in decision making which in turn enhances trust and so helps to establish the credibility of the organisation with both its staff and those outside. Laschinger et al (2002) expand on this by linking staff feelings of trust and confidence to a work environment that supports staff acting on their expert judgement and by providing them with the commensurate authority. The findings would suggest that in this study, the host organisation's structures and culture have facilitated feelings of trust, confidence and empowerment and as a result credibility between the

organisation and the MMs, all of which support them in their leadership and management decision making.

6.5.4 Staff Development

The Trust has a comprehensive range of staff development courses displayed graphically as a 'map,' to make them easy to see and to understand how and where they interconnect. There is a general principle that for generic topics such as leadership, courses should be open to anyone and actively recruit mixed groups that will include a range of clinicians and non clinicians. This is to foster a culture of shared learning and shared understanding across professions and sectors within the organisation.

The MMs cited five core, internal training and development programmes that the host Trust runs and which they had access to. These include:

1. Leading an Empowered Organisation (LEO) – a three day programme
2. Flexible Thinking – 2 day programme
3. Leadership Effectiveness Analysis (LEA) – a two day 360° individual leadership diagnostic and feedback programme
4. Critical Incident Training – one day training programme
5. MM development programme – 3 ½ day workshops looking at operational and strategic issues to help prepare the Modern Matrons coming into post

The first two programmes are listed by the host organisation as being part of its 'core' training and development package. The first programme all staff are required to attend, the second is open to anyone and staff are encouraged to attend. As part of their preparation and development as MMs, they are all required to attend programmes three to five, but not in any specific order. The five programmes highlighted all focus on applied learning and the intention is that the participants apply the learning and techniques that they have acquired from the programmes back into the workplace. To

help with that process, the Trust has trained up internal trainers to deliver the programmes (rather than relying on external consultants and facilitators). This is relevant for two reasons:

1. it demonstrates the organisations commitment to the long term running of the programmes
2. it helps to develop internal capability and capacity and helps to promote a sense of confidence and self reliance within the organisation.

The decision making framework that has been developed from this study will be offered as the basis of a comprehensive decision making toolkit to all MMs within the Trust.

6.5.5 Modern Matron feedback on the organisation

There was no overt criticism by the MMs of the host organisation. This was apparent at the end of the first stage of analysis. When given the opportunity to comment on, or clarify the initial findings, they were generally in agreement with the analysis that the culture and behaviour of the organisation was supportive of them in regards to their roles as MMs and decentralised decision making. There is the occasional example of mild dissatisfaction, but mainly in relation to an individual as opposed to a more generalised comment about the organisation. This would appear to be positive, but it is unusual and therefore important to explore whether there are any other factors other than being happy with the organisation that they work for.

This lack of critical feedback could be because of four main factors:

1. They were concerned that any negative comments might be fed back to the senior management team and be attributable to individual MMs – this is unlikely as within the study information sheet and during the recruitment phase, there were clear statements relating to participant confidentiality and that MMs would be able to review and comment on any summary report before it was submitted to the Director of Nursing. In addition, a few of the MMs did make reference to

- the occasional incident when they had felt 'hindered' in their decision making by particular individuals, which one would anticipate would be a more risky disclosure than commenting on the Trust as a whole.
2. All of the participating MMs had been recruited to their roles from within the organisation, (this was true for all of the MMs in post at the time of the study). They all reported being approached and encouraged to apply for the post that they now held and therefore it is likely that they would feel a strong sense of loyalty to an organisation where with active encouragement they had been able to develop their careers. In addition, seven of the nine originally worked on the hospital site that had taken a pro-active approach to Leadership Development and an organisational culture of empowerment and decentralised decision making prior to the 'merger' of the two hospital sites. Therefore, these MMs would have had more exposure to and experience of the principles and culture of decentralised decision making.
 3. The study participants were MMs who had chosen to participate and therefore may have been individuals who were particularly happy with the organisation which was why they were willing to participate in the study. There were no overt refusals to participate in the study. However, the MMs were invited to 'opt in' to the study and therefore it is possible that any MM who may have expressed dissatisfaction with the organisation chose not to participate.
 4. The Trust has an established track record of both signing up to and implementing the principles of empowerment as an organisational priority and therefore any 'niggles' are seen in the context of a positive wider picture

Summary

As a result of basing the study in a high performing organisation and the subsequent lack of critical feedback from the MMs, what has emerged are the positive organisational factors that support decentralised decision making. It could be inferred that some of the hindering factors will be the opposite or absence of the positive factors (and there was some evidence of this in the history of the two sites and two organisations before the merger) but there may also be other factors that have not come to light in this study. The principal supporting organisational factors include, for example:

- An organisational commitment to a philosophy of empowerment and decentralised decision making
- The philosophy delivered in observable staff behaviours throughout the organisation – eg: encouraged to get involved in decision making, staff ideas listened to and acted upon
- A robust staff development programme whose content reflects the principles of empowerment and a learning organisation
- Appropriate role recognition (position power) - The Trust was an early implementer of the role and showed their commitment to the role by creating twenty posts, graded at an H (some Trusts grade their Modern Matrons at a lower level), with clear role descriptions, and significant levels of responsibility for out of hours services.

One potential hindering factor that will be discussed in next section is the lack of any organisational supported forums or systems to support the MMs in engaging in a process of active reflection on their performance in the role which could then include their decision making

6.6 Reflection

Reflection and reflective practice is a core nursing activity and viewed as both an expectation and a requirement of being a registered healthcare professional. However, there is a dichotomy between the MMs saying that reflection is an important component of the decision making process and yet there not appearing to be any formal, structured time for it to occur. This section will look at reflection in the context of organisational structures and the type of reflection occurring within individual examples of reflective decision making and discuss its relevance to the practice of decentralised decision making.

6.6.1 Reflection and the organisation

As has been discussed, the MMs do not formally organise any time for reflection, relying on ad hoc opportunities, and the same is true for the organisation. There is a supervision policy for all nurses at G Grade level and below, but not for H Grades and above. Senior staff are encouraged to engage with a mentor, but only one of the MMs had done. All staff are expected to participate in an annual appraisal and whilst this might lead to some reflection it is not its core purpose and an annual event does not happen in a timely manner to support reflective practice. There is nothing specific in the Trust guidelines for the role of MM specifying the need for regular, structured time or space to reflect on their performance in the role. This is important as Bal et al (2008) identify a lack of time to learn and to think as a significant organisational inhibitor on leaders effectively using their power bases. Learning through reflection should be an integral staff activity for an organisation that is aspiring to meet the criteria of a 'learning organisation.' The apparent absence of organised time for reflection would appear to be an example in this organisation where the organisational structure is not in alignment with the strategic commitment to the role of MM and the espoused organisational philosophy of empowerment.

This lack of structured time is a missed opportunity as the dissonance that can arise between a 'theory of action' (in this instance that reflection is important) and a 'theory in use' (the lack of systems and processes to support it happening) has the potential to generate very powerful insights and learning. However, generally, the process needs facilitating. At the very least by the MM having time ring fenced for reflective activity and more generally in some designated shared space and time with one or more other people. The current ad hoc approach is succinctly reflected by MM 4 who, when talking about taking on the role of the Modern Matron said,

"I've just sort of picked up the role and run with it. A little bit of it was saying to people like my line manager 'is everything okay?' and the answer being 'well, if it wasn't you would know, but you are doing an okay job.'" (MM 4:14)

Here, the MM recognises that she is new to the role and reflecting that there were maybe things that she could improve on is asking for feedback. The manager misses an opportunity to engage with her and invite her to reflect on her performance and what has gone well and what has been more challenging to then have a more detailed discussion with her. Instead, the Modern Matron receives a bland *"you are doing an okay job"* and that if she wasn't she would soon know. Whilst the MM was happy enough with the reply that she received, it was not one that was in keeping with the organisation's stated commitment to the principles of empowerment and a learning organisation. If the manager had engaged with the MM and asked why she was asking or what specifically she wanted feedback on, they may have uncovered issues around induction and role clarity, both of which are also embedded in the MM's first sentence. These are both issues that would impact on MM decision making, particularly one that was new in post.

This MM returns to the issue of feedback and demonstrates an openness to reflection and possibly changing behaviours as a result

“The LEA, I would like to do that again because it really does give you a marker in time of how you are perceived and then you can sort of amend some of your behaviours”
(MM 4:21)

However, she did not follow this up by articulating any plans as to when she might ask to do the LEA (a 360°feedback appraisal on 22 leadership behaviours) again and so activate a process of structured and facilitated feedback and reflection.

6.6.2 Types of reflection

A number of times in the transcripts, the MMs talk about ‘phoning a friend’ and ‘running a plan or an idea’ past someone else, not for permission but to hear someone else’s opinion and feedback which may support or conflict with the MMs’ intended actions. What these strategies do is create the opportunity or space for the MMs to reflect and if appropriate take a different decision. It could be argued that those MMs who ‘phone a friend’ are in fact inviting in an outsider view to share his or her insight on an important decision making issue (Bazermann 2002,p.156). One scenario where the MM does not describe speaking to anyone else about the situation that she was facing is MM 3 and the non traditional uniform scenario.

In this instance, it is not possible to establish the effectiveness or otherwise of the MM’s approach to this decision making scenario. However, it is clear that the transactional leadership style that she adopted was not consistent with the organisational philosophy of transformational leadership, empowerment and decentralised decision making. During the interview, The researcher asked “on reflection, would you do anything differently?” MM replied “*no, I might have made the decision sooner, but not really no.*”

The MM was not aware of the incongruity between her account of the scenario, her strategies for reaching the decisions she did and her espoused belief regarding the principles of empowerment and the clear organizational commitment to establishing a culture of empowerment. Inviting an ‘outsider’s’ view may have prompted the MM to

explore alternative approaches. Some structured time for facilitated reflection may have enabled her to recognise the contradiction and explore in more detail, her thinking and actions and their consequences.

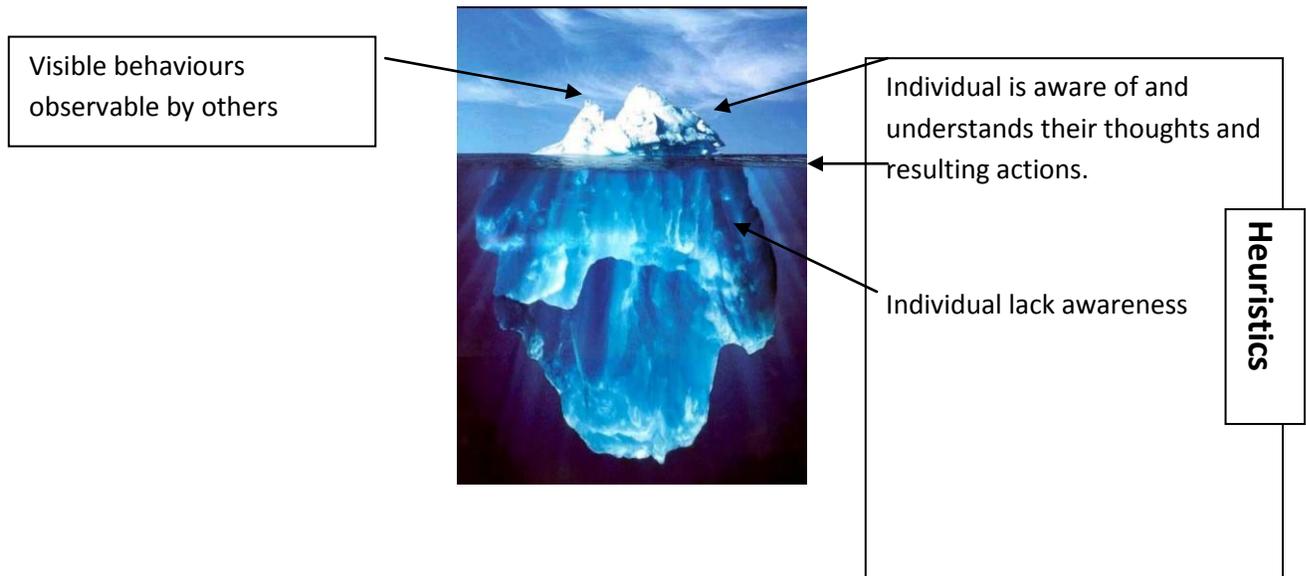
The literature (Freshwater et al 2008; Argyris and Schon 1974) discusses the theory of single and double loop learning and in some of the scenarios described, there is evidence that the MMs have engaged in double loop learning. They have reflected on their own and in their own time (often after the event) and been able to explore and recognise the factors that led up to the decision making situation that they faced, the range of possible decisions that they could have taken and the resulting reactions from the actual decision they made. However, due to the reliance on self generating episodes of reflection, there were also scenarios where the MM did not demonstrate that they fully appreciated the complexity of the situation and the decisions they were making and their consequences. This is evident in the scenario where MM 1 had a patient removed by the police. In her account of the situation, the MM only demonstrates single loop learning because she seems to focus on the implications for staff and does not appear to explore the difficulties or implications the situation and her decision may have raised for either the person being forcibly removed or the member of the public who was so angry about what they were observing and what the situation looked like from their point of view.

To demonstrate double loop learning, the MM would need to have spent more time exploring and understanding the perspective of the person removed by the police – the MM had position power and authority over the individual, the person involved may have felt powerless and coerced which could have been contributing to their behaviour. The member of the public might have needed some support to deal with the distress they felt at the action taken or they might have gone to the newspapers. None of this was actively considered or explored, either during the situation itself or afterwards. Similarly, MM 3 does not display any double loop learning in relation to the scenario involving the wearing of non-traditional uniforms. Her decision making is quite linear

and does not appear to take into account the range of possible staff reactions to the decisions she made or to consider other options other than the one she proposes.

Taking time out to reflect or even being required to take time out to reflect appears to diminish with seniority in healthcare. For some of the MMs in this study they said it was the first time they had actively and constructively reflected on some of the scenarios they cited (although for a few they had thought about them a lot). This parallels the findings of a study by Fish and Coles (1998,p.290) looking at the area of professional judgement in healthcare where they found that “most professionals do not have the opportunity in the course of their daily practice to look in depth at what they do routinely and resolve its complexity.” As a result, their study participants were surprised to discover “that their professional actions (the decisions and judgements that they made) were determined more by their own personal theory – their values, beliefs, assumptions and expectations – than by the formal theory” that they had been exposed to. In other words, like the MMs in this study, much of what they did was informed more by their experience and personal heuristics than formal learning. The issue this raises is to what extent the MM are aware of and understand their own personal theory and its influence on their decision making. Verklan (2007,p.173) suggests that people do not have “absolute knowledge of themselves” and therefore are often not aware of why they think and behave as they do or how that behavior is perceived and experienced by others. In analysing this issue, Luft (1969) developed the Johari WIndow which represents personal awareness as four quadrants. Two quadrants addresses things that ‘are not known to self’ and he calls them the ‘area of unknown activity’ and the ‘blind area.’ The phrase ‘blind area’ suggests potential for risk and therefore harm and is expanded upon by Fish and Coles (1998) through the metaphor of an iceberg.

Figure 12: Understanding and Awareness (Fish and Coles 1998)



The small part of the iceberg that is above the water line relates to the visible side of what a healthcare professional does and what the people around them observe. The water level relates to the individual professional's understanding and awareness of what they are saying and doing, how they are doing it and why. Sometimes a person operates just above the water level and does understand and at other times, they are just below the water level and maybe not fully cognisant of the contributing factors that resulted in them deciding to do x or y. It is the times when people are operating just below the water level that decision making frameworks and principles can have a significant impact by providing a structure to assist people. In his study of 'power' Luke (2005:53) suggests that "there are a number of ways of being unconscious of what one is doing. One may be unaware of what is held to be the 'real' motive or meaning of one's action (as in standard Freudian cases). Second, one may be unaware of how others interpret one's actions. Third, one may be unaware of the consequences of one's actions." This is important in relation to decision making and the ability of the MMs to raise their level of consciousness in the three areas to on or above the waterline of the iceberg in order to be able to think through and to be able to make more informed assessments of the

likely impact and outcomes of a decision by reducing the risk of being unaware of potential consequences. If either MM 1 or 3 in the scenarios identified in this section had actively reflected with someone, in a structured manner on the scenarios they described, they may have considered their role in the scenario more fully along with the possible wider or unanticipated impact of their decisions.

It is this area also, where heuristics can play such an influential role. Sometimes people are aware of their heuristics and the impact they have on their thinking processes which in turn influences the decisions that they take. However, very often the heuristic is below the water line and people are not aware until you ask them to describe something or explain a decision or course of action that they have taken. It is that process of reflection and explanation that can move a heuristic from below the water line to just above it and continuing with the metaphor of an iceberg, thereby make it visible and reduce the risk of damage. Bazermann (2002,p.152) suggests that “some researchers believe that the process of improving judgement will occur naturally as individuals receive feedback about their past decisions.” Whilst this may be true, and is in part evidenced by this study as clearly the MMs have learnt through experience, it is a passive approach to developing a skill as opposed to the active engagement with reflective practice that would be expected of a MM and any registered healthcare professional.

Through their engagement in this study’s 1:1 interviews, the MMs have in effect engaged in a process of reflection-on-action. They have been asked to identify real life decision making scenarios that they have experienced and describe their decision making processes and actions in that situation. Recalling a situation is not in itself reflection, but their engagement with the recollection and their response to the exploratory questions that followed in many instances did demonstrate reflection-on-action. As Argyris and Schon (1974,p.12) identify, “learning a theory of action so as to become competent in professional practice does not consist of learning to recite the theory; the theory of action has not been learned in the most important sense unless it

can be put into practice.” This is important in regards to addressing the issue of reflection as an important component of decision making.

Reflection in order to increase self awareness regarding one’s thinking and actions in relation to different decision making scenarios is clearly a desirable practice for MMs taking on increased levels of decision making. At present, although recognised as an important behaviour in effective decision making, both the MMs and the organisation seem to have an unstructured and ad hoc approach to the practice of reflection. It is an area where the organisation could improve its structural alignment by more actively establishing processes and forums that both support and expect regular and active reflection by the MMs. Likewise, the MMs could be expected to take personal responsibility, as required in their nursing professional code of conduct, to be more proactive in reflecting on their decision making and whether their knowledge and practice of that is as good as it is for clinical procedures.

6.7 Conclusions

Being an effective decision maker is clearly an essential facet of both the MM and other leadership roles within a healthcare organisation. It is not, however, one that the MMs in this study find easy to describe. This could be because they have become unconsciously competent in this area. More likely is that as one or two of them identified, it wasn’t really something that they had thought about or reflected on. As demonstrated by this study, the MMs in this study have developed a variety of decision making strategies that they use and some of those are similar in nature to recognised decision making steps within the literature. These strategies appear in the main to have emerged through clinical experience and been applied to leadership and management decision making situations. There is scope to add value to this experiential learning by establishing a more structured approach to educating the MMs about the principles and practices of leadership and management decision making and in particular some key concepts that underpin those practices and support effective decision making. To help

address this, a model has been constructed that encapsulates the principle outcomes from this study in a visual format and directs the reader to the key learning points.

The literature review and study findings suggest that currently, there is no

- recognised decision making framework that the MMs consciously use to support them in their leadership and management decision making
- readily available framework that is pertinent to MM leadership and management decision making

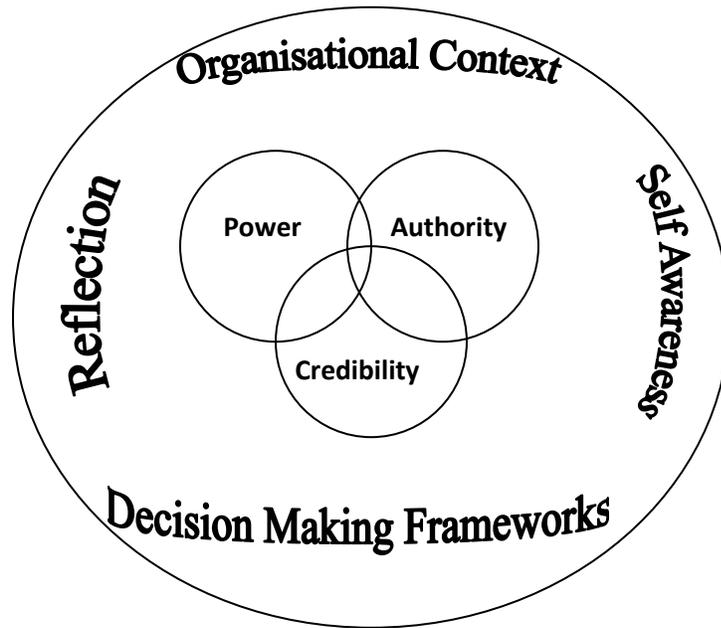
Instead, there are a range of practical strategies arising from their clinical training and experience that they appear to have developed and adapted at an implicit level to meet the leadership and management demands of their role. Any new learning that they have had either through specific preparation for the role of MM or through experience in the role has been integrated with their existing knowledge. The framework that has been developed is relevant to the new learning and understanding that MMs need in relation to the leadership and management decision making requirements of their role.

Whilst the study set out to identify the decision making strategies of MMs, what has emerged is that knowledge or use of specific strategies is only one component of decision making in relation to leadership and management scenarios. To be effective, a MM employs a much wider range of behaviours that help them with this type of decision making. Individual strategies can be used and applied, but the real skill is in understanding the broader context and how to establish and develop a range of more subtle, but important factors that will facilitate effective decentralised decision making and the use of specific decision making strategies.

This Framework provides an holistic approach to decision making that addresses not just the process of decision making in relation to individual scenarios but the broader strategic context of factors that contribute to both an individual's ability and an overall culture of effective decentralised decision making. It integrates the findings of this research study with established decision making and leadership literature to illustrate

and reflect the complex nature of MM leadership and management decision making in this study.

Figure 13: Framework for Effective Leadership and Management Decision Making



The visual layout of the model demonstrates the interconnectedness of the three concepts of Credibility, Power and Authority and their pivotal role at the centre of effective leadership and management related decision making. Decision making frameworks and the steps within them can be taught, as with clinical decision making. However, it is the other five aspects of the framework that are far more complex and require significantly more insight, understanding and skill for someone to be able to consistently take good decisions and honestly appraise their performance.

The study set out to identify and describe:

- MM decision making strategies
- The factors that help or hinder MM decision making

What has emerged is a model of leadership and management decision making for the MMs in this study showing the inter relationship between the knowledge of specific decision making strategies with a range of influencing factors that can help or hinder the MM in the actual practice of decision making.

The following section provides a succinct overview of each of the individual components of the model, beginning with those concepts at the centre of the model and working outwards.

Credibility is an essential component of the MM role. The Department of Health guidance states that the post holder will require clinical credibility. This is true, but in relation to the broader leadership and management aspects of the role, they need to establish a broader credibility base. Clinical credibility is in part rooted in 'expert power'. Similarly, Leadership and management credibility is also rooted in expert power and therefore to establish credibility a Modern Matron needs to establish their leadership and management credentials. Clinical credibility does not automatically confer leadership and management credibility. The latter has to be demonstrated and earned in order to carry resonance. Despite effective decision making being a core leadership and management skill, MMs have not generally considered how to plan and actively develop their knowledge and abilities in this area.

Understanding the level of authority an individual has for a particular decision is an important component of effective decision making and when allocated appropriately potentially empowering for staff. However, as previously discussed, a lack of clarity can not only lead to confusion, it can cause resentment and stress for the individual concerned. The role of MM is a complex one. In this study, they work across two hospital sites managing one clinical speciality and regularly carry out of hours responsibility for the entire service on one site. They need to be clear about the level of authority they have for different aspects of their role and to be confident that there is a shared understanding with the organisation about the different levels and why they exist. An appropriate level of authority for a particular task contributes to the degree of

credibility that someone is perceived as having. Similarly, the MMs also need to be clear with staff that they are delegating to what level of authority is being given to the task, to ensure clarity and that the level of authority being agreed is commensurate with the degree of responsibility and accountability associated with the task.

Power is a well established concept within the nursing leadership literature and the principles of transactional and transformational leadership are rooted in where an individual's power base comes from, their position or through who they are, what they know and how they behave as a person. In this study, power is more diffuse and generalised than authority. It is the outcome or result of other factors, such as the relationships established with key people or the networks of contacts that can be called upon for advice, information or support when facing a difficult decision. The learning for MMs is to firstly recognise the value of spending time increasing their power base and then to understand what steps they can take to do that. Understanding and knowing how to implement the small practical steps that facilitate strong networks and relationships is an important skill for the MM as it enables them to call on a wider range of expertise and experience to support them in making good decisions. The notion of 'power' as an outcome of other behaviours is supported in this study through the MMs' references to empowerment. There is a recognition that they can do things to help create an environment such as putting supportive systems in place, giving people the authority to be able to take on expanded roles and run new projects where people can choose to empower themselves but that they can't actually empower people. Empowerment is a self-generating feeling and behavior that can be fostered but not made to happen. To empower an individual implies that someone can make them be empowered, the opposite of the principle of empowerment which is about an individual proactively choosing to do something.

Another important component of understanding power in relation to decision making is how to effectively share it with others so that it positively strengthens the MM's credibility and in turn their power base to appropriately influence decision making

within the organisation. In other words how to create an environment that fosters empowerment and encourages staff to develop and take on higher levels of decision making. This in turn frees up the MM to address other decision issues. Empowerment is at risk of losing its value due to an over use and sometimes mis-use of the term during the last decade. It is, however, a concept that is critical to the notion of decentralised decision making and therefore as leaders and managers, one that MMs need to understand and know what they can do to help establish a culture of empowerment.

Organisational Context is an important part of the framework in two ways. Firstly how it behaves can either help or hinder MMs in their decision making. This is set through the strategic vision and implemented through the operational plan and subsequently staff behavior. There needs to be a synergy between all three in order to support effective decision making. Secondly the attributes of credibility, authority, power and reflection are as relevant to the organisation as they are to the individual practitioners. Through its actions, the organisation can either enhance or undermine the credibility of the MMs. This can happen in part by the level and breadth of authority the organisation gives to the role and as a consequence the degree of position power the role is perceived as holding. Equally, the organisation has to demonstrate its credibility through its policies and behavior being in line with those expected of an organisation committed to the role of the MM and effective decentralised decision making. As MMs are part of the organisational context they need to understand how, within their circle of influence, they can positively contribute to and support a organisation that helps effective decision making. Likewise, senior management need to understand their role in providing a helping or hindering culture and what specific steps they can take to create a helpful and supportive culture.

Decision making frameworks. A key difference for the MMs between clinical as opposed to leadership and management decision making expertise is that clinical decision making knowledge and skills has at some point been taught. This is not the case in regards to leadership and management. There may have been some exposure to

leadership and management teaching, but generally, MMs adapt/modify their clinical decision making experience and strategies to leadership and management decision making scenarios. There are a number of useful models from the broader decision making literature that MMs would benefit from knowing about. Once understood and used, they can provide the same supportive structure as clinical decision making models. They do not replace expertise or remove the scope for intuitive judgement. Instead, as with clinical decision making frameworks that are well established and accepted they provide a point of reference and therefore, if required, guidance.

Reflection and reflective practice is a core nursing behaviour that all of the MMs will have engaged in throughout their nursing career in regards to clinical decision making. It is probably why they identified reflection as an important factor in decision making, but as demonstrated by the scenarios they chose to describe, not necessarily a behaviour that they proactively incorporate into daily decision making practice. The purpose of reflection is increased self awareness (Freshwater, 2008,p.5) in order to be more aware of one's thinking and behaviour and how that impacts upon the decisions you make and how they are received and then implemented, both by individuals and when appropriate, the organisation. The challenge is how best to support that behavior and process at both an individual and organisational level to ensure that it is happening.

6.10 Summary of study outcomes and contribution to professional knowledge

This study set out to understand how MMs make leadership and management related decisions within a generalised context of decentralised decision making and what factors helped or hindered them in that process. Whilst the introduction and the impact of the role of MM had been researched and written about, this is the first time this important aspect of the role has been studied. A number of findings have emerged that are relevant to the role of the MMs in this study and contribute to their understanding of their leadership and management decision making. These are summarised below.

Decision making strategies and processes

- The MMs have idiosyncratically developed their own strategies and in the absence of any formal learning, on occasions appear to transfer and apply some clinical decision making processes to leadership and management situations.
- There are existing models in the general decision making literature that MMs would benefit from being aware of in order to improve their decision making processes in leadership and management situations
- There are three key steps in the decision making literature that the MMs did not describe. They are:
 1. Being clear and defining the objective of the decision
 2. Assessing the wider risks and consequences
 3. Evaluating the impact of a decision.
- Heuristics are an integral part of decision making and an understanding of the phenomenon and increased self awareness of one's personal heuristics and their influence on decision making is an important insight of which MMs need to be aware of

Helping and hindering factors

- Decision making processes and models can be learned and applied, but the real key to success is the presence of a number of other essential factors. Most of these factors have to be expressed through actions over time. In other words, the principles and theory can be learned, but it is only when they are applied and experienced by others over time that they gain credence and become an asset.

This is relevant with respect to the behavior and actions of the individual MM and to the behavior of the 'organisation' through the structures and processes put in place by senior management.

- The role of the organisation in establishing a culture of empowerment that reflects the principles of transformational leadership and within that milieu then facilitates decentralised decision making is well recognised. What has emerged from this study however, is a greater clarity about four specific factors that together, contribute to a culture of transformational leadership, empowerment and decentralised decision making. These are credibility, authority, power and reflection.
- There is a significant level of interdependence between each of the concepts. The following scenarios provide just two examples. Initially, credibility and authority combined confers a level of power on an individual that can be personal, position or for the MMs more likely a combination of the two. However, in leadership and management situations, without observable active reflection and learning in relation to mistakes it is likely that the MM's credibility will diminish and in turn their personal power base. In contrast, authority and position power does not give credibility, it just gives the organisational right to make decisions. Without an accompanying level of personal credibility, the risk is the individual will have to rely on position power (as opposed to consciously choosing to use it) to get things done, which is characteristic of transactional leadership, a style the NHS is trying to move away from.

6.10.3 Establishing The Framework's Credibility

A framework has been established that captures the key findings of the study in a graphical format that is easy to read and recall. The framework has been presented:

- in a feedback session with the MMs in the participating organisation

- in lectures on effective leadership to three different sets of Masters level students on two different courses, MSc in Advanced Practice and MSc in Health Informatics
- at a university based Phd seminar

The feedback has been positive, with both the MMs and the MSc students appreciating the value of the key concepts and being able to provide examples of the impact of the presence or absence of the concepts in their experiences of leadership and management decision making.

6.11 Further Developments

The initial feedback to the framework has been positive, both when formally fed back to the MMs and used with MSc students. It has also been discussed informally with a number of academics. The framework has provoked a lively debate around three main areas:

- The challenge of establishing and maintaining leadership and management credibility in comparison to clinical credibility
- The practical steps that can be taken at both an individual and organizational level to establish higher levels of credibility, authority, power and self awareness through reflection
- Features that are there in the decision making models from the wider literature that can be usefully applied to leadership and management decision making in the NHS

These issues can be summarised as people wanting to know more about each of the facets within the framework and what can be done to improve performance, particularly in the area of 'credibility.' MMs (and possibly other senior staff) and

healthcare organisations would benefit from having a toolkit of concepts, strategies and practical steps that they could take and integrate into their decision making practice and culture.

The next stage is to use the framework as the basis for the development of a leadership and management decision making toolkit for use within the host organisation for the study. The toolkit will address each area of the framework in turn, providing a theoretical underpinning to its role and value in decision making, combined with a series of practical strategies and examples that can be applied in practice to improve the MM's competence and confidence and to contribute to the organisational effectiveness.

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Appendices

Appendix One

Search Strategy

During the course of the study three separate literature searches were undertaken:

- Jan/Feb 2005– to establish at the beginning of the study what was already known about the proposed topic and to establish whether the proposed study would contribute anything new and relevant to the understanding and delivery of healthcare.
- Summer 2008 – to identify any new literature and where relevant include in order to strengthen the study and ensure it is current in regards to new understandings
- Summer 2010 – to review any new literature that might be relevant to the study and contribute to the understanding and discussion of the findings

Strategy

Two electronic databases were used Medline and ABI/INFORM GLOBAL. These were chosen because Medline is a major healthcare database and ABI/INFORM GLOBAL a major database used by the Business Schools, which is where decision making research is generally located. Using the search terms identified below, I also searched the library catalogues for both the University of Leeds and Northumbria University.

Search Process and Terms:

Initially I used the Medline database and searched *Modern Matron* and *Modern Matrons* – a subtle difference but some papers were only listed under one of the terms. A review of this literature then contributed to the identification of further search terms, in particular the study by Read et al (2004) which then (and still) is the largest and most comprehensive study of the role of the Modern Matron. This led to the following search terms being used: *Decision Making, Leadership, Management, Credibility, Authority,*

Power, Reflection and Organisational Context. The final search term was *Decision Making Strategies* as that was the key Modern Matron action that the study planned to explore.

Each search term was used individually and then in combination with Modern Matron and Modern Matrons in order to ensure an appropriate breadth and depth of searching was undertaken.

As a newly introduced role, Modern Matron(s) was the search term where the literature base changed the most during the course of the study as the role became established and more studies were conducted.

To give an indication of this I have listed the increase in relevant publications that were highlighted during the course of the study.

2005	2008	2010
22 publications	32 publications	43 publications

ABI/INFORM GLOBAL

Decision Making research is generally located within University Business Schools and therefore a 'business' related electronic database was also used to identify other literature that might be relevant. Initially the same search terms were used, but then, following a discussion with my supervisor, *Modern Matron(s)* was changed and *healthcare* and *nursing* were used instead. Modern Matron was a very narrow term for the business literature and did not yield anything of value. In contrast the broader terms of healthcare and nursing did allow other literature to be identified, which when combined with the other search terms produced a more manageable amount of literature to be reviewed.

Leadership decision making	3,756 articles listed
Nursing leadership decision making	49 articles listed

Decision Making Literature

It quickly became apparent that the wider decision making literature was vast and experts within the subject generally specialize in certain areas of decision making theory and philosophy. To attempt to read this breadth of literature before undertaking the study was not practical or appropriate and to read only a selected part of the literature, risked influencing the analysis of the data. Following a discussion with the supervision team (outlined in the main body of the thesis) a conscious decision was taken to focus on two broad approaches to decision making that the literature indicated were recognised and relevant to healthcare – rational and intuitive decision making. This decision resulted in a change on search terms for the business literature from decision making and decision making strategies to rational decision making and intuitive decision making. In regards to the searches via Medline, the original terms remained and the new ones added in. This difference in approach between the two databases was because the number of articles being listed by Medline was more manageable from a reviewing perspective.

Appendix Two RESEARCH STUDY INTO THE DECISION MAKING STRATEGIES OF MODERN MATRONS

INTERVIEW INFORMATION SHEET

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Modern Matrons are at the forefront of the NHS Plan and the Modernisation Agenda for health. They are expected to operate in increasingly de-centralised organisations and to take on devolved decision making on a wide range of clinically relevant but not necessarily clinically specific issues. Due in part to the newness of the role, there is little robust evidence as to *how* Modern Matrons make these decisions and the different strategies they use. A greater understanding would help to identify what support, training and development might be required to facilitate future staff entering into the Modern Matron role.

The study intends to explore what strategies Modern matrons use when making leadership and management decisions specifically relevant to their role? Within this overall purpose, the study will address the following questions.

- *Why* do they make decisions in the way that they do?
- *How flexible* are they in their use of decision making strategies?
- *What factors* support/hinder Modern matrons when making decisions?

Why have I been approached?

I am seeking the views of people employed as Modern Matrons within Calderdale and Huddersfield NHS Trust.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

The study has two stages of data collection.

Stage One – You will be asked to participate in a 1:1 interview that will last for approximately one hour. The principal question you will be asked during the interview will be:

"Can you talk me through and describe a leadership/management decision-making scenario specifically relevant to your modern matron role that you have experienced."

The three subsidiary questions you may be asked in order to gain clarity will be:

Q. Could you describe to me why you made the decision in that way?

Q. What other strategies could you have used to help you make that decision?

Q. What sorts of things made it easy or hard for you in making that decision?

The interview will be audio recorded and then transcribed so that the researcher can analyse the data from the interview.

Stage Two – You will be asked to participate in a second 1:1 interview. This second interview will be to discuss any issues arising from the content analysis of the first interview and the themes that have arisen.

What are the possible benefits of taking part?

The information gained will help to generate understanding of the complexities of the decision making processes inherent within the Modern Matron role and the range of strategies that are used to make those decisions? Specifically: *why* do they make decisions in the way that they do?, the range of decision making strategies they use?, and *what factors* support/hinder Modern matrons when making decisions?

On an individual level, the process of participating should help you to reflect on your personal approaches and strategies towards making decisions.

All participants in the study will be offered a one day workshop to discuss the study findings and to explore some models of decision making that they might usefully take back to their work environment.

Will my taking part in this study be kept confidential?

All data will be anonymised at source with a reference number. Only, I, the researcher will know who the data came from. All tapes, transcripts and notes will be locked in a secure place at the University of Leeds. Electronic versions of the interview transcripts will be stored on a password-protected computers at The University of Leeds in the researcher's office.

All participant data or quotes will be anonymised before inclusion in any study related reports.

No staff from the organisation will be informed of who has participated in the study. Those staff who do participate in the focus group interview will be asked to agree to respect the principle of confidentiality and not disclose the content of the discussions within the focus group or who took part in the focus group.

What will happen to the results of the study?

The findings will be published in an internal report and made available to the organisation. Study participants will have the opportunity to review and comment on any summary document before it is presented to the wider organisation. It is envisaged that the focus of this report will be participants' perceptions of how and why they make the decisions that they do and what factors influence them in that process.

The study will form the basis of the researcher's Phd dissertation and therefore the dissertation (which will include much of what is written in the internal report) will be read by the researcher's supervisor and two external examiners.

External reporting will include conference paper(s) and journal articles.

Who is organising the research?

Elaine McNichol, Director for Enterprise and Innovation at The Centre for The Development of Healthcare Policy & Practice, at The University of Leeds has designed the study and will be leading the research

Who has reviewed the study?

The proposal to undertake this study has been reviewed by: an ethics committee that is within the The University of Northumbria, The Research & Development Department at Calderdale and Huddersfield NHS Trust and through the National Research Ethics Committee.

Further Information

For further information about this study please contact:

Elaine McNichol. Programme Director, CDHPP, 4th. Floor, Baines Wing, University of Leeds, Leeds. LS2 9UT

e-mail: E.McNichol@leeds.ac.uk

Tel: 0113 343 1257

Thank you for reading this information.

The Decision Making Strategies of Modern Matrons:

Stage One: 1:1 Interviews

- Participants will be asked: one key 'open' question that will begin:

Q. Can you talk me through and describe a leadership/management decision-making scenario specifically relevant to your modern matron role that you have experienced.

- Then if required in order to maximise the insight to be gained from the scenario described, there will be three 'open' prompt questions related to the secondary research questions:

Q. Could you describe to me why you made the decision in that way?

Q. What other strategies could you have used to help you make that decision?

Q. What sorts of things made it easy or hard for you in making that decision?

The first interview is scheduled to last for an hour, therefore depending on how many scenarios the modern matron describes during that time, the above questions may be asked more than once.

Stage 2 - 1:1 Interviews

The exact nature of these questions will be influenced from the analysis of the data gathered during stage one. As this interview is about validating the data and the theme identification from stage one to establish a shared and consistent understanding of the data, two further questions might be:

Q. Can you explain the significance or relevance of that?

Q. Could you explain that a little bit more?

Appendix Five

Schematic Account of Analysis Process

To keep the analysis process consistent with the philosophy and practice of hermeneutic phenomenology, three key steps underpinned the data analysis process:

1. Lindseth & Norberg’s (2004) interpretive framework was used to provide a structure for the process of analysing the data
2. As the researcher, I have kept a research log and where appropriate in the study acknowledged my personal reflections and awareness of how I have influenced the analysis process and interpretation. Within the thesis, these reflections are typed in italics to make them easily distinguishable to the reader
3. The principle of co-analysis has been maintained with the MM

Lindset & Norberg Framework of Interpretation	Co-production of understanding with study p/pants	Use of hermeneutic Circle and Researcher Reflexivity	Stage of Analysis	Interpretive Framework	Researcher Analysis Activity
			Stage 1	Initial Naïve reading	Immersion in the data by reading the all of the transcripts
				Thematic Structural Analysis	Reading and re-reading of individual sections of text Highlighting of text in different colours and collapsing of data to establish phase 1 themes Coloured index cards with references to locate themes and text in whole transcript Mind Map of emerging themes
			Stage 2	Data Collection	Mind Map presented back to MM for comment, expansion and prioritization in order to continue an approach of co-analysis to arrive at the final themes Researcher recording thoughts in research log
				Initial Naïve reading	New data initially read in entirety and then in conjunction with phase 1 data
				Thematic Structural Analysis	Reading and re-reading of individual sections of text Highlighting of text in different colours and collapsing of data to establish final themes Coloured index cards with references to locate themes and text in whole transcript
				Comprehensive Understanding (interpreted whole)	Whole of the transcript is re-read and final themes established Final themes are presented back to MM in a feedback workshop

Example of Coding Schema for Stage One of The Analysis

Transcript Location	Phrase from Transcript	Key words	
MM 1.15	I can make things happen because on this site everybody who knows me respects me. I have a history and credibility with them	Make things happen Knows me Respects me History Credibility	
MM 3.8	I think my advantage is that I have got quite a lot of credibility with the Directors	Advantage Credibility with directors	
MM 1.7	I would say that from a nursing point of view, I have authority to implement most things	Nursing Authority Influence	
MM 4.13	They are a very open culture within the division. Your opinion is sought and you know you can put your spoke in.	Open culture Division Opinion sought Put spoke in	

- Above process repeated through all interview transcripts – phrases identified, key words established leading to a grouping under themes
- Covered wall of study with flipchart paper, wrote all keywords and themes on post its and moved around the wall until I felt that I had collapsed them down to a point where I needed to re-present and discuss them further with the study participants in order to clarify and refine the interpretation so far and then move to the next stage of analysis.
- Themes were presented back to each MM as part of a Mind Map (Appendix 4) for further discussion and clarification.

- To help the MM describe their decision making in more detail in order to ‘surface’ meaning and establish a depth of understanding, the MM were asked to prioritise ten themes from the analysis in terms of their importance to their leadership and management decision making.
- These were examined further through a 2nd semi-structured interview with the MMs when they were asked to provide an explanation of what they meant by the themes they had prioritised.
- In addition, the themes were cross referenced back to the original transcripts to establish whether the themes they had identified as being most important to their leadership and management decision making could be supported by the initial interview data.

The table below illustrates part of this process in relation to the themes of Credibility, Authority and Organisational Context.

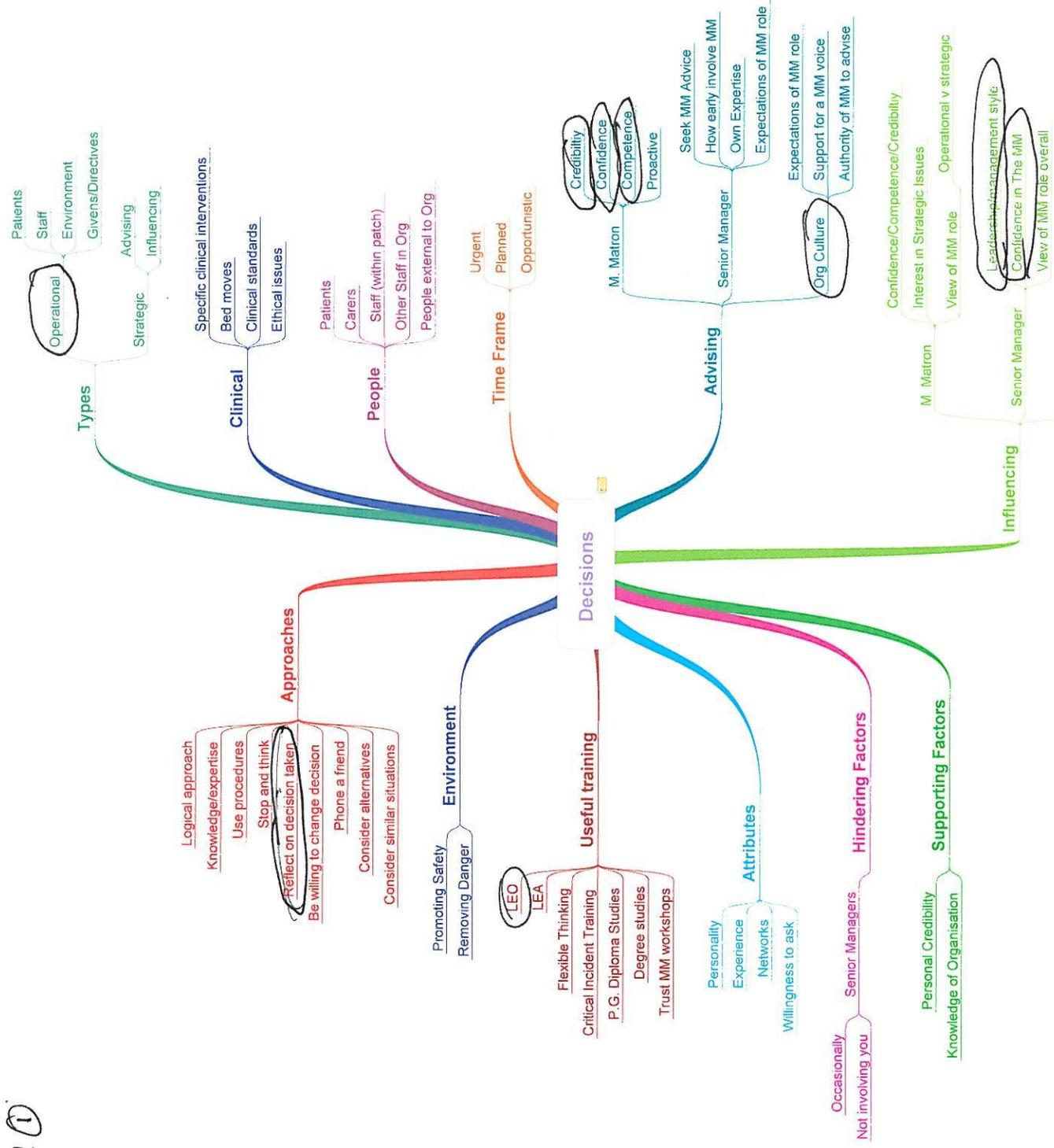
Theme	Descriptor from 2nd round of 1:1 interviews	Supporting data from transcripts from 1st. round of 1:1 interviews
Credibility	I can do the job and feel I am trusted to do the job. We know what we are doing. Earned it through lots of years of experience.. People ask us our opinion. Managers will listen to us. Gives us power and authority which is useful in tricky situations. About trust	“I think you need to be out there and also important to really keep yourself updated on what is going on and what is changing [in order to maintain your credibility]”(MM 5.22)
Authority	Can get on with the job, Backed up by line manager/organisation. Frustrating if you need it but haven’t got it as it can slow things down. Helps make me more credible as it says I am trusted to do the job	“If there is a problem [out of hours], I think most of us make the decision and deal with it” (MM 9.9) “I have loads [of authority]. I have definitely been empowered” (MM3.18)
Organisational Context	Empowerment, everyone but everyone has to go on LEO, No blame culture, Expected to get on with it. Its generally a nice atmosphere and people get on which makes it easier to make decisions and work through things that might be difficult.	“I said ‘at the moment, I feel comfortable with it, but you know that if it gets uncomfortable, I will be shouting.’ And I will, I am not scared to say ‘I can’t do this’ and they will say ‘no, you are right, you can’t, we have given you too much to do. And they

	<p>Devolved decision making. Encouraging staff to fulfill their potential. About trust and respect and everyone doing their bit.</p>	<p>will support me and that is a nice feeling” MM3.19</p> <p>“I do think they [senior managers] are happy for you to make the decision” (MM 5.31)</p>
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Appendix Six

Mind Maps and Field Notes for each Modern Matron

MMO



Interview 2

MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM1

Word/Phrase circled	Field notes of description
Credibility	I've worked here a long time. I know many of the consultants & Sen. Nurs. when they were juniors. People know me, how I work, that I'm good at my job. I can do the job & feel I am trusted to do the job.
Reflect on decision	Of course it's important. It is how we learn from our mistakes. I should maybe do it more often. It's about stopping & thinking & being honest to yourself.
Organisational Culture	strong ethos of staff involvement & people being accountable for their decisions LEO is a big thing - everyone but everyone has to go. It's good - I like the culture. I'm glad it's spreading to the other site, will help join us up better.
Authority to advise/take a decision	Freedom to get on & do what I think as an expert prof nurse needs to be done. It has boundaries, usual professional ones. Means more responsibility - but so long as you know what you're doing, that's O.K.
Modern Matron competence	Means being capable, knowing what you have & being able to do it, having confidence in your abilities.

Interview 2

MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

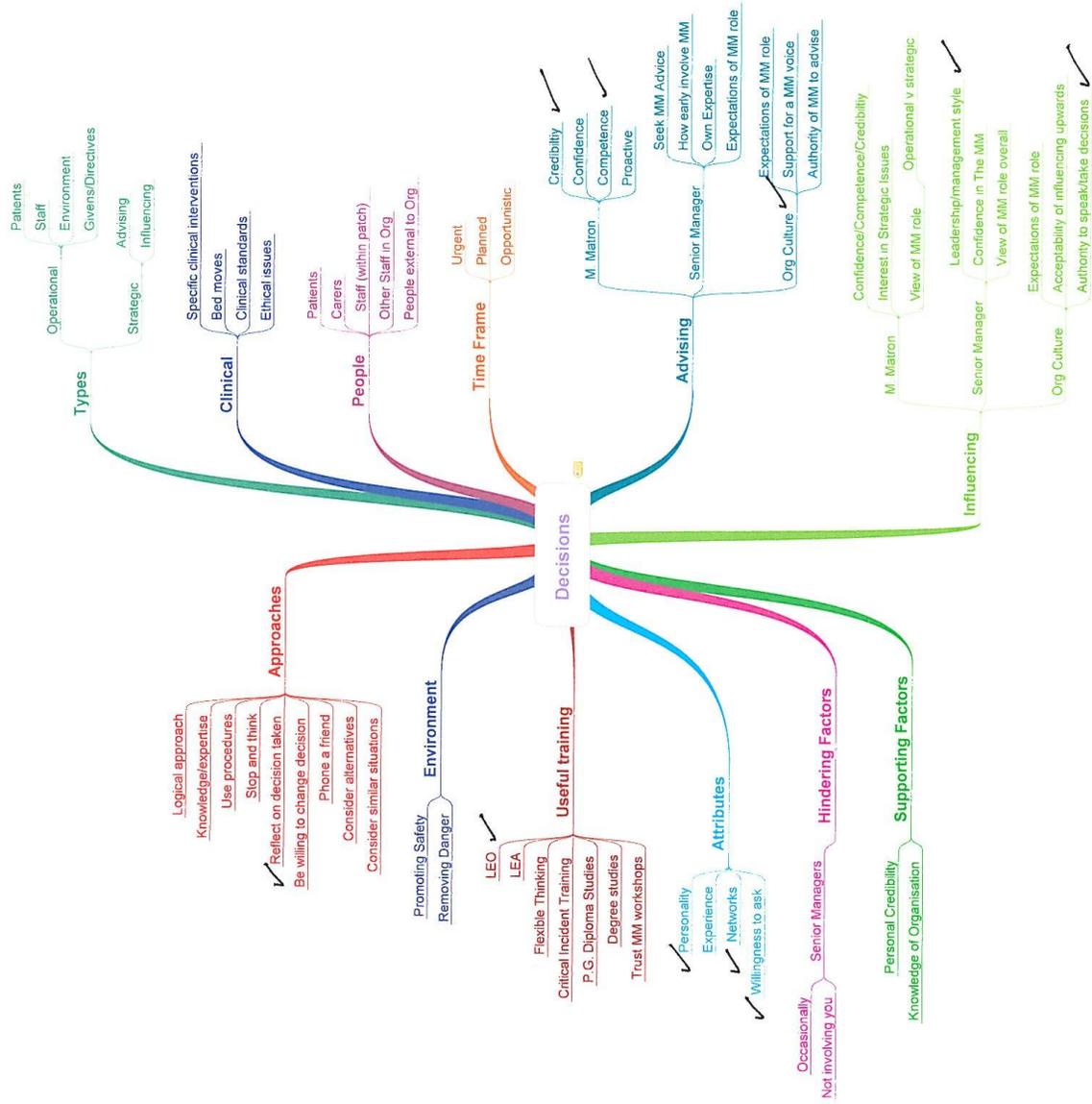
MM2

Word/Phrase circled	Field notes of description
Credibility	<p>About who we r & what we do. About walking the talk, doing what it says on the tin. You earn it through being capable consistency</p>
Reflect on decision	<p>About stopping & thinking about what I am doing I try to encourage staff to do it - if they ask me what I think I try & get their thoughts & reflections 1st & then offer mine</p>
Organisational Culture	<p>Feels good working here - we have our ups & downs, good & bad days but generally I like coming to work. I feel respected.</p>
Authority to advise/take a decision	<p>Means I can make decisions & because I have the right & responsibility to take those decisions I am backed up by my manager! org. Back stops here.</p>
Modern Matron competence	<p>- Being able to do the job. Having the expertise & experience & competence to do the job. Being fit & purpose</p>

you don't have to worry about being hung
drawn & quartered if you get it wrong.

Confidence	Thats I make better decisions when I'm confident - is my comfort zone - I'm more clear & assertive. Confidence grows \bar{c} experience & a supportive org helps because
Personality of Modern Matron	Personality must influence d.-making. If not the actual decision but itself, how it's conveyed - I know I am more direct than some - others give a lot more explanation
Logical Approach	Most decisions benefit from a steady sensible or logical approach being applied to them. Putting in a step by step process that makes sense to everyone
Consider Similar Situations	v. few situations r unique. Most times they will have features / components similar to another decision you have taken. Need to think laterally. Just helps me as a strategy when I'm not sure.
Use Procedures	There r policies & procedures for e1 thing we just forget to use them. When in doubt, they can be a useful starting point to get v on the right path.

MM3



Interview 2

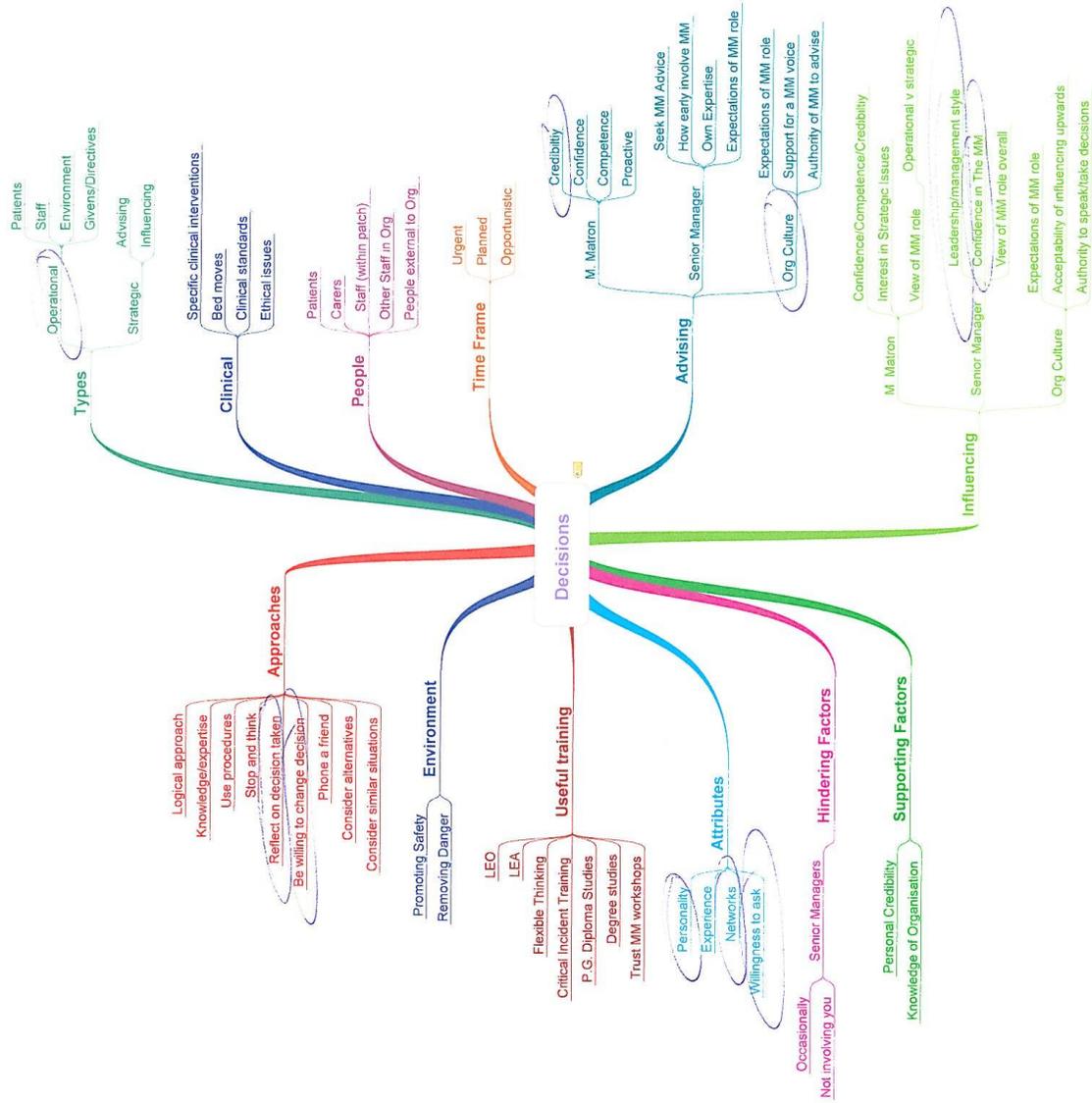
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM3

Word/Phrase circled	Field notes of description
Credibility	About a track record & having earned your stripes. Have demonstrated that we know what we r doing & that we have consistently performed well. People believe in us & trust us.
Reflect on decision	I like 2 stop & think, often not able to because of time pressures. Part of being a prog. nurse:- reflective practice Good practice.
Organisational Culture	Org believes in empowerment & devolved d. making We get a lot of staff dev. opportunities I have been encouraged to take on more & more, has been a steep learning curve at times, but generally it works. I like encouraging staff to fulfill their potential - gives them ^{power} authority
Authority to advise/take a decision	I like it when I have the authority to get on do. I find it difficult sometimes if I have to wait for others to decide as you lose valuable time.
Modern Matron competence	It's 2 experience. It's a reflection of having a lot of experience. It's a combination of knowledges skill gained over time. Means other people can be confident u can do the job

MM3	
Networks	About having people I can ask formally or informally for advice or info. I find my networks v supportive
Senior Manager leadership style	A good working rship = Sen Mgrs is essential. I feel they have my trust & I have theirs. Its good when they involve you early - easier to make decisions / influence outcomes
Willingness to ask	I've always been happy to ask for help/advice, admit I'm not sure (don't know.. People here have always responded +vely - I am always happy to help people who ask me.
Leading an Empowered Organisation (LEO)	I've done LEO & really enjoyed it. Thought some of the strategies were really helpful. Because everyone does it - clinical staff, HR, catering etc it means we all have some staff training in common.
Personality of the Modern Matron	Who I am influences how I take decisions. I like to work w people rather than confront things sometimes that is good. I can get folks on board - " not so good as I maybe don't decide on a definitive strategy quickly enough. But I know that & try to work w it in difficult situations

4.



Interview 2

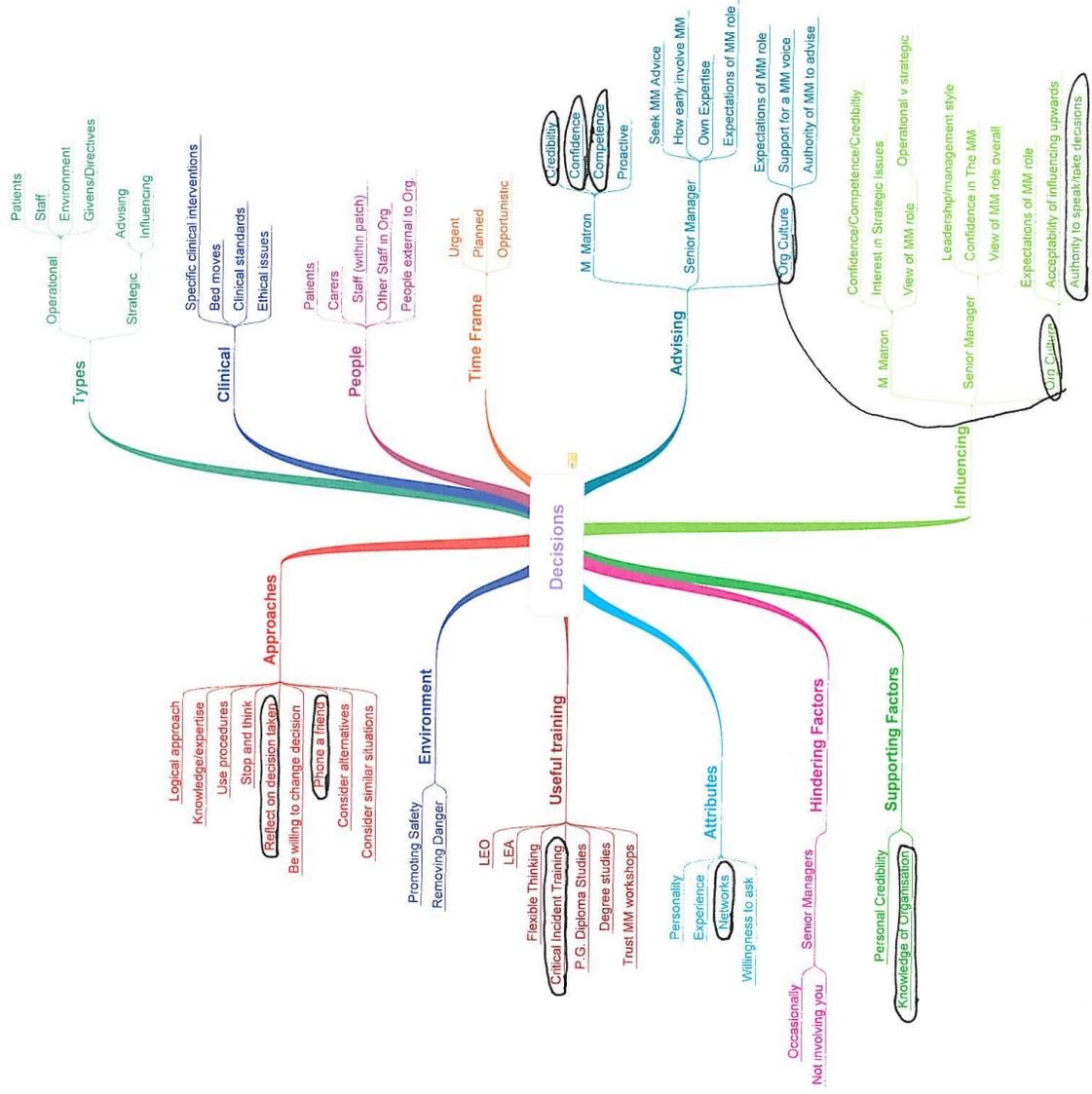
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM4

Word/Phrase circled	Field notes of description
Credibility	knowledge + skills + respect all help you to be credible. Its important. Its why you need to be a nurse to be a M-R. About being able to do the job + people knowing you can.
Reflect on decision	About taking time out. Thinking could I/should I have made the decision differently? What else could I have done.
Organisational Culture	This org is strong on empowerment, each of us taking responsibility Its generally a nice atmosphere + people get on which makes it easier to make decisions + work through things that might be difficult.
Networks	lets you access to more info/intelligence. About making an effort to get to know people. Useful way of making contact + people + or issues
Senior Manager leadership style	Really important to how you work. Need to let them work in their style to get the best out of them. Mine is great - there when I need them, otherwise leave me to do the job. People still need to know u + boss - balance between ^{styles is} needed.
Willingness to ask	goes back to networks - having people u can ask for help/advice.

<p>Willingness to Ask cont.</p>	<p>Can be daunting asking for help, but usually worth it. You can get another perspective - get clarity on what I should be doing.</p>
<p>Personality of the Modern Matron</p>	<p>Personality can't help but influence decision-making - it's a reflection of who v r. & so impacts how people present issues & j. This in turn influences how v & the situation & then respond & so on. They know what I will & won't tolerate.</p>
<p>Operational Decisions</p>	<p>The day to day decisions I have to take are ones that you have more exp of & so are easier than the strategic ones. You know the ins & outs & likely consequences of operational decisions.</p>
<p>Senior Manager Confidence in MM</p>	<p>High confidence = they trust v & give you space to get on i things. It adds to your credibility & stays & other managers - means your manager believes in value of your role. If they don't have confidence v - feels v. undermining even if it is the role of MM as opposed & v as in that role. Not been a problem for me personally.</p>
<p>Be willing to change a decision</p>	<p>You can't be right all the time. Sometimes you get more info - or you stop & think & realise things weren't quite so straight forward. People respect you if you admit that maybe you got it wrong & v want & change your decision.</p>

NMS



Interview 2

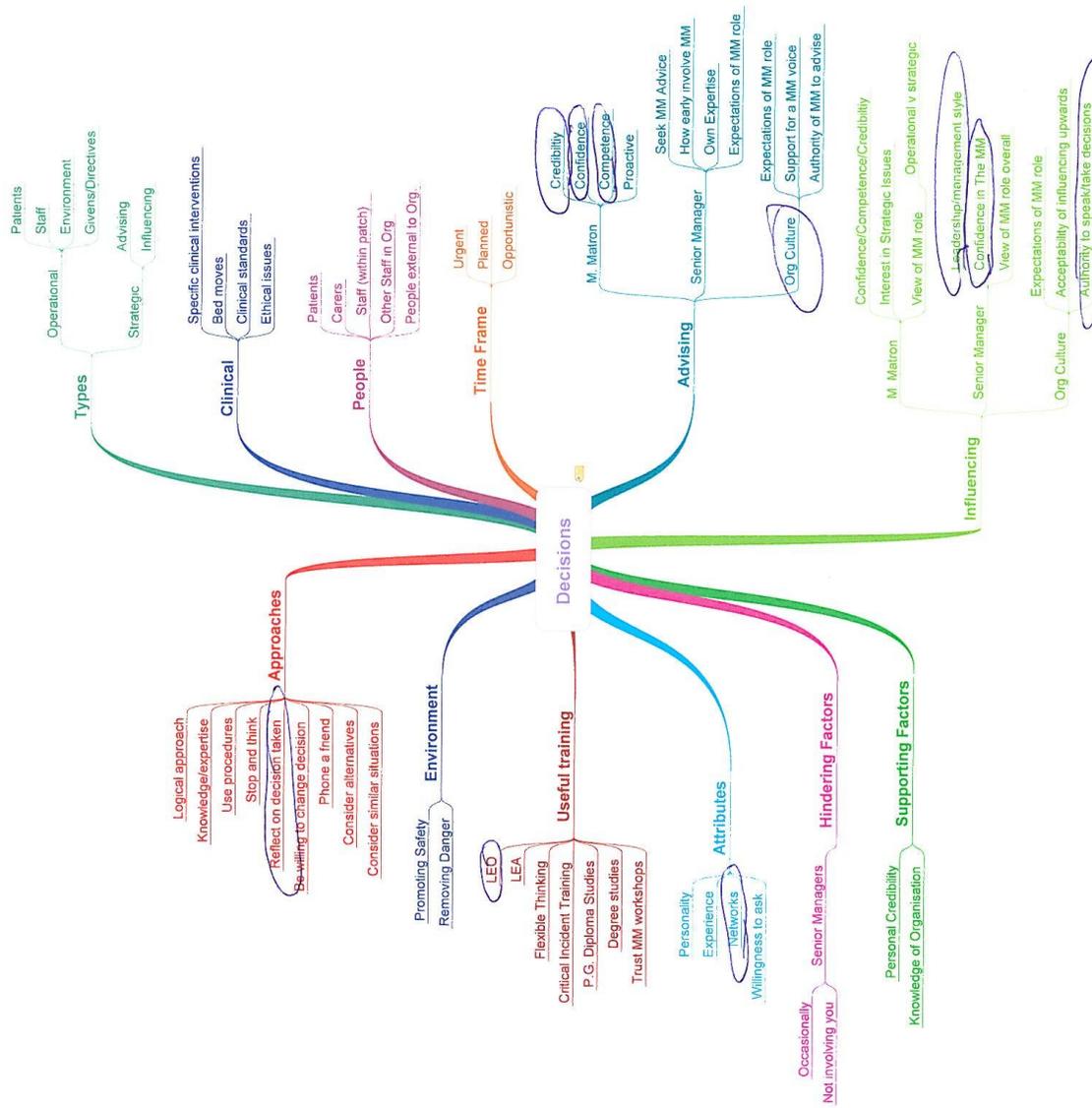
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM5

Word/Phrase circled	Field notes of description
Credibility	Means someone can do the job & has demonstrated that they can. It shows that we know what we r doing. We've earned the right - we've earned it through lots of yrs of exp.
Reflect on decision	It's an imp thing to do to learn from your decisions. Not sure I did it as much as I should. I try & do it & stop - encourage them to answer their own q's by reflecting on the q's & coming up w options. Something we should all do - part of learning.
Organisational Culture	The board has put a lot into developing an org culture through 100 etc. - to help w the merger of the 2 orgs as one. Culture is about the principles & learning how we all work together - about trust & respect & getting on w things - everyone doing their bit.
Authority to make decisions	Means you don't have 2 go elsewhere for permission, decision rests w u. Also means people don't circumvent & around me to get a diff decision. speeds things up as I can say a/way. Sometimes I wish I didn't have the authority as back stops u.
Modern Matron competence	About being able to do the job in a consistent & reliable way. About people having confidence in you - you have a track record that gives people confidence. Means u r safe - people can rely on u.

Networks	<p>Help me do my job as they provide other avenues for support.</p> <p>You can use them to indirectly make something happen or get some info somewhere.</p> <p>About staying in touch w people & what's happening.</p>
Critical Incident Training	<p>I found this helpful really good.</p> <p>Provides a framework to help you think through situations & make considered decisions.</p> <p>Gave me confidence to tackle big & for more contentious issues</p>
Knowledge of Organisation	<p>I've been here a lot of yrs & know loads of people, particularly on the one site where I was originally based. I guess I know people's personalities, jobs, maybe things they're passionate about & so make decisions accordingly to get best out of them.</p>
Confidence	<p>Part of being competent - knowledge & skills is not enough, need confidence to use them or to do other things on that overlap - like ask for help.</p> <p>Also people need to have confidence in u - one feeds the other.</p>
Phone a Friend	<p>Having people other than your manager, or who you can ring for advice/who are a decision - person might be another one but u're ringing them as a friend for their support/advice.</p> <p>It isn't possible to always be confident & competent to make a decision, having a network of friends is really helpful - don't have to be v. good friends, mass some of mine I know & get on & but maybe have specific skills/knowledge I don't.</p>

MM6



Interview 2

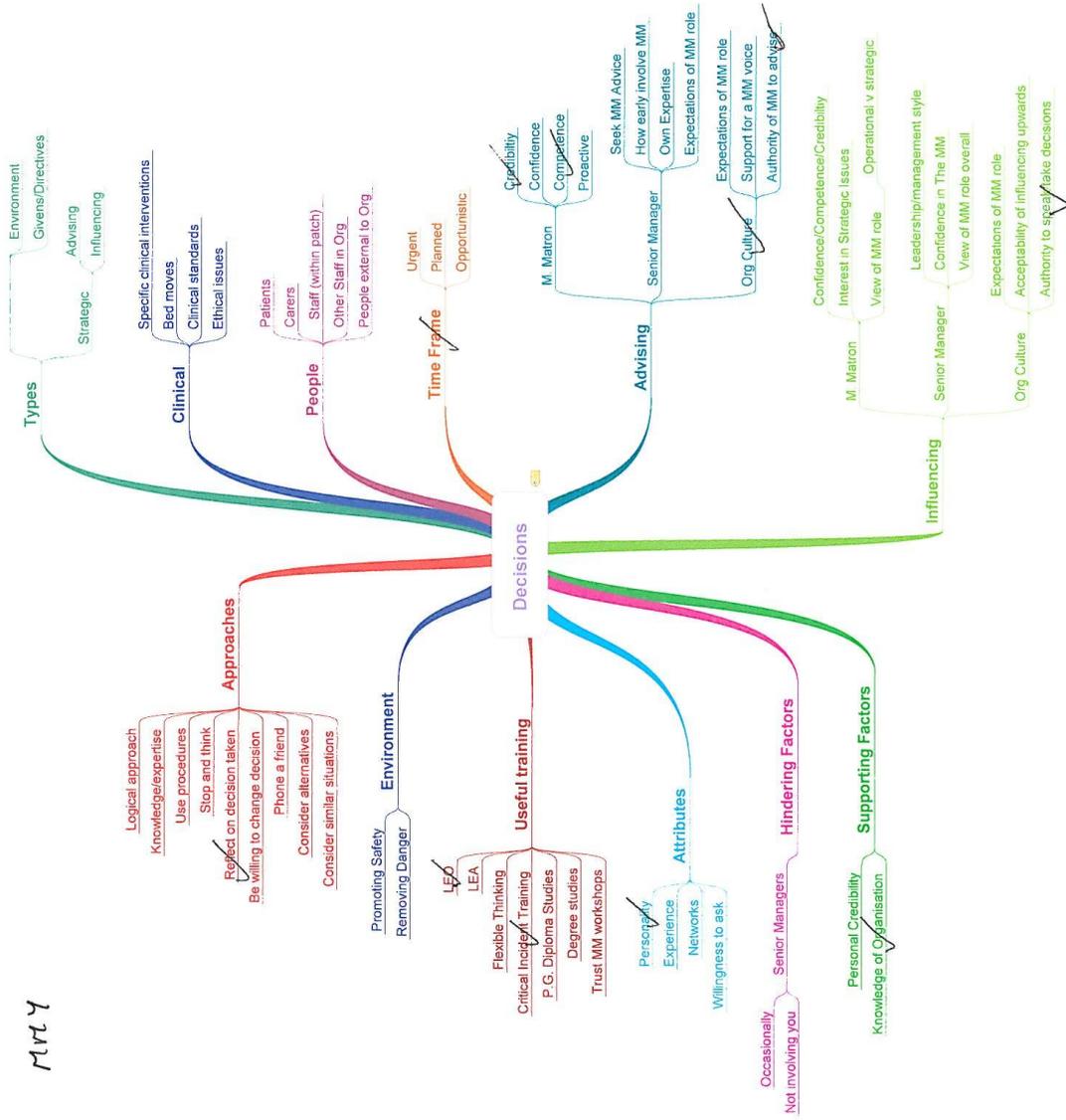
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM6

Word/Phrase circled	Field notes of description
Credibility	Means people believe u can do the job People believe in u, respect u, see u do it before you have a track record. Essential to do the job - for decisions to be respected & implemented, the MM has to have credibility in the eyes of others
Reflect on decision	Time to think/consider Taking time out to press the pause button. Don't always have the time - maybe its more & don't make the time.
Organisational Culture	Its generally good. - about atmosphere you work in & how much space u have to do the job I've done 100 as has most of the opp & so the aim is all about empowerment & a no blame culture & helping staff reach their potential - can't really argue & these principles. Some find it easier to let go of control than others.
Authority to make decisions	Means I can get on & the job. Helps make me more credible as having authority says I am trusted to do the job Frustrating if you need it & haven't got it as it slows the job down - having to check & others when it might not be a priority for them & so you r kept waiting
Modern Matron competence	Essential to do job - must be competent have to have knowledge & skills & experience to enable you to take decisions lead staff & deliver pt care effectively Some areas will be stronger than others, some aspects of role a person may need to develop

Networks	Networks might be direct specific or role specific & can be useful to only. They're useful for making contact & people & helps me to know what is happening, either in general terms or more specifically.
Senior Manager Leadership style	How much authority they give you - whether they are transformational or transactional in style. Mike is → - good for me & so I perform better, I think.
Leading an Empowered Organisation (LEO)	This is a core story for course & everyone has on. Has some good techniques that I use & it often gets referred to - usually +vely. About empowerment & trust & being accountable & to alone making decisions.
Confidence	Imp. M.H. feel confident taking decisions so that staff can be confident in them & the decisions they're making. About believing in yourself & your ability to do the job & right to take decisions - comes in experience.
Use Procedures	There're procedures for most things, we just forget to use them. When I'm not sure I often just look at trust policy & guidelines often gives me a way forward.

MMY



Interview 2

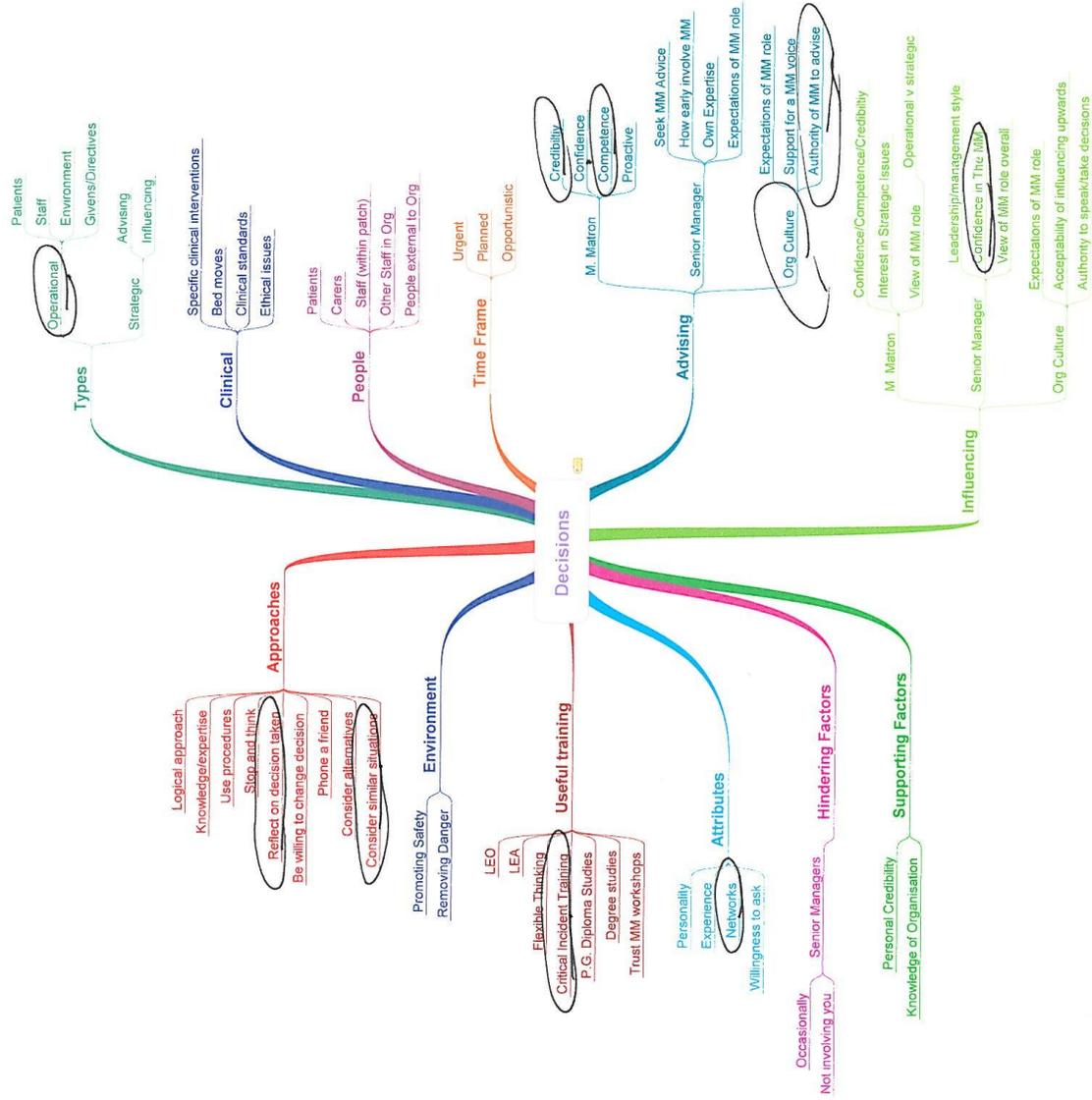
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM7

Word/Phrase circled	Field notes of description
Credibility	People ask us our opinion - they believe we know what to do. Makes me feel good that people think I'm credible. Managers listen to us. to what we say
Reflect on decision	It's a no-brainer really, good practice to reflect on our actions & decisions - I tend to do it when I'm not sure I struck or when decision has been really difficult & caused me lots of angst. Means taking time out to think about a decision, alone or with others. I tend to be a bit ad hoc when I consciously do it.
Organisational Culture	About how the org. functions or ticks, what it's like to work in. Ours is alright - there are buzz words such as empowerment & developed d. making - some people get a bit cynical but the intentions of LPO etc are good. About spreading the power about.
Authority to make decisions	Means being able to take decisions because of my role & because of who I am. Ties back into credibility above. If you're credible you can take decisions it gives you that right - the power to say yes or no because people think you know what you're on about.
Modern Matron competence	Again part of credibility - I suppose MM comp & authority. Comp gives you credibility which gives you authority. About combination of exp, knowledge, skill - being a rounded package, says to do the job.

Critical Incident Training	All the MM did this as part of our complaints management training. - It gave a structure & way of looking at things & getting the whole picture - I can use the flowchart when making other types of complex decisions.
Leading an Empowered Organisation (LEO)	This was also quite good - again it provided some techniques & strategies that as a MM I could use & stay to get the best out of them.
Personality of Modern Matron	I think my personality influences my d-making - sometimes that's good & sometimes not so good. Have been known to be too quick off the mark & had to practice responding a little slower - but that's not easy. My natural personality is to make a decision & move on.
Time	How much time I have influences the quality of a decision & the nature of the decision. A lot of our decisions move from planned to urgent because things not seen didn't & when they should have. Time influences how much info you can get to make a rounded/informed decision.
Knowledge of The Organisation	When you've been somewhere a while you get to know who's who & where to take issues & decisions for a +ve outcome.

MNS



Interview 2

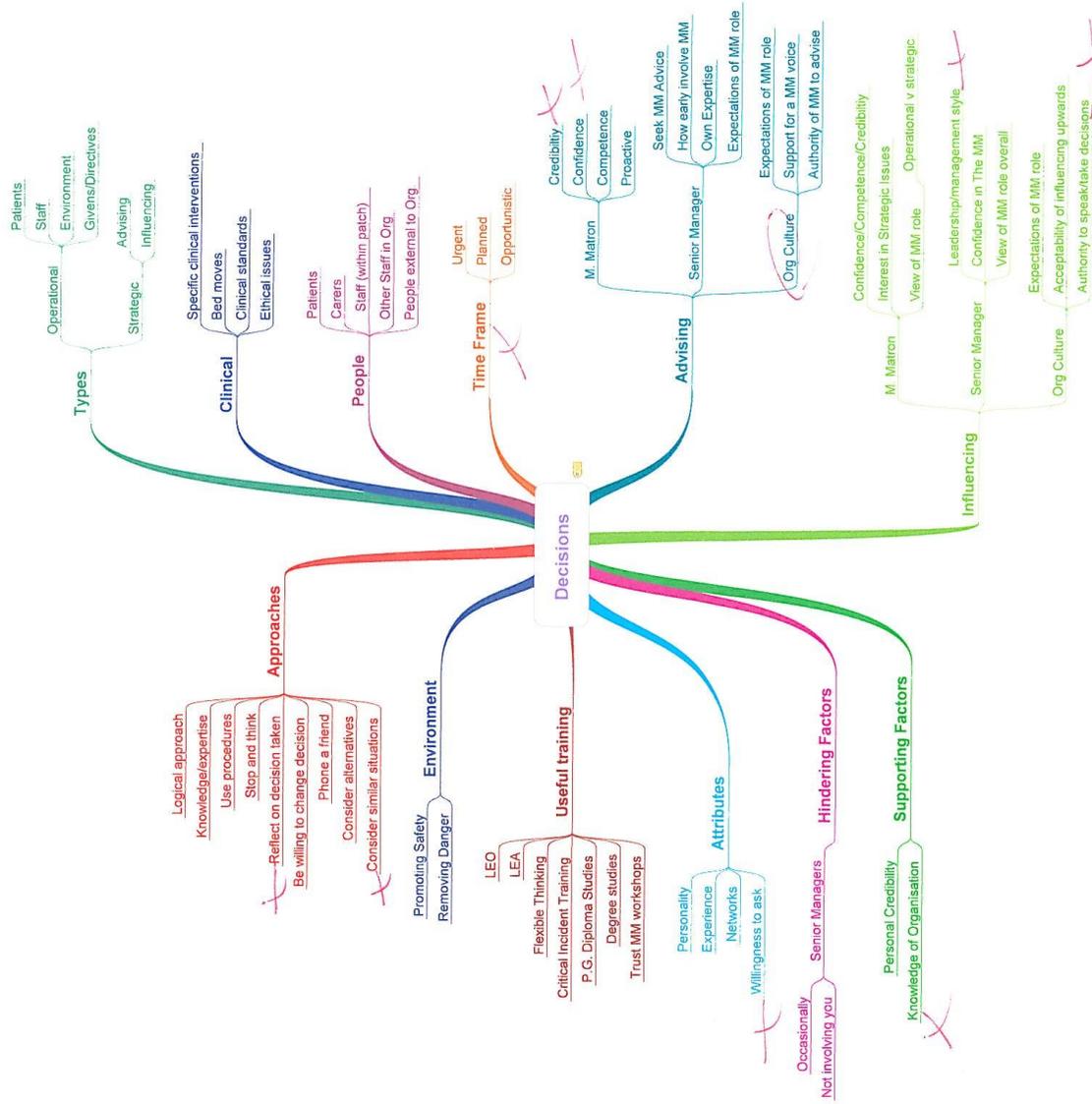
MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM8

Word/Phrase circled	Field notes of description
Credibility	I feel credible as a MM - I know what I'm doing - have been here a long time so people have seen me in an assortment of roles & know I can be trusted - know I can do the job - so I think its about ability + trust + respect or confidence in the MM.
Reflect on decision	This is clearly imp if we r going to learn - all staff r encouraged to do it but I think yours is on staff junior to MM role. I encourage it in supervision session & SVI's etc (serious untoward incidents) About what else could have been decided - how & what were implications considered etc.
Organisational Culture	About feel of an org - what it is like to work in. R.I. told what to do or consulted about what v think should happen. About systems & processes & how everyone communicates & each other & patients & carers etc.
Authority to make decisions	About being able to take decisions - generally we can take decisions - but there are limits when it involves finance, esp. an increase in it. About space to take decision & checking out when you r not sure.
Modern Matron competence	Comp should come by exp with. - More comp v r the more with u can have as you have proved yourself capable. I think the MM are seen as being competent - we have been nurses for a long time & in this org a long time so people know us.

Networks	They r essential - helps me stay in touch w the bigger picture. Can be a quick way of getting info.
Consider Similar Situations	Most times there is a similar situation we have experienced or witness that can be considered when faced w a diff situation. Context maybe diff but looking for similar principles can help provide some ideas as to how but to make the decision.
Critical Incident Training	I like this one - the structure & systematic approach is really useful. Doesn't tell u what to do - but provides clear guidance.
Operational	Op decisions are easier as generally you've encountered something similar at some point. The Mx role means that generally we have the authority to take operational decisions - unlike strategic ones where we r often just providing some input.
Senior Manager Confidence in MM	Looks to above - more confidence senior manager has more resp u have for op decision making but also the more likely u r to be asked for your input early on into strategic issues. Someone having confidence in u feels v. motivating.

MM9



Interview 2

MM provides an explanation of what they mean by the different words/phrases they circled on the mind map from stage one of the data collection.

MM9

Word/Phrase circled	Field notes of description
Credibility	People believe you can do the job / take the decision. Gives us power & authority which is useful in tricky situations
Reflect on decision	This is a sensible thing to do, not sure I always do. Means being honest to yourself, asking & /back from others & then accepting it. allowing time & it. Capturing the learning
Organisational Culture	what it feels like to work in an org. eg. enjoyable, fun, scary, horrible? on the whole I enjoy coming to work. commitment to staff development of both individuals & team
Authority to make decisions	The power to say Yes, No, I'll think about it & also the expectation that I will make these decisions. It's about a right & an expectation of the role of MM, that it will do x, y, z.
Senior Manager leadership style	Can make work of MM easier or harder. Depends how much they r willing to let go of / devolve downwards. Can dump & offload MM or hold on to everything & limit what MM can do - need a happy medium.

Consider Similar Situations	This is a useful strategy for me - if I'm stuck, not sure, I think about situations I've known in some similar features & see if I can apply the same process/decisions
Willingness to ask	we talked about credibility earlier, there is a lot of credibility in admitting you don't know & asking for help in something. Need to know when to ask. Can be easier to sometimes to ask networks rather than immediate colleagues
Knowledge of organisation	sometimes it's easier to make decisions when you've been in an org a while - you know its history, custom & practice, the the unwritten rules that apply
Time	Some decisions require more/less time than others - need to be able to assess when to give a situation more time, when to give a quick response & deal with the issue
Confidence	Really imp MM is confident - need to inspire/develop confidence of others in you. Need to have courage of your convictions & say/do what you think

Appendix Seven Final Themes and Supporting Transcript Data

In order to stay connected to the original transcript data which is where the MMs actually described the decision making scenarios that they chose to highlight, it was important to cross reference the themes back with the raw data. This is particularly true for 'power' to ensure that it was present in the original data, even if its significance was only established during stage two of the analysis. This process is illustrated in the tables below.

Theme	Transcript Data
Decision making approaches	I do like to ask other peoples' opinions. I think you should do, especially if the decision is going to be far reaching (MM7.9)
	I think of a few solutions and pick the best one (MM8.5)
	You can call on past experiences (MM3.12)
	I tend to look at things more widely now. I tend to think things through a bit more (MM 5.28)

Theme	Transcript Data
Credibility of the Modern Matron	I can make things happen because on this site, everybody who knows me respects me. I have a history and credibility with them (MM1.15)
	I think my advantage is that I have got quite a lot of credibility with the Directors (MM3.8)
	I think you need to be out there and also important to really keep yourself updated on what is going on and what is changing [in order to maintain your credibility](MM 5.22)
	"You have got to have the conviction behind why you are doing something (MM.6:17)

Theme	Transcript Data
Power	If I compare it to management power, I probably feel I have more of it now [as a Modern Matron]. Nurses are hierarchical and they look to that so you get your position and your power from that. (MM4:9/10)
	It's nice really, being able to make decisions for myself and that I am not dictated to (MM2:24)
	It's not easy trying to influence other people that you don't have any direct control or jurisdiction over (MM7:14)
	If there is a problem with holiday requests and someone says, oh well I am going to book it anyway, then they would just wheel me out in that sort of situation. (MM8:16)

Theme	Transcript Data
Authority to take a decision	I would say that from a nursing point of view, I have authority to implement most things (MM1.7)
	So I made the decision that day that we would close ward 12. That was difficult in itself, because then it was me that had said which ward, no-one else (MM6.2)
	If there is a problem [out of hours], I think most of us make the decision and deal with it and then just ring the on-call manager up to say 'this is what's happened, this is what I have done, but I just thought you needed to know.' So I think we take a lot of pressure off the on-call managers (MM9.9)
	I have loads [of authority]. I have definitely been empowered (MM3.18)

Theme	Transcript Data
Organisational culture	I have definitely been empowered, definitely been empowered. And I am supported. I am really really supported (MM3.18)
	I said 'at the moment, I feel comfortable with it, but you know that if it gets uncomfortable, I will be shouting.' And I will, I am not scared to say 'I can't do this' and they will say 'no, you are right, you can't, we

	have given you too much to do. And they will support me and that is a nice feeling. MM3.19
	I do think they [senior managers] are happy for you to make the decision. I can't see the point of ringing at 2 or 3 in the morning .. and I've never had a negative response from them, its always been 'well thanks for letting me know' or 'thanks for not ringing me at 2 or 3 in the morning' (MM5.31)
	They [modern matrons]are all there, if I think I have got a problem, there is always one of then that you can go to that will help. Plus your manager, plus anybody really (MM8.18)
	They are a very open culture within the division. Your opinion is sought and you know you can put your spoke in. (MM4.13)

Theme	Transcript Data
Reflecting on decision taken/to be made	I do reflect when I have got decisions to make, particularly with staff issues. I do look back to situations that I have been involved in and how I felt and I have just called on my past experience and how I would feel as that person. (MM3.12)
	I do think I reflect, really learn, so that maybe see if you could do things better, or f it has been a good way of dealing with things, then to use those strategies again. (MM7.4)
	I think you just do it without thinking about it sometimes. But if there are difficult ones to make I like to mull it over ... go away and think about it, 'have I done the right thing.' (MM2.22)
	I try not to be knee-jerk, I do try and think about things and I say 'Caroline, I can't make these decisions like that, you have just got to give me time to think about it.' Very often I find that because I am driving between sites, that time when I am sat in the car on my own thinking about things, then I will ring up and I might not have to change the decision, but add something to it you know. (MM3.13)

Appendix Eight

Transcript Scenarios

The following three transcripts are referred to on a number of occasions in the Discussion chapter and are typed out in full here for reference:

Scenario: A 90 year old patient reported being knocked over by a porter with a trolley, but no-one witnessed it. Her son was very irate:

"I spoke to the staff and kind of looked at the whole scenario. Everybody realized that this lady had ended up on the floor, they'd called a crash team because they thought she had collapsed and there was blood everywhere. I spoke to the crash team and I still wasn't getting any answers whatsoever. So at that stage, I took the investigation a little further and spoke to the Head Porter. Yes, looking at the log, a porter had been in that area but not at the time specified. It just didn't seem to add up. So I went back and thought about it more and realized there were CCTV cameras covering that area, so watched them. The lady had not been run over by a trolley, she had actually tripped and fallen herself." "I suppose maybe that is experience, and not jumping to conclusions and looking at the whole picture as opposed to maybe just the facts that you are initially presented with." (MM7.3)

Scenario: Wearing of non-traditional uniforms

"One of my biggest issues and they know it is, because they quoted me, saying 'we know what you are like with uniforms, but can we ...?' My initial reaction was 'no'. Then I looked into it further. If I let them do that [wear a cooler non-traditional uniform in hot weather], they were not allowed to go off the ward in them, go down to the dining room, no whatever. My 'win' was that if I allowed them to do that, then all the jewellery came off, so that was my negotiation.

I went off for two weeks and came back to a meeting to find a staff nurse there not wearing the proper uniform. So I pulled them up about it after the meeting and said 'look not acceptable, you heard what I was saying.' The two staff nurses who were on duty, one of them was very challenging, saying 'I don't care, I am wearing it, it's too hot. I don't care what the chief exec says, they want to come up here.' I said, 'look, I don't

care, these are the agreements, if they are breached, then it spoils the agreement for everybody.'

I had to really. It was difficult and it felt uncomfortable, because I really had to stand my ground because I knew if I lost, I may as well throw in the towel. There was something about putting boundaries down and how far they could push it, and they were certainly pushing it. So I think we won that battle actually and came out of it okay" (MM.4.1)

Scenario: Calling Police to remove a patient

"A difficult one that springs to mind is when I got a call to say they had got a problem with a relative, not a relative, but a visitor. We'd had a patient who was a regular patient, known to us, who self harmed and was known to be violent and had attacked nurses with scissors prior to this. She had become aggressive on the MAU and the police had been called. The police had removed her from the hospital and put her outside and told her that she couldn't go back otherwise she would be arrested. This visitor had gone to MAU and complained saying it was appalling that this girl was outside, did we see the state of her and she needed help and was demanding that the girl was brought back to MAU. So I went round to MAU. This lady was insisting that we re-booked this girl back in and that we get her seen in A&E. So I explained to this lady that for ethical reasons I couldn't discuss the girl's case with her at all, but the Police had been involved and that she had been removed from the premises and that she would be arrested if she came back in. I did explain that this lady had been seen by both the psychiatrist and the physician that morning and deemed medically fit to be discharged. This lady continued to complain bitterly that we were allowing this girl to be discharged from' hospital. I just stood my ground basically and said 'I'm sorry but we are not bringing her back in again.' To which she said she would make a complaint to the Trust and I said 'okay, that's fair enough, you can do that. She insisted that I gave her the names of the consultants, so I gave her them and off she went very very angry. I informed risk management the following morning that this discussion had taken place with this visitor and what the

decision had been. We never heard anything again, so. I suppose I based my decision on the fact that this patient was known to be violent and aggressive. She was obviously aggressive that morning, albeit verbally, we knew that this was a pattern of escalation with her behaviour and from a staff safety point of view I felt that I didn't have any other choice than to make that decision. And it would have made a mockery of the whole system that we don't actually tolerate violent behavior had I insisted that she come back and be seen by a doctor. (MM1.1)

Appendix Nine Modern Matron Demographic Detail

	Gender	Age Range	Years Qualified	Years worked in Host Org	Worked in any other org?	Worked outside of the region?
MM 1	F	40-50	28	20	Y	N
MM2	F	30-40	19	15	N	N
MM3	F	40-50	26	18	Y	N
MM4	F	30-40	15	8	Y	N
MM5	F	30-40	19	19	N	N
MM6	F	40-50	26	26	N	N
MM7	F	50-60	36	36	N	N
MM8	F	40-50	25	25	N	N
MM9	F	50-60	38	38	N	N