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# Evaluation of a family liaison officer role introduced during the COVID-19 pandemic: A mixed methods study

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## Abstract

**Rationale:** The restrictions to hospital visiting for carers and relatives during the pandemic were unprecedented. To ensure patients could stay in touch with their relatives and carers new liaison roles were introduced.

**Aims and Objectives:** The aim of this study is to report on the evaluation of a Family Liaison Officer (FLO) role to understand the rationale for introducing the role along with the challenges and benefits of its implementation.

**Methods:** A concurrent mixed methods design was used, triangulating both semi structured interviews and online surveys. Data were collected during 2021 from postholders, patients/relatives and key stakeholders.

**Results:** The family liaison officer role occupies a key brokering role between clinical teams and patients/relatives. All participants agreed the importance of the role particularly in relation to communication. Postholders noted issues around clarity of scope of practice. Patients reported the social benefits of the FLOs particularly in relation to technology. There was also key learning in terms of induction, training and line management of this nonprofessional role.

**Conclusion:** There is limited research that evaluates emerging nonprofessional roles that connect clinical teams and patients/relatives. This evaluation study although limited to one organisation provides important insights to the strategic and operational learning to introducing a family liaison officer role during the COVID-19 pandemic.

KEYWORDS

broker, carers, family liaison officer, patients, relatives

## 1 | INTRODUCTION

The Family Liaison Officer (FLO) role is a well-established brokering role in some public services such as the police and prison services, education and bereavement services.[1] In healthcare, there are limited examples of family liaison roles to draw upon particularly in a hospital setting. This may reflect the complex issues of bringing family members into a patient's care, which requires a sensitive balance between the family's need for information and access to their relative alongside the medical teams often time sensitive management of ill

patients.[2] However, communication between the healthcare team and patients' family members is a critical factor that impacts on patient experience and is often the source of complaints.[3]

The impact of brokering roles has been reported, for example, Allied Health Liaison Officers which resulted in improved quality of life outcomes in children with chronic noncomplex medical conditions and their families.[4] This liaison role was responsible for facilitation of healthcare access across hospital, education, primary care, and community sectors and showed improved clinical outcomes. One area in healthcare where FLOs are well established is in Aboriginal health. Aboriginal Health Workers and Liaison Officers (AHWLOs) were introduced in countries such as Australia during the 1980s to help to break down cultural barriers to existing health services and provide base health services to Aboriginal communities.[5] The role of the AHWLO is varied and may include chronic care, mental health, drug and alcohol services.[5] The AHWLOs are recognised as being essential to closing the gap between health and social outcomes, they are seen as a unique profession, which are beginning to achieve professional legitimacy.[5] However, significant challenges are noted for AHWLOs working in an acute setting, which include heavy workloads, unclear roles, insufficient support and training which impact on retention.[6–8] What is unclear is whether all AHWLOs have a clinical background or whether these roles are occupied by nonprofessional staff. More generally there is a call for further research to understand the impact these liaison roles can have on patient health care especially in acute care settings.[5]

More recently, against the backdrop of the COVID-19 pandemic when hospital visiting was halted, some healthcare organisations introduced new broker roles to bridge the visiting gap to ensure that patients and their relatives were able to remain in contact. An FLO role, using redeployed staff, was introduced at a central London hospital in the early stages of the first wave of the pandemic.[9] The views of patients and families are missing however, the FLOs reported the role had a very positive impact, for example, benefit of consistency of care to help build rapport and trust with patients, family and clinical staff.[9] The FLOs experienced challenges such as a lack of induction and boundaries or clear structures.

To date there has been limited reporting on the role of the FLOs in healthcare. When identified some common themes are apparent such as improved communication between families and healthcare staff and challenges such as lack of role definition. However, critical information is often missing, for example, patients and families' perspectives, background requirements for FLOs and role clarity. The aim of this paper is to address these omissions by evaluating a new FLO role. The evaluation examines the rationale for introducing the FLO role along with the challenges and benefits.

## 2 | METHOD

### 2.1 | Context

In Spring 2020, with the advent of the COVID-19 pandemic, the patient experience team at Hywel Dda University Health Board in Wales, UK introduced a FLO role to all its 10 hospitals (four acute general hospitals, four community hospitals and two temporary field hospitals). The need for the role was derived directly from patient and relative feedback indicating the necessity to facilitate and improve communication channels. The FLO posts were short term contracts at the Agenda for change band 2 pay scale, which includes posts such as Healthcare support workers and Catering Assistants. Line management was undertaken by the Patient Experience team. The primary aim of the role was to facilitate communication between patients and their relatives/carers, while hospital visiting was heavily restricted. All ward areas were provided with essential technology in the form of iPads.

### 2.2 | Study design

#### 2.2.1 | Evaluation framework

We used Stake's[10] framework (Figure 1) to assess the rationale, context and where possible the outcomes associated with the FLO role. This framework was selected as it is one of the few models that provides a comprehensive and multidimensional approach to examining the development, delivery and outcomes of an intervention, capturing all elements, all relevant data, and providing a clear strategy for analysis of findings, thus offering a comparable and credible evaluation pathway.[11]

We had two distinct but complementary foci. First, to establish the extent to which the role has been successful in meeting its objective to facilitate communication between patients and their relatives, while hospital visiting was heavily restricted. Second. to examine expectations of the role and whether those intentions have been met (Figure 2).

A concurrent mixed methods approach was taken which included online interviews and surveys with participants involved in designing and managing the post, the postholders themselves and patients/relatives.

#### 2.2.2 | Sample/Participants

Participants included key stakeholders, such as lead nurses, education team, along with patients and relatives and the FLO postholders themselves. See Table 1 for details of the FLO recruitment and ward allocation. FLOs were not allocated to Paediatric services, Critical Care, mental health and learning disabilities, theatres and outpatient areas and therefore excluded from this study.

#### 2.2.3 | Data collection and procedures

Data collection took place from June to September 2021, employing both semi structured interviews and surveys, which enabled data to be collected and analysed in parallel.[12]

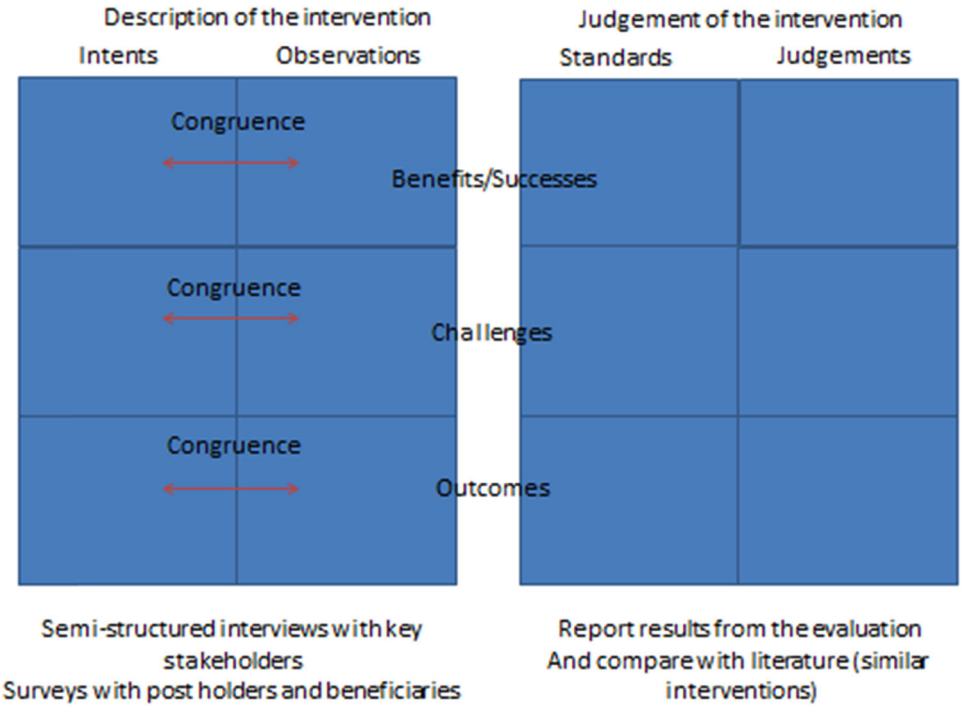


**FIGURE 1** Evaluation framework based on Stake's[10] model. NB: Judgement against standards can refer to any published standards, similar evaluations, or any published good practice (professional or academic). *Source*: Adapted from Stake.[10]

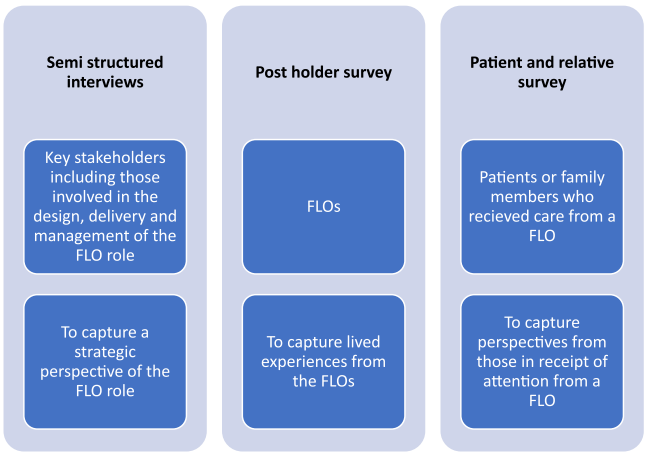


**FIGURE 2** Data collection, participants and purpose. FLO, Family Liaison Officer.

**TABLE 1** Family Liaison Officer recruitment, training and ward allocation.

| | Cohort 1 | Cohort 2 |
|---|---|---|
| Date of recruitment | May 2020 | September 2020 |
| Applicants' background | Mass recruitment initiatives? | Direct application for the FLO role |
| Training | A short training programme was developed at pace by the nursing education team and was based on the 'skills to care' programme[19] delivered to Health Care Support Workers. | |
| Allocation to wards | General inpatient wards, for example, frail elderly care, stroke and orthopaedic wards where the demand for communication with families had grown during the early phases of COVID-19 pandemic. | |

The survey questions were based on operational knowledge, the FLO job description and role expectations. Similarly, the interview questions, based on Stake's framework, included rationale for and intentions of the post, benefits and challenges and suggested improvements to introducing the FLO role (see Supporting Information). The same interview questions were asked to all stakeholders with each being provided with the opportunity to add any additional comments or suggestions about the FLO post. Survey participants were given the option to complete the survey in Welsh or English. Any Welsh responses were translated before analysis.

### 2.2.4 | Stakeholder interviews

Stakeholders were invited to take part in online semi-structured interviews based on their involvement with the FLO role including those involved in the design and introduction of the role through to those involved in the more operational elements of the role. The

interviews were conducted via Microsoft Teams and lasted between 30 and 45 min. All interviews were conducted in English.

#### 2.2.5 | FLO online survey

All those occupying the FLO posts at the time of the survey were invited by email to participate in an online survey. All participants were assured of anonymity and participation was voluntary. The survey consisted of 20 questions which focused on the postholders' perceptions of (1). The FLO role before commencing in post versus the role in reality, (2). The training provided and ward induction, (3). The level of support they received in post, and (4). The rewards and challenges they encountered in the role.

#### 2.2.6 | Patient and relative online survey

A link to an online survey was distributed via email to patients and relatives that had engaged with FLO(s) while in hospital. All respondents were assured of anonymity, and their contribution was voluntary. Patients and relatives were selected for inclusion on the basis that they had previously responded to data collected by the Patient Experience Team, and indicated their willingness to be contacted again. The survey consisted of 12 questions which focused on (1). Were the patient or family were introduced to the FLO role, (2). what tasks the FLO supported them with, (3). Positive and negative experiences, and (4). The impact and overall experience the FLO had on the patient's hospital stay.

### 2.3 | Ethical considerations

This study was reviewed and approved by the Local Health Board as a service evaluation. Consent was obtained from all participants that took part in the study.

### 2.4 | Data analysis

The interview data were transcribed and analysed using content analysis. This form of analysis was selected to identify the specific requirements of Stake's[10] evaluation framework, for example, rationale, purpose and intended outcomes and guided by the directed approach to content analysis.[13] The FLO and patient survey data were analysed using descriptive statistics (percentages) with quotations from open questions included.

## 3 | RESULTS

The results are reported using the key elements of the Stake's[10] framework from the three data sources. First, we present those participating in the data collection activities. Second, we report on the rationale for the FLO post by examining whether the objectives of the post and the recruitment process were clear, which are established largely from the stakeholder interviews. Third, we report on operational considerations and the challenges and benefits of introducing the FLO role, which draws on data from stakeholders, postholders and patients. Fourth and finally, we consider whether any improvements could be made to the role which we take views from all participants.

### 3.1 | Participants

We had a good response to all the data collection activities (Table 2).

## 4 | RATIONALE FOR THE FLO POST

### 4.1 | Objectives of the post

All key stakeholders described the primary objective of the role as supporting and facilitating communication between patients and their loved ones during the pandemic whilst visiting was heavily restricted, and to act as the conduit between hospital and home. Largely, this included the use of digital devices, either supporting patients to use them, or arranging timetables of use ensuring accessibility for all who required it. Additional duties included the collection and return of laundry, getting items from the hospital shop, using interactive devices (RITA systems), playing games and talking to patients. Some stakeholders extended this thinking to the potential of releasing nursing staff time to undertake clinical duties.

All stakeholders concurred the role achieved the primary function of enabling communication between hospital and home.

**TABLE 2** Response rates for data collection activities.

| Data collection tool | Participants | No. invited | No. participated |
|---|---|---|---|
| Stakeholder interviews | Senior health board postholders, for example, directors, senior nurses/charge nurses and carers' representatives | 30 | 24 |
| FLO online survey | All FLO post holders | 64 | 33 |
| Patient and relative online survey | Patients and relatives | 128 | 36 |

Those stakeholder participants with a more operational focus described how the role had evolved to suit needs of specific clinical areas, which is supported by approximately half ($n = 17$) of the FLOs reporting roughly half the tasks they were asked to carry out were tasks not part of their job description, and potentially outside of their level of competence.

### 4.2 | Recruitment and selection

It was evident from several of the key stakeholders that the selection process for the FLOs varied between the first and second cohorts. Some participants described how the first cohort were recruited as part of a wider mass COVID-19 recruitment campaign. This resulted in some candidates being appointed who had not necessarily applied for specific FLO roles. For cohort 2, the recruitment was tailored to the FLO role and candidates were interviewed over the telephone by members of the Patient Experience team. The nursing team in one of the general hospitals was involved at this stage of the interview process; however, no other sites were. All the ward sisters and senior nurses interviewed agreed it beneficial to have nursing input into the recruitment and selection process of further cohorts. Equally, where nursing colleagues were involved in the interview process, they felt that more flexibility was needed in the interviews questions to enable interviewees to provide more information about previous roles held. Some participants reported the rigidity of the interview script did not allow for the full exploration of experiences, hobbies and skills acquired outside of healthcare.

### 4.3 | Characteristics of postholders

The desirable characteristics for the FLO post were noted by many stakeholders as being personable, adaptable and having excellent communication skills. It was also reported that kindness was paramount over the need for academic qualifications, with the ability to use common sense and make things happen while putting people at ease, which was of particular importance during the pandemic when there was a heighten sense of fear and anxiety for patients, relatives and staff. Two participants who worked with FLOs reported not always being aware of when the FLO was on duty, but being aware of the deficit when they were not, and in many cases patients' families would request to speak with the FLO.

## 5 | OPERATIONAL CONSIDERATIONS

### 5.1 | FLO role and training

The induction training plan for the FLOs was reported by some interviewees to have been developed at pace and was based on the Health Care Support Workers (HCSW) training, named Skills to Care, and was delivered by the nursing education team. Many interviewees reported the need for a more in-depth induction to ensure postholders clearly understand clinical areas and the things they are likely to be exposed to. The FLOs agreed with this suggestion, especially as most of them were new to clinical areas. One stakeholder reported that FLOs have purposely not been trained in clinical tasks (e.g., personal care, patient handling and mobilisation) to ensure the role remains specific and protected and does not merge into the Health Care Support Worker role. In attempt to try and avoid any confusion it was reported by some stakeholders the support mechanisms available to FLOs as being fundamental to enabling the post to function well. It was also suggested that a more formal process of clinical supervision and peer group supervision could be considered to ensure there is the opportunity to share experiences and learn collaboratively from each other.

Communication between hospital and home was reported by all FLOs to be a key element of their role, closely followed by arrangements for patient laundry (94%, $n = 31$) and updating relatives on patients' nonclinical condition (70%, $n = 23$). Figure 3 demonstrates what post holders understood the FLO role to involve. FLO Participants were asked to list tasks they undertook (see Table 3). Many of these tasks are outside the role described earlier by the stakeholders.

### 5.2 | Line management structure

The FLOs were line managed by the Patient Experience team via two designated leaders. In many cases the FLOs maintained a close working relationship with the patient experience leaders except for

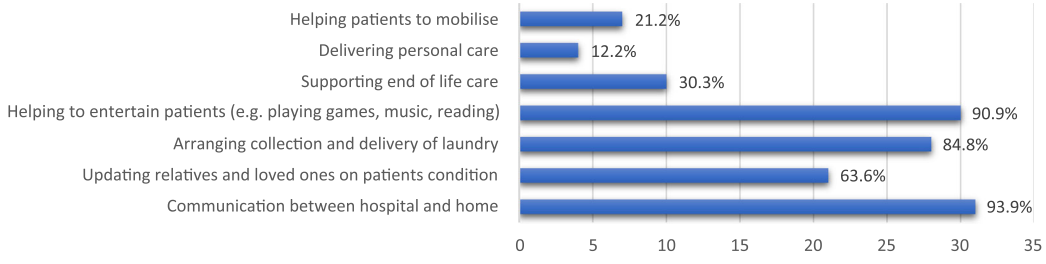


**FIGURE 3** Key elements of the Family Liaison Officer role.

**TABLE 3** Typical tasks and activities undertaken by FLOs.

| Theme | Example |
|---|---|
| Personal care | Toileting and catheter care; moving and mobilising patients; assisting with washing and toileting of patients, accompanying patients to the bathroom; COVID-19 swabbing; emptying/replacing urinal bottles. |
| Assisting other staff | Taking patients to X-ray, scan or out in wheelchairs; assisting with cleaning duties; making beds, arranging bed cleaning teams to come to ward. |
| Social support | Supporting patients with dementia, including one-to-one support; serving food, organising meals for new patients, going to kitchen to collect food; assisting completion of the 'This is me' document; making teas/coffee and milkshakes; packing belongings for discharge, including completing the patients property records; travelling with a patient to their home or other hospital upon discharge; speaking to relatives about patient death; supporting patients with dementia, including one-to-one support. |
| Administration | Collecting medications from pharmacy, including control drugs; taking specimens to the laboratories; answering the ward telephone; photocopying documents; completing food charts. |

Abbreviation: FLO, Family Liaison Officer.

one general hospital where Patient Experience provision was limited. Many of the stakeholders agreed the line management of the FLOs would be better at ward level, as this would provide greater control over rostering. All stakeholders confirmed the importance of the Patient Experience team being involved in managing these roles particularly during the fast-moving environment of the COVID-19 pandemic.

## 6 | CHALLENGES AND BENEFITS OF INTRODUCING THE FLO ROLE

The experiences of the FLO postholders have provided invaluable insight into the successes and challenges of the role. For example, 91% (30 of 33) indicated that they would consider a long-term career as a FLO, with one respondent noting it was 'the best job in the world'. Several postholders reported the most enjoyable part of the role was helping patients and families to receive the best care possible (see Table 4).

When asked whether the training received before starting their posts was sufficient two thirds (67%, $n = 22$) of postholders responding positively. Postholders were also asked what other training they would find beneficial; many suggestions were provided by the participants. These have been themed in four key areas (see Table 5). The breadth of suggestions shows how the scope of the role has expanded in practice and indicates some overlap with other key ward-based roles such as ward clerks and HCSWs, including activities which are out of the scope of the FLO role, for example personal care, manual handling and restraint.

### 6.1 | Patient experience

A useful indication to evaluate the FLO role is the impact on patient experience. From the perspective of the stakeholders all were positive about the role, with a key benefit being described as the special rapport established between the FLO and the patients. In terms of the patients, 86.3% ($n = 31$) of respondents reported positive experiences of the FLOs (see Figure 4). Clearly the support offered by the FLOs has been recognised by the participants along with the liaising, communicating, and connecting elements of the role being especially valued which were expressed both in English and the Welsh language (yn gwneud—doing; roedd cael—had). Several of the patient/relative participants reinforced the positive impact of the social support aspect of the FLO role (see examples in Table 6) which included assistance with technology, transition to home and companionship.

**TABLE 4** Comments about the role from FLO participants.

| |
|---|
| 'seeing the patients walk out the door to go home and see their loved ones again'. |
| 'the FLO role is, to me, the best part of care'. |
| 'making people smile'. |
| 'Hearing some amazing life stories from patients and gaining their trust in me to open up and talk about themselves which gave the nursing team extra information to help them with the patients'. |
| 'Going home at the end of the day knowing that you've done, maybe very small things that have made a big difference to patients and their families'. |

Abbreviation: FLO, Family Liaison Officer.

The 13.7% ($n = 4$) of respondents who reported a negative experience related to either being unaware of the role, not understanding the role or not being offered video calls or daily updates despite the presence of a FLO (see Table 7). For example one respondent responded '··not made aware through ward, no offer of video calls, we never had daily updates not even weekly'), which links to our previous discussion on the scope of the role and relevant training.

Since the introduction of the FLOs one stakeholder reported there has been a reduction in the number of formal complaints

**TABLE 5** Suggestions on the scope of the FLO role.

| Theme | Example |
|---|---|
| Personal care | Manual handling (including patient handling), first aid, restraint and one-to-one training, including de-escalation techniques, Personal care, Dementia, and mental health awareness. |
| Communication | Managing complaints. |
| Social support | Zoom and Microsoft Teams; de-escalation skills; patient engagement and communication. |
| Administration | Welsh PAS, General ward functions/management/processes. |

Abbreviation: FLO, Family Liaison Officer.


**FIGURE 4** Word cloud of patient and relative key words for Family Liaison Officer experiences NB: Welsh language translation—yn gwneud —doing; roedd cael—had (support).

**TABLE 6** Positive comments from patient/relative participants.

| |
|---|
| 'The family liaison officer(s) provided me with a phone charger, connected me to hospital wi-fi, and helped me to watch the Euros (football) online'. |
| 'Assisting with a call to Australia where family live - so pleased that the family were not t oo far away!' |
| 'helped to make the transition between in-patient and home coming a little easier'. |
| 'he was interested in me, remembered "previous chats", he knew if I'd had a bad/good day etc'. |
| 'Made tidy cup of tea'. |
| 'An essential part of my stay at hospital'. |

**TABLE 7** Issues from patient/relative participants.

| |
|---|
| 'lack of communication or even awareness of the role on this unit'. |
| 'Not made aware through ward, no offer of video calls, we never had daily updates not even weekly'. |
| 'the wards need to explain this and need to make sure it happens'. |

received in some clinical areas where the FLOs are placed. Others, while the numbers of complaints have not changed, found there is often a positive comment included in the complaint regarding the FLO. Early resolution complaint numbers have decreased, which is often associated with the quick actions of FLOs in managing concerns at the point at which they arise.

## 7 | FUTURE OF THE FLO ROLE

Using Stake's[10] framework the aim of this study was to evaluate the FLO role and to assess where improvement could be made in the development of the role. Figure 5 provides an overview of the key findings in relation to the intentions of and the rationale for the post, what was observed from analysing the data, whether there is any standards or evidence available to compare these results and where judgements have been made based on the data collected. From examining the first column (intents) the primary intention of the FLO role was to improve communication between patients and their relatives, which was confirmed by the stakeholder interviewees. There was agreement from most of the participants that the role was viewed as a success as it provided the vital connection between clinical teams and patient families/relatives. Although, there was recognition from some stakeholders (e.g., ward sisters and charge nurses) when establishing the FLO role there was the potential for overlap of some duties with ward clerks and HCSW.

The skills or training programmes identified by some of the stakeholders were seen as beneficial and should be considered when implementing FLO roles, especially skills such as communication and dementia training. However, providing restraint, for example, is not included in the job description and is not an objective of the role, and therefore should be excluded. Role ambiguity remains an issue and clarity is required for those that occupy the role and those that interface with the role.

All stakeholders agreed if the role were removed from clinical areas, it would be a loss to patients, relatives and clinical teams. They confirmed that the focus of the role needs to remain as patient

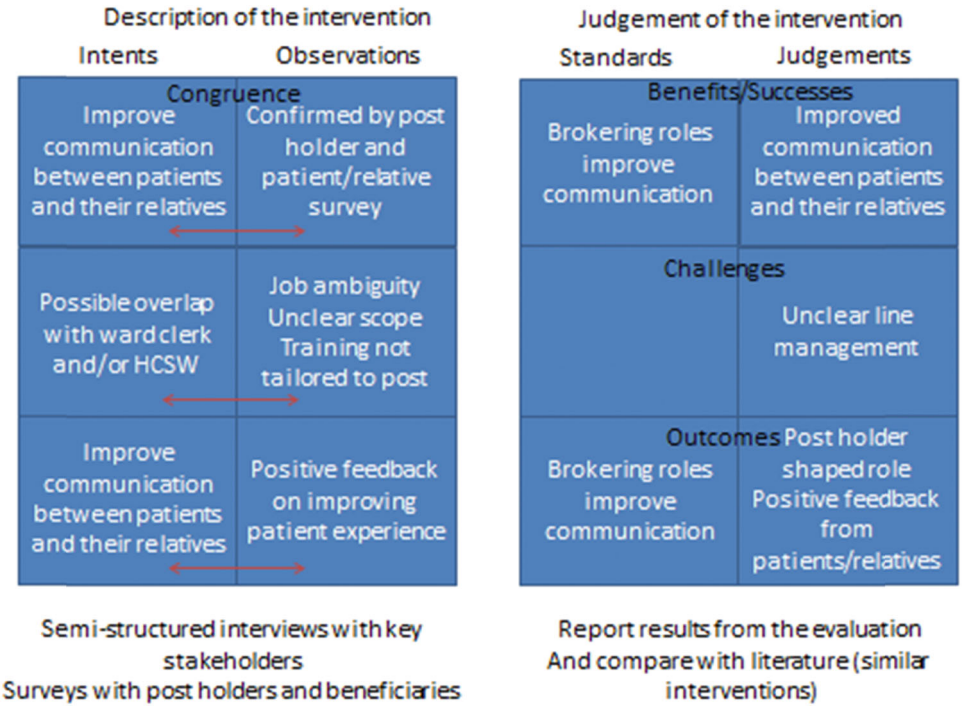


**FIGURE 5** Evaluation results using Stake's framework.

communication and nonclinical support to patient care which can be strengthened by the recognition of key performance indicators for the role. Some stakeholders noted future recruitment of FLOs provides the opportunity to enhance the interview process to assess candidates for the necessary skills. There were a few patient respondents that were unaware of the FLO role which suggests further work is needed to promote the role.

Several of the stakeholders recommended that FLOs be line managed by the ward sister/charge nurses with supervision from the Patient Experience Team; or, alternatively, remaining with the current Patient Experience structure which may help to protect the role in its planned function, reducing the risk of it morphing into a more clinical role as noted as a risk by some stakeholders.

Some stakeholders noted there is scope to expand the role of FLOs in the future to work more closely with therapy colleagues to support the rehabilitation phase of patient journeys by engaging patients with therapy techniques, albeit doing a jigsaw, catch and throw of a ball etc. Other areas were nutrition and hydration and end of life and bereavement processes by, for example, returning property to loved ones, sending of bereavement cards and being a point of contact.

## 8 | DISCUSSION

Brokering roles offer the opportunity to improve communication between healthcare teams and members of the patient's family, yet there are limited examples of such nonprofessional roles within the acute care settings.[5,9] The results of this study have identified the challenges and benefits to introducing a FLO role. Clarity is needed in key areas such as purpose of the role, induction and training and scope of practice. Key benefits of the role included improved patient experience via the use of technology to communicate with family members, companionship and in some instances assisting with elements of the discharge process.

A key benefit reported by Nagel and Thompson[14] of the engagement of a liaison officer was improved communication but did not indicate how this was achieved. This study has demonstrated that communication is improved, especially through the use of technology along with other benefits such as companionship, social activities and personal care.

Previous research has raised confusion surrounding the introduction of new brokering roles such as FLOs, not only with the clinical team but with the postholders themselves as well as patients and their relatives.[5,9] It is clear from this study that the preparation of postholders and ward nursing teams was not sufficient before the commencement of the post and more clarity around the intention of this nonprofessional role was needed.

Challenges experienced by those holding brokering roles are often associated with workload and inadequate remuneration.[5] Such challenges were not evident in this study but this may reflect these were nonprofessional roles and the initial introduction was during the pandemic when postholders may have viewed these roles as temporary employment.

It is clear from this study and previous research FLOs occupy an important brokering and connecting role, where they operate as conduits for the transfer of advice, social support and information.[15] It is often assumed that brokers such as FLOs have a good

understanding of the roles, professions and organisations in which they are brokering, which suggests typically healthcare professionals are more likely to play this role. It is therefore important nonprofessional FLOs receive a well-designed induction programme and ongoing training that enables them to fulfil the role.[5] Much of the previous research related to brokering roles has focused mainly on managers, healthcare professionals[16,17] and to a lesser extent patients/relatives.[18] The evaluation of this nonprofessional FLO role provides us with another important perspective that has rarely been considered.

### 8.1 | Limitations

This study has been conducted during the pandemic and within one health board located in Wales, UK and, therefore, results may be limited to this context. As this role was new there was also a limited pool of postholders and beneficiaries that could be approached to take part in the study. Therefore, a mixed methods approach was taken to enable triangulation of data sources. The evaluation framework was useful to examine the rationale for the post, whether the intension of the post had been achieved, the benefits and challenges of the introducing this new post. The framework also encourages observations of and comparisons to be drawn with other similar roles (standards). As there is not a dearth of studies on these nonprofessional liaison roles within acute healthcare this was not always possible.

## 9 | CONCLUSION

The aim of this study was to evaluate the introduction of a new family liaison role during the COVID-19 pandemic. Using Stake's[10] evaluation framework, this study assessed the intension of the role and whether this had been achieved. Overall, the role has been seen as a positive introduction and fulfils vital roles, especially during the Covid pandemic. The results show that the FLO role is valued by staff and patients alike.

Although the initial aim of the role to improve communication between patients and relatives was clear, it would seem that the scope of the role has extended over time. The widening of the scope of the role needs to be controlled. Implementing a comprehensive induction programme tailored to the role and the environment in which FLOs work could provide clarity for all involved with the role. In this research we asked postholders what tasks were involved in their role; we did not enquire about previous experience or what they enjoyed doing. To assist with recruitment, retention, and job enrichment of FLOs this area of enquiry could be extended to inform the discussion on scope of practice.

Other key recommendations to enhance the FLO role include clarifying the scope of practice to prevent blurred role boundaries and duplication of work, and to ensure FLOs work to their level of competence. Agreement of key performance indicators specific to the impact of the FLO role are needed which would enable the ongoing role evaluation. Such indicators could include patient satisfaction and family feedback, complaints and concerns, and compliments. Realignment of the line management structure of the FLO role to the ward nursing teams, would help to embed the role within the local environment (e.g., ward) and strengthen the team dynamics. There is a need to strengthen record keeping and FLOs would benefit from access to the digital patient record. Further research is also needed to ensure other lessons are captured as these brokering roles such as FLOs mature and develop.

### AUTHOR CONTRIBUTIONS

**Alex Walsby**: Evaluation design; data collection; data analysis; and writing of paper. **Louise O'Connor**: Knowledge of FLO role; writing of paper. **Stephanie Best**: Data analysis and writing of paper. **Sharon J. Williams**: Evaluation design; data collection; data analysis and writing of paper.

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### CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### ETHICS STATEMENT

This study was classified as a service evaluation; therefore, NHS ethical approval was not required. Organisational permission was received from Hywel Dda University Health Board to undertake this evaluation.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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