KMC and breastfeeding every six hours. All mother-neonate dyads admitted in the postnatal care ward from 01/01/2021 to 28/02/2021 were included in the study. A re-audit was performed from 01/06/2021 to 10/07/2021 in the same ward. (figure 1)

**Results** We included 32 mother-neonate dyads in the initial audit and 36 dyads in the re-audit. (figure 2)

**Abstract 1350 Figure 1**

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Baseline (N=32)</th>
<th>After 1st PDQA cycle</th>
<th>After 2nd PDQA cycle</th>
<th>After 3rd PDQA cycle</th>
<th>Re-audit (N=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportions of mothers breastfeeding in the KMC position</td>
<td>0</td>
<td>22.3%</td>
<td>81.2%</td>
<td>77.4%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Mean Duration of KMC (hours/day)</td>
<td>0</td>
<td>1.5</td>
<td>4.8</td>
<td>7.9</td>
<td>6.4</td>
</tr>
<tr>
<td>Proportions of mothers using formula feeds</td>
<td>74.8%</td>
<td>62.4%</td>
<td>34.2%</td>
<td>31.1%</td>
<td>38.8%</td>
</tr>
<tr>
<td>Mean monthly expenditure on formula feeds</td>
<td>28 GBP</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10.5 GBP</td>
</tr>
</tbody>
</table>

**Abstract 1350 Figure 2**

**Conclusion** The quality improvement team successfully met its goals. We plan to extend this initiative to further increase the rate of exclusive breastfeeding and reduce the expenditure on formula feeds. During the Covid-19 pandemic-mandated lockdown, the number of home deliveries in the city grew. We also envision studying the safety and implementation of home-based or domiciliary KMC.

To attempt to counter this, a communication framework was developed to ensure that information could be reliably provided at set times and allow for consistent dissemination. This rapidly iterated into a weekly communiqué via an email newsletter to share information, links to updated policies along with other departmental requirements, such as staffing gaps and reminders of teaching and educational opportunities. This further iterated into an opportunity to develop closer working relationships via ‘soft touch’ sections such as interviews with staff members, an agony aunt column and sharing excellence.

Qualitative and quantitative surveys were held before starting the Quality Improvement Project, and then at regular intervals throughout to adapt the content to be of maximum benefit.

**Results** Before starting, the departmental responses on information sharing showed a gradient correlating with seniority. Consultants scored the department an average of 72%, whilst registrars scored the efficacy at 49% and SHOs at only 33%. Trust communications were felt to be significantly more effective than departmental communications by trainees (70% vs 38%), and less effective by consultants (56% vs 80%). This pattern was repeated for other categories including education and staffing where consultants felt information was shared more effectively than trainees. 80% of staff felt a single source of truth would be useful.

After LOLIPOP! had been running for 6 weeks, this survey was repeated. The overall score improved from 50% to 85%. All grades now rated the efficacy of information sharing at over 80%, removing any gradient. This was consistent for staffing and education as well. All grades now felt the department was sharing information better than the trust, with a 45% improvement in departmental communication across all grades. 100% of staff now felt the project was useful.

Qualitative feedback was universally positive. Trainees felt that LOLIPOP! ‘brought the team together’, ‘lifted everyone’s spirits’ and that the project was ‘one of the highlights of the year’. The tone and frequency was felt to be appropriate, with staff feeling that too much information on a regular basis would ‘lessen the impact’ and might mean information would get lost.

**Conclusion** LOLIPOP! provided a touchstone in the week where all staff knew they would be able to receive the most accurate information, along with other reminders. It became a key part of the departmental information sharing. It showed clear benefit in ensuring accurate information was easily available, allowed a wide team to share their skills and was shown to have bond a team working under difficult conditions. The project continues with a new editorial team at the helm.
Aims PIFU is a novel alternative to standard outpatient-based follow-up in adult healthcare settings to maximise the utilisation of available resources. However, limited UK data is available on PIFU in the paediatric cohort. This is a pilot project to look into the following aspects of PIFU in a paediatric setting:

1. To explore the suitability of PIFU to offer time-appropriate, safe and outcome-based paediatric care when required.
2. To explore parental perspective on safety and acceptability of PIFU process.

Methods A qualitative observational study (data collected from parents over eight months from the paediatric pilot clinic).

Patient selection
Indications - Parental agreement to engage in the PIFU process is a prerequisite:
- Stable patients with regular input from tertiary/specialist care.
- Follow-up patients with chronic conditions in secondary care that require infrequent input.

Contraindications – • Children under social care with current/previous child protection concerns.
• Patients with mental health issues.
• High-risk patients who may rapidly deteriorate because of their underlying health conditions.
• End of life/palliative care.
• Suspected/know factitious and induced illness.
• Type 1 Diabetes Mellitus
• Patients who require MDT input in every clinic appointment.
• Parents with learning difficulties/special needs.
• Parents with limited access to electronic communications/travelling families.
• Parents who did not want to engage in PIFU arrangements.
• Identified disagreement over the care provision and diagnosis.

Results The total number of patients contacted for the PIFU process (n=30).
Parents agreed to participate (n=26; 87%) Parents did not agree (n=4; 13%) figure 2.

Conclusion The initial data suggests that most parents feel PIFU is an acceptable alternative to regular outpatient appointments. The parental comments were mainly themed around the ability to access the system and autonomy to engage in the shared healthcare processes. Parents appeared to appreciate the reassurance of being in the follow-up healthcare pathway and readily available ongoing support when required.

The main hesitancy to engage in PIFU was a lack of trust in the new process, negative experiences from previous consultations, mixed messages and the uncertainty linked to a flexible approach. During the data collection period of the first eight months, parents made only six contacts with the PIFU team and only one patient required a clinic appointment.

Limitations - Since this is a pilot project, more data will be required to understand the real-time impact of the PIFU process on reducing the number of missed appointments and reduction in unnecessary clinic attendance.

Appropriate patient selection, well-defined pathways, robust communication links between parents and healthcare providers, and open discussions with parents before introducing PIFU are necessary for the safety and success of this process.

To summarise, in our experience, most parents accept and engage positively with the PIFU process. PIFU could be an alternative method of safe healthcare delivery in the general paediatric setting for carefully selected patients, which needs further exploration.

REFERENCE