	PLAN	DO	STUDY	ACT
PDSA 1: Clinic Template change	We had previously collected data on how long consultations generally took in 2019. The mean time taken to see women by each doctor was 25 minutes. The range was 15-60 minutes. It was also observed that whilst some clinics were fully booked, others were under capacity. This was thought to be due to popularity of morning over afternoon appointments. We hypothesized that capacity issues would even out as the previously under booked clinics could absorb the extra demand.	We had requested the template change several months prior, before the start of the pandemic. The changes came in fortuitously in mid-March 2020.	Administration staff reported that previously popular clinics would often be fully booked (this is not a change from previous) but as the new template reduced the number of women attending a fully booked clinic, any extra demand would spill into previously under booked clinics on other days and times. There was no overall demand and capacity issue. Our SPC chart for waiting times show a reduction for women attending the clinics.	We adopted this change as a permanent change.

	PLAN	DO	STUDY	ACT
PDSA 2: Pre-vetting of clinics	This intervention was instigated by "Gold Command" and coincided with the cancellation of elective work that gave consultants time to vet clinics. Consultants began pre-vetting their clinics from 13th March 2020. Administrative staff contacted women by phone to inform them to stay at home or to come into hospital.	Initially, there was a lot of motivation to make remote clinics work and this was a necessary step. We found that the vetting could not be done too far in advance as more women could be added to the clinic list at any point prior to the clinic date. We also found that administrative staff were often unable to contact women by phone so despite vetting, many women would come into hospital for their appointments when they could have had a remote appointment. Consultants could alternatively choose to text women themselves at the time of vetting using the AccuRx platform, negating the need for extra administrative staff.	Pre-vetting certainly enabled remote consultations to take place, as demonstrated by the chart showing the increase in number of remote consultations, analysed in June 2020. Sending text messages at the time of vetting was an effective way to communicate with women prior to the appointment but required a level of engagement and comfort with using the AccuRx platform, which varied amongst consultants. There was a lot of dissatisfaction amongst consultants as the vetting time was not job-planned and in-built administration time into clinic templates was perceived to be insufficient. As elective work resumed, many consultants stopped pre-vetting and abandoned remote consultations.	We explored ways in which the decision for a remote consultation could take place at the time of booking the appointment, by the midwife or doctor asking for the appointment. We wrote a detailed guideline with various conditions and indications for referral to the consultant antenatal clinic, including guidance as to which should be booked as remote and which as face-to-face. However, the clinic template was not set up to allow automatic pre-clinic communication with women to inform them of whether appointments were remote or face to face. This is an ongoing challenge.

	PLAN	DO	STUDY	ACT
PDSA 3: Telephone consultation	The rationale for introduction of telephone consultation was that this allowed self-isolating staff to conduct clinics from home, and reduced footfall into the clinic enabling social distancing.	Telephone consultations were introduced on 16th March 2020 and were technically easy to conduct from the point of view of the clinician. There was some initial confusion as it was not obvious from the clinic template or electronic patient record that a woman was planned to have a telephone consultation. We had some women waiting at home for a call which they never received.	Since the introduction of remote consultations overall, there was a drop in the waiting time for women who did attend the clinic, from February through June 2020. Survey results from May to June 2020 and listening events via Zoom from September to November 2020 revealed that whilst women were tolerant of telephone appointments at the time of the pandemic, most women preferred in-person early contact with midwives (the first midwife appointment was done over the telephone initially). Regarding consultant appointments, the feedback was that women did not feel a telephone appointment to be a "real" appointment and it was harder for them to connect with the clinician on sensitive issues.	Throughout the scope of this report, we did use feedback from listening sessions to re-instate the first midwife appointment as an in-person appointment in August 2020. Out of 68 women surveyed, 34 expressed preferences for video and 27 for telephone consultation, so we felt we should ideally have both options available to women.
PDSA 4a: Video consultation - Attend Anywhere	Our hospital trust had procured this platform to use in all outpatient areas and had a team dedicated to integrating it with all pre-clinic communication letters and text messages. We were told that other outpatient areas like Orthopaedics were using the platform successfully.	We tested the platform with the Attend Anywhere team using a dummy patient on 23rd March 2020. The platform requires the patient to be booked into a video clinic slot on the clinic template, so that the patient would receive an email and text message with the website link for the virtual waiting room to enter at the time of their appointment.	During testing, we realised that our clinic templates were not set up and we could not be given a timeframe. This meant that the clinician would need to manually email the joining instructions to each patient at the time of vetting.	The cumbersome and time-consuming process for getting the virtual waiting room link to patients meant Attend Anywhere was not suitable for use until the clinic templates were set up for video consultation. We abandoned this idea after one week, with the view to potentially revisiting it in the future.

	PLAN	DO	STUDY	ACT
PDSA 4b: Video consultation - AccuRx	We were informed that AccuRx was a validated tool available to us, and that it met with data governance policies. 52/56 women surveyed said they had the technology (internet access, smart phones, etc) needed to have a video consultation.	We initially tested AccuRx with a dummy patient on 25th March 2020 and found it easy and intuitive to use from the clinician's point of view. It also allowed generic text messages to be sent to patients by the clinician at the time of vetting. We then tested AccuRx in a real clinic and following this incorporated written guidance and a demo video for dissemination on 26th March 2020. Video consultation for patients using AccuRx was initiated on 31st March 2020.	Amongst clinicians who adopted AccuRx as their preferred method for remote consultation, feedback was very good and there were high levels of sustaining the practice of pre-clinic vetting, texting patients, and then using the platform on the day of the clinic. We found most women were able to connect easily using their mobile devices, and feedback was positive, with women commenting "it felt like a face-to-face conversation" and "very convenient".	We have adopted AccuRx for video calling and continued with the system of consultants texting their own patients and copying and pasting a copy of the text in the electronic patient record, so that this communication can be seen in case women phone to enquire.