Scottish Government
Riaghaltas na h-Alba

An exploratory qualitative study of the Mental Health after Covid Hospitalisation (MACH) service

HEALTH AND SOCIAL CARE

social research

Acknowledgments

We would like to extend our gratitude to all participants for their time and support in conducting this research.

Acronyms

DSM: Diagnostic and Statistical Manual of Mental Disorders

ICU: Intensive Care Unit

MACH: Mental Health after Covid Hospitalisation

MDT: Multidisciplinary Team

NSAG: National Specialist Advisory Group

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Executive summary

In 2020, the Scottish Government commissioned Dr Nadine Cossette to examine the mental health needs of people hospitalised due to COVID-19, leading to the publication of Meeting the Mental Health Needs of Patients Hospitalised Due to COVID-19 report. The report made six recommendations, one of which included establishing a network of mental health clinicians across Scotland to screen and treat those who had been hospitalised due to COVID-19. 5.6. The Scottish Government have made £4.5 million available over three years (this is the final year) to facilitate development of the network, known as the Mental health After Covid Hospitalisation (MACH) service.

MACH is based on a 'screen and treat' model of service delivery. All patients who have been hospitalised due to COVID-19 are proactively contacted by their local MACH service. Patients are then screened and those who screen positive are then invited for an assessment with a senior mental health clinician. Following this initial assessment, patients may be given self-management information, referred to third sector or other NHS services, and/or be offered further treatment by the MACH service.

This qualitative research explores the MACH service from the perspective of practitioners and advisors involved in the set up and delivery of MACH with a view to understanding how the service has been implemented and developed since it was launched. It provides insight about the learning emerging from the development and delivery of MACH as well as potential areas for improvement.

The research explores four elements of the MACH service:

- enabling factors which facilitated the set up and delivery of the MACH service
- barriers and areas of difficulty which were experienced in the set up and delivery of the MACH service
- areas identified for improving the delivery of MACH or a similar service
- key overarching learning which could be valuable legacies of the MACH service

Facilitators to MACH included:

- The **practical approach** taken by the Scottish Government to setting up the service, which included engaging with clinicians to identify patient needs and how a service could meet these needs. Health boards were given the latitude to implement their own MACH service to suit local circumstances.
- The **professional networks and peer support structures** put in place to support MACH, which provided both clinical and operational advice, and allowed for learning to be shared nationally.
- Positive **team dynamics** across MACH services and within the professional support structures previously noted, which helped to forge and sustain connections between different services.

- Taking a **digital approach** to connecting MACH services, which was valued, as this enabled networking opportunities and helped connect services from more rural parts of Scotland.
- The **outreach approach** to delivering MACH, where the service contacts potential patients.

Several barriers to setting up and delivering MACH were identified. These included:

- The **limited resources**, including both staffing and space limitations.
- The **high administrative workload**, due to factors such as the burden of screening patients and the lack of administrative resources, which meant some clinicians had to priorities administrative work over clinical time.
- An emergent **mismatch between MACH staffing and patient needs**, with some elements of MACH services being underutilised and aspects of patient needs not being met.
- Challenges in the **onward referral** of MACH patients to other services.

Based on the views of the participants, this research identified several areas in which MACH could be improved. These included:

- Implementing **service guidelines** to support service implementation and delivery.
- Adopting a wider, **multidisciplinary approach** to delivering MACH, as this might help better meet some of the wider needs of MACH patients that were being identified (e.g. poor physical health).
- Engaging with a **wider range of patients**, beyond solely those hospitalised with COVID, to possibly include those with COVID who received treatment in the community or people suffering from long COVID.
- Improving patient **signposting**, to improve linkages with other services and possibly improve referral outcomes.

Key learning elements from the MACH service, which could be used to inform further service provision included:

- The success of the **proactive approach** to reaching out and contacting patients. Strengths of this included that it may have exerted a preventative effect by bringing people into contact with a service before their symptoms worsened or their needs became more complex.
- The **screening of patients** ahead of them potentially receiving treatment, which meant that patients could potentially receive the right kind of support sooner.
- The interlinking of MACH services, which helped facilitate **cooperation at a national level** and the **sharing of skills and knowledge**.

While this research has provided some important early learning about the facilitators, barriers and key learnings from the implementation of MACH in Scotland it has several limitations. These relate to a lack of direct patient voice, with this research solely based on views of healthcare professionals, a lack of comparisons between MACH services across Scotland, and the use of focus

groups to conduct this research rather than individual interviews, which may have influenced the data collected.

1. Introduction

1.1. Background

In 2020, the Scottish Government commissioned Dr Nadine Cossette to examine the mental health needs of people hospitalised due to COVID-19. Dr Cossette's report, Meeting the Mental Health Needs of Patients Hospitalised Due to COVID-19, highlighted that the effects of severe COVID-19 often continued after a patient left hospital, with approximately one-third of COVID-19 patients admitted to hospital developing serious mental health consequences, including depression, anxiety, PTSD, and cognitive problems. The Cossette report identified that mental health services in Scotland are not currently configured to meet these needs, nor do they have the capacity.

Dr Cossette's report made six recommendations, one of which included establishing a network of mental health clinicians across Scotland to screen and treat those who had been hospitalised due to COVID-19. The Scottish Government have made £4.5 million available over three years (this is the final year) to facilitate development of the network, known as the Mental health After Covid Hospitalisation (MACH) service.

1.2. The Mental Health After Covid Hospitalisation (MACH) service

At the time of this research, thirteen health boards in Scotland are currently providing a MACH service. A range of different professions are involved in delivering the service in each board, including psychology, psychiatry, mental health nursing, and occupational therapy.

MACH is based on a 'screen and treat' model of service delivery. All patients who have been hospitalised due to COVID-19 are proactively contacted by their local MACH service. Patients are then screened using a questionnaire pack designed to identify common psychological problems (for example, mood changes, fatigue or cognitive problems). Patients who screen positive are then invited for an assessment with a senior mental health clinician. Following this initial assessment, patients may be given self-management information, referred to third sector or other NHS services, and/or be offered further treatment by the MACH service. Support for MACH is provided by a National Specialist Advisory Group (NSAG), which offers multidisciplinary clinical expertise.

1.3. Research aims and objectives

This research explores the MACH service from the perspective of practitioners and National Specialist Advisors from the NSAG with a view to understanding how the service has been implemented and developed since it was launched. It provides insight about the learning emerging from the development and delivery of MACH as well as potential areas for improvement.

1.4. Research methods

Fourteen participants, consisting of clinicians delivering local MACH services (11) and members of the NSAG (three), were recruited on a voluntary basis. A qualitative approach was taken involving individual interviews with the three NSAG members and one clinician (four in total), and one focus group with ten NHS clinicians. All interviews were conducted virtually, audio recorded and transcribed.

The interviews were semi-structured, giving participants and the interviewer latitude to explore emergent topics. To capture learnings from different stages of the service development, the interview questions were structured around the set up of MACH, delivering the service, and looking to the future. Anonymised quotes from select interviewees are included in this report.

2. Research findings

The research findings are presented in the follow sections: enabling factors which facilitated the set up and delivery of the MACH service; barriers and areas of difficulty which were experienced in the set up and delivery of the MACH service; areas identified for improvement delivery of MACH or a similar service; and key overarching learning which could be valuable legacies of the MACH service.

2.1. Facilitators to MACH

Several factors where identified throgh the research process as having worked well to enable the MACH service to meet its aims. These include aspects of the MACH set up and structuring, collaboration within and between MACH services and the approach to delivery. This section provides an overview of the main factors which were identified as faciliators to MACH set up and delivery.

2.1.1. MACH structuring approach

The first facilitator to setting up MACH identified by interviewees is the practical approach taken by the Scottish Government, referred to by one interviewee as a "real pragmatic steer from Scottish Government". Based on their experience of setting up MACH, this meant that the approach taken by the Scottish Government meant that "actually things will happen rather than meeting for years and years." Crucial to this, according to several interviewees, was the decision by the Scottish Government to reach out to a clinician with the relevant experience, Dr Nadine Cossette, which was felt to be efficient and productive. As described by a NSAG member:

"a large part of why the MACH service feels quite effective and dynamic is because the Scottish Government directly approached a clinician with current, front-line clinical experience with this patient population. They said, very clearly, tell us what these patients need, and then were very supportive of how to pragmatically operationalise this."

Health boards also had freedom and autonomy to implement and deliver their own MACH service. As one clinician described:

"we've had a lot of freedom to develop our own way of dealing with cases as they come in, so we've created a step-care model, we've adapted other materials to be Covid-specific, so we have a Covid-specific, guided self-help service which is delivered by our assistant psychologist; we've developed a group specific to the issues that we've seen … we've had a lot of freedom, and I get the feeling that it is the same for other services as well to design things in a way that works specifically for their service, that's been great."

MACH practitioners identified several areas of the service that benefited from health boards having the latitude to adapt and develop MACH in a way that best suited local circumstances, such as the differences in the composition and structure of mental health services in different health boards. Flexibility in tailoring MACH

service guidelines and resources across health boards was therefore felt to be essential.

2.1.2. Professional networks & peer support structures

Four network groups, described in Table 1, were put in place to support the MACH service. These were unanimously considered by respondents to be a fundamentally important element to setting up the service and subsequent delivery.

Table 1: Professional networks supporting MACH

Group	Purpose	Membership	Meeting frequency
National Specialist Advisory Group (NSAG)	To provide leadership and operational oversight of the MACH programme	The National Clinical Lead, five National Specialist Advisors, project management and administrative support, and a representative from the Scottish Government	Fortnightly
Clinical Hub	To discuss clinical matters arising in MACH work*	MACH clinicians from across Scotland and National Specialist Advisors	Fortnightly
Operational Group	To discuss set up and delivery of MACH services	Representatives from health boards responsible for setting up/delivering MACH services and National Specialist Advisors.	Fortnightly
Assistant Psychology network	To discuss matters arising from Assistant Psychologists' role in MACH Services, career progression and CPD opportunities	Assistant Psychologists from MACH Services across Scotland. Chaired by a National Specialist Advisor	Monthly

* For governance purposes, supervision of MACH clinicians resides within health boards, whereas the NSAG provides consultancy and specialist advice.

These four networks provided dedicated spaces to share and discuss learnings from the set up of MACH, which was considered vital by interviewees. Regular access to these confidential and supportive spaces allowed for continuous learning across the different health boards. Regular communication among MACH practitioners also helped to avoid duplication across services and increased service efficiency. As one clinician noted:

“Being able to share processes, experiences, thoughts with other health boards has been so valuable; it means we're not having to duplicate work a lot of the time, having that shared working has been brilliant.”

From the perspective of the MACH networks enabling the sharing of in-depth learning, one participant noted that this enabled people “to think ideas through, think problems through, with a group of experts, that allows for some real creativity and imaginative ideas to come forward.” The networks “brought together a whole range of different MH experts with a really broad range of perspectives and that's made many of the discussions that we've had really rich and varied”.

The professional networks offered support from a clinical and operational perspective, which was valued by interviewees. The positive experiences of having these networks prompted the suggestion that a similar approach could be used in other service areas.

“The network of professionals that have been brought together; how quickly that can be mobilised again in the future for something else or used as a framework or a model for other issues in other areas. I think the set up has been really good, the fortnightly meetings, having that distinction between operational and clinical; the sub-groups that are coming out of that.”

Staff development was another element that was greatly enabled by the four professional networks, particularly as the staffing profile involved in MACH across Scotland was felt to be a “unique group of clinicians”, and providing a national perspective allowed for a better understanding of the different roles that staff were playing in the delivery of MACH. The networks also offered opportunities for shared discussion, mutual learning and peer supervision, which was high valued by interviewees.

“That [cooperation] is a very unique and really rich forum for sharing learning and for receiving support, as a clinician working in this service, and for training and opportunities to share cases. And to do that on a national level, across the whole of Scotland, … I've never come across that before in my career at all… that's been a real achievement.”

As well as mutual learning, the networks also provided spaces for solving challenges, such as data protection and governance, often via “sharing ideas and frustrations and common experiences”. As one interviewee explained, working closely with other health boards via the MACH networks had positively impacted on the “speed and ease of setting up the service”. Added to supporting the set up of the MACH service, several interviewees highlighted how the MACH networks had

provided opportunities for training and staff development. Summarising these views, one participant referred to “phenomenal learning” and how the experience had been “really developmental” for them.

2.1.3. Team dynamics

The positive dynamics among MACH teams and across the four MACH networks, as described by several National Advisory Group members, were also highlighted as a key facilitator for the MACH service. The positive approach to service development was described as beneficial and linked to a constructive working atmosphere.

“Nice collegial working-together atmosphere has been fantastic. Maybe something about the ‘short-termness’ enables that, or just that it is something different so we do not have to do our usual roles, just a bit more, like, enjoy working with each other.”

Furthermore, the positive interaction and enthusiasm among MACH staff was noted by NSAG members, as one of them reflected:

“I have been absolutely amazed how people have embraced and really put so much passion and good will into the programme, despite it being time limited. It's been very heart-warming how genuinely caring and passionate clinicians and managers have been embracing this project.”

2.1.4. Digital service & connectivity between MACH services

In terms of the delivery of the MACH service, a key enabling factor was the digital nature of the service, which applied to both staff networks and engaging with patients. A digital approach to connecting the MACH networks enabled cooperation between practitioners across different health boards. This was highly valued by some interviewees, in contrast to the previous, pre-COVID, focus on in-person networking, which could leave some staff being isolated.

“it's very valuable to have those networking opportunities and being able to join in on teams like that, which historically we haven't had those opportunities, because you would be expected to attend meetings in person”.

Moreover, digital spaces like the clinical and the operational hubs allowed learning and advice from the NSAG to “permeate more widely”, taking into account the different approaches taken to delivering MACH across Scotland.

Regarding engaging with patients, delivering aspects of the service digitally compensated for the limited office space available to some MACH services, allowing patients to continue to be supported:

“One of the enablers has been to be able to work online. We offered clinical work online. [without the online option] We wouldn't be able to do it, and that's not just because of Covid distractions, but because of our limited clinic space - we wouldn’t be able to see people”

2.1.5. Outreach approach

Finally, the outreach approach to service delivery used in MACH, under which patients were contacted directly by the service, was identified as a key enabling factor of MACH. This approach garnered positive engagement and feedback from patients and was widely praised by clinicians.

Being contacted by the MACH service appears to have validated the feelings people may have experienced because of being hospitalised with COVID-19. As one clinician described, these feelings of validation may have been particularly impactful for those hospitalised during “the first wave” of COVID-19 infections as they may have experienced “the longest gap between having been in hospital and having any sort of contact” and may have had a “significantly distressing time” in hospital. Another clinician described that “getting the chance [for patients] to be heard” because of the outreach approach taken to delivering MACH had been “brilliant” and “so positive” for patients.

2.2. Barriers to MACH

Alongside factors which worked well in the set up and delivery of the MACH service, a number challenges were also highlighted in the research process. This section provides an overview of the main barriers which were encountered within MACH set up and delivery.

2.2.1. Limited resources

Across numerous aspects of the MACH service, respondents highlighted the impacts of limited resources. This related to funding, staffing and service capacity, as well as clinical time and office space. As one interviewee described, MACH was a service that was “operating with limited resources, limited funds, limited staff”. However, how this played out across health boards varied due to differences in capacity, processes and systems, as well as patient numbers.

The limited clinical time and lack of office space to deliver their MACH service was highlighted by several interviewees. A consequence of these limitations was instances where some services relied more on digital provision as opposed to seeing people in person. As one interviewee described, while offering remote support helped deliver the service, for them it was also a barrier because it “doesn't give the same level of being able to understand people's difficulties”. The same participant also highlighted that not offering face-to-face support could present challenges when supporting specific groups, such as older people, because it was “something that they are not used to”.

2.2.2. Administrative workload

The administrative workload involved in delivering the MACH service was described as a barrier to setting up the service up, an issue compounded by limited dedicated support for administrative work, and ascribed to a combination of financial constraints and recruitment challenges. A consequence of which was that MACH practitioners had to give up clinical time to devote to administrative work. As

described by one of the clinicians, this was felt to be “not the best use of resources” but “it had to be like that to make it [MACH] happen”.

The screening process was described as having a particularly high administrative workload, reasons for this included the number of screening tools being sent out to patients and difficulties with identifying patients for screening within the MACH database.

To meet these challenges, MACH staff were required to work flexibly and show adaptability throughout. As described by one clinician:

“it took a long time to get set up and figure out a way that our processes were going to work that was actually compatible with ou]r team and our resourcing available, and that included things like: getting the names from IT, getting the actual database set up at the start was quite resource-hungry and it took us a long time to get that right … then working out the flow of work, so how many letters are we going to send out, how many are we likely to get back, how are we going to deal with them.”

2.2.3. Mismatch between staffing & patient needs

A further barrier to implementing and delivering the MACH service was an emergent mismatch between how MACH services were staffed and the needs of MACH patients. When setting up MACH, the staffing of the service was based on anticipated patient needs relating to their mental health. As one participant described, the initial staffing in their service was “dependant on the kind of client group that we were expecting, which ended up being a bit different” and “didn’t really match the kind of work that we were doing”.

Further examples of the disconnect between anticipated patient needs and the staffing of some MACH services were given by several interviewees who described how psychiatrists were underutilised as they “aren't seeing many patients” and psychiatric support was not “something that we really needed” to the extent that had been anticipated. When reflecting on this, several interviews noted that having a broader range of clinical and therapeutic staff would have been “more helpful”.

However, it was also noted that how MACH services were staffed varied across different health boards. This variation in staffing profile meant that it was quite difficult to establish a consistent offering for patients across different MACH services. As one participant described:

“It was a bit of a challenge when each individual board set up their services so differently in terms of the staffing profile; that was quite difficult then for each service to have a similar service. So there's quite a variation within each board as to what the service patients get; and it's been particularly challenging.”

Consequently, further flexibility in terms of spending and recruitment would have been welcomed during service set up and delivery:

“We had created this service based on what we thought was going to happen and then we got new information, we couldn't really change that. We were stuck with a

service that didn't really fit. If that could be more flexible to fit with the service as it started to evolve, would have been helpful."

2.2.4. Difficulty referring MACH patients onwards

Referring MACH patients to other services was described by several interviewees as a barrier to delivering MACH. For example, as one clinician described, they sometimes experienced difficulties when trying to refer patients to other clinical specialities, sometimes because of not knowing what services to refer patients to, or because how wider patient needs that were impacting on their mental health had not been established. Added to which, sometimes the needs and concerns of patients were being attributed by other services to them having long COVID, without further investigation or support:

"There's some difficulties in knowing who to refer people onto when there are gaps in our own MDTs. I see a lot of people whose physical health is actually impacting onto their mental health, and they have not been properly assessed or treated from that point of view and it feels like there's no one to refer them onto. We're coming up against a bit of a wall when we're trying to refer people into respiratory or whatever specialty that may be, I think they're just told 'it's long COVID - off you go and go on with it'."

Moreover, interviewees also described that the lack of a designated long COVID service made it difficult to support patients and raised concerns about potential gaps within the MACH service:

"We don't actually necessarily have a service to easily refer them [MACH patients] into anywhere, and especially now, with the large rally of people with long COVID, who maybe weren't necessarily relevant to our service, it made me wonder about overall the design of [the MACH] service, and what might be missing or needed in terms of the service for these people."

2.3. Areas for improvement

Interviewees made several suggestions for ways that the MACH service could be changed to improve the set up, delivery and impacts of the service. This section provides an overview of areas for improvement.

2.3.1. Clearer service guidelines

Participants identified that clearer implementation and governance guidelines for MACH would have aided in setting up the service. Examples given of this included providing guidance on data management and contacting patients. Several participants highlighted that having nationally agreed governance arrangements for these areas would have been beneficial.

2.3.2. Adopting a wider multidisciplinary approach

The second area for MACH improvement identified by interviewees was a suggestion that the service would benefit from a more comprehensive, multidisciplinary approach to enable the service to better respond to the needs of patients. While a multidisciplinary approach was intended to be a key feature of the

MACH service, it was noted by several interviewees that the focus was primarily on delivering mental health services and support via a range of mental health professionals, whereas some patients could have benefitted from support with their physical health as well. This was noted by one interviewee, who described how some patients' mental health had physical health impacts. A member of the NSAG described that MACH could likely better meet patient needs by involving "involving physiotherapy, occupational therapy, rehabilitation medicine … rather than solely focusing on mental health." They suggested that a better way of structuring the service would have been to take a more "social approach" rather than focusing just on psychological mental health issues. This wider approach to delivering MACH, according to the same interviewee, was justifiable because the impact of COVID on people can be viewed through a "biological, psychological and societal lens, all at the same time".

While limited resources within MACH were identified as one of the barriers to adopting a multidisciplinary approach, as well as the staffing profile of some MACH services not being aligned with emergent patient needs, the professional networks supporting MACH acted as a facilitator to multidisciplinary work by exposing MACH teams across Scotland to how other health boards were implementing and delivering the service. As described by one clinician:

"I would have loved it if we had a multidisciplinary team (MDT), but getting the chance to come to those fortnightly meetings [of the MACH clinical hub] … and that is a MTD team … and work with or speak to other people across Scotland working in the same area, but thinking about things using maybe slightly different models or slightly different approaches has been a real privilege and I have found it so helpful and it's been an absolutely fantastic aspect of the job … It's been great to have this MDT perspective in the Clinical Hub."

As noted by several interviewees, the needs of some MACH patients were wider than just support with their mental health, meaning that MACH was unable to meet the full spectrum of patient needs. For example, patients in certain health boards, who required support with physical conditions had to be signposted to other services. For some, this meant delays in accessing treatment, due to challenges signposting patients to other services. Having more diverse teams of professionals within the MACH service, who could offer both mental and physical health support, would allow the service to meet a broader range of patient needs without the need for referring patients to other services.

2.3.3. Range of patients

Several interviewees made the suggestion to expand the offer of treatment to a broader range of patients than had been first anticipated when MACH was set up. The focus solely on those who had been hospitalised with COVID-19 was identified by several interviewees as a potentially limiting factor of the service because, as one noted, "the real issue [for patients] hasn't been the hospitalisation".

Views on this were echoed by a member of the NSAG who offered a detailed relfction, remarking that, with the benefit of hindsight, MACH "should not have been

a service purely for people who were hospitalised". They then explained further by noting that being hospitalised for COVID may act as "a red herring in terms of the severity of the mental health issues" and that someone who "wasn't hospitalised with COVID-19, and had Covid in the community, can be just as psychologically affected as somebody who was hospitalised". They concluded that this meant that because MACH was only supporting people who have been hospitalised with COVID, "a huge amount of people who were not seen, who are having the exact same difficulties, but they just happen to not require an admission".

Interviewees also identified that people with long COVID might also benefit from being supported by the MACH service. According to several interviewees, including clinicians and NSAG members, not supporting those with long COVID was a "missed opportunity".

As highlighted by one interviewee, there was also a practical element to expanding the range of patients who could access MACH, with demand for the service declining as the number of people hospitalised with COVID has reduced over time. Moreover, sustaining the service would mean that the knowledge gained by staff about how COVID can affect people would not be lost.

However, it should be noted that some interviewees were of the view that focussing the service on people who had been hospitalised with COVID was justified because, as one described, the "long-term consequences of COVID-19 infection were unknown".

Summarising much of the above, and from the perspective of one interviewee, the future for MACH should involve drawing on the learning acquired from delivering the service so far and utilising this to create an expanded service that enables the application of learning from the experiences of delivering MACH to meet a broader range of patient needs.

2.3.4. Signposting

A further area where interviewees suggested how MACH could have been improved stemmed from having encountered difficulties signposting patients to other services, which one described as "quite a challenge". Several clinicians highlighted the need for closer cooperation across services to support this, particularly when patients were moving on from MACH support. As one describes:

"If there had been a bit more joint working, linking up better with other services, trying to get some pathways started right at the start, so that we're not at the point that I feel like we're at now - when we're going to reach the end of this funding period and that's the kind of well, yeah, where do our patients go now, what's next?"

2.3.5. Diversity and inclusion

The final area for improving MACH, as described by several interviewees, was the scope for further exploration and accounting for diversity and inclusion within the how the service was delivered. As identified by an NSAG member: "one point that

could have been explored further was how we manage diversity and inclusion". As mentioned by some interviewees, a barrier to embedding considerations around diversity and inclusion included a lack of ethnicity data, which would enable improved understanding about levels of engagement with MACH across different groups. As one described:

"what we don't know... we don't have ethnicity data attached to people's IT file, so we don't know until we actually send out the ethnicity questionnaire and if people complete it, what the profile of our population is. So we only ever have the profile of the population who responded."

A further area for MACH improvement relating to inclusion was concerns raised by one interviewee regarding the accessibility of the screening packs that were sent out to potential MACH patients. They described it as "absolutely enormous" and questioned whether those who were seriously ill or had additional needs would complete the pack, labelling the pack as a "potential barrier to [accessing] the service".

2.4. Key learning

There were several overarching key learnings from the MACH service identified by interviewees which could be drawn on to inform future service provision and appraoches. This section provides an overview of these.

2.4.1. Proactive and preventative outreach

Proactively reaching out to patients was considered critical to the MACH service and a key learning for the future. For many interviewees, this was their first experience of offering access to treatment in this fashion. As one described:

"I've never run a service before where we actively seek out and contact patients who may wish to access a service. Normally we would wait for referrals to come to us rather than actively seeking out patients."

According to several interviewees, engaging with patients proactively meant that the service could have a preventative effect by engaging with patients before their symptoms worsened or developed in the first place.

"being able to pro-actively reach out to a population that we know is at higher risk of developing certain symptoms … means that hopefully you can get in there early and not have people deteriorate over months and not being able to get the support that they need."

Contacting people proactively was also felt to enable the service to connect with patients who might not be in regular contact with healthcare services:

"The biggest thing has been [being] able to contact people who weren't accessing any services, to [contact] people who were struggling, in some cases really having quite severe difficulties, but haven't made any contact with any services, even with the GP, to get any help … it's preventing crisis, preventing things from deteriorating

further.”A further component to reaching out to patients was increased patient choice, meaning they could “decide to become involved in our service or not”.

According to interviewees, the responses received from patients about the outreach approach to delivering MACH was overwhelmingly positive across health Boards:

> “the feedback that we've had from patients that have come in to the service, [they] have found it very helpful and very beneficial.”

The early-intervention model was, therefore, considered “a real strength” of the MACH service, especially when compared to the “reactive, referral-based” services that most participants had experience of previously. The success of the approach led to several interviewees recommending a wider application of this kind of outreach model across other NHS services to support different patient groups, such as those suffering with long-term conditions.

2.4.2. Screen and treatment approach

The screening and treating approach to delivering MACH was considered successful by interviewees because it helped to streamline patient assessments and increase efficiency in service delivery. One aspect to this, as described by an interviewee, was that screening MACH patients meant that patients could then see the “right clinician …. straight away” and provide treatment and support to those who need it, rather than “seeing the people who [the service] can't actually treat”.

Based on the success of the screening approach taken by MACH, several interviewees suggested that this could be an approach used in other services. As one described:

“I'd like to suggest that we keep this screen and treat type approach for other services. So, I would definitely do this again, having not experienced the idea of reaching out and seeking out people who have been affected by a particular condition. Going forward, if I was setting up a new service again, I might consider doing something similar, because this has been a very positive way of opening a service up to any patient who feels that they need some help and support.”

A further element to the success of the screening and treatment approach to delivering MACH was that it mean that patients were more likely to see the relevant clinician first time around. One interviewee referred to this as patients being able to see the “right people as timely as possible”.

However, as one NSAG member described, while this should have meant that MACH patients were being connected to senior clinicians sooner than if the service were being administered using a referral-based system (which is prevalent across much of the NHS), this was not always the case. As they describe:

2.4.3. Distributed leadership

The MACH service was not delivered in the same way across different health boards. When describing this, one participant referred to MACH services as being

implemented in ways that reflected the “diversity of approaches and diversity of pressures across the country”. Leadership of the MACH service also had a diverse element, where it was distributed across the NSAG, allowing National Specialist Advisors to take the lead on projects that aligned with their expertise and skills. In addition, health boards were given latitude in to decide on their own approach to delivering their MACH service approach and were encouraged to go to the NSAG for advice and support, rather than being directed on how to proceed.

2.4.4. National cooperation

With services running in health boards across Scotland, several interviewees described successful cooperation at the national level as a key learning component from MACH. Instrumental to this was the professional networks that facilitated connections between health boards, acting as crucial conduits for sharing learning and collective troubleshooting. As one interviewee described, they had not had experience of working in a service that had been “quite so well joined up as this has been". The same interviewee described that the level of cooperation they had seen in MACH at a national level, bringing clinicians together to learn from one another, was a “real legacy” of MACH as it provided a:

“national view; being able to see and hear and understand what's going on in different health boards and to share learning and to support each other. I think that's a much better way of working.”

2.4.5. Skills sharing

Another important learning from MACH was the consolidation of skills and knowledge achieved through delivering the service, which improved the clinical understanding of various conditions, as explained:

“One of the things that's been really good about the MACH service is that opportunity to really consolidate our skills and understanding of things like fatigue, which up until now we didn't have a service for in psychology. I feel we've got a lot better at understanding and treating that now because we've been just seeing so many cases.”

It was emphasised by multiple interviewees that the learning that had been accumulated since MACH was launched should be shared widely. They suggested that it could be shared via academic journals and stakeholder events, to support future developments within healthcare in Scotland.

3. Conclusions

3.1. Limitations and possibility for future research

While this research has highlighted important areas of learning about the MACH service, it has some limitations.

Potentially the most significant limitation of this research is the absence of the views and perspectives of MACH patients, with the research presented relying on the views of service staff as a proxy indicator for how patients experienced MACH. Learning about the experiences of MACH patients could provide additional insights and potentially a broader understanding about the set up, delivery and impact of the service.

Due to time and resource pressures, aspects of the research had to be conducted at pace, meaning that specific methodological choices had to be made. For example, most people participated in this research via a focus group, comprised of clinicians delivering local MACH services, rather than individual interviews. While this had the advantage of enabling the collection of perspectives from several people at the same time, some participants may have been reluctant to speak in a group setting (as noted in methodological reviews of focus groups[1]).

The group dynamics of focus groups can influence participant responses to questions. The composition of this group contained staff of varying seniority and specialism (e.g. nursing, clinical psychology and occupational therapy) which may have influenced the responses participants gave. Further research, drawing on the findings in this report, on the experiences of different professionals about their experiences of MACH using individual interviews could provide additional insights, as well as potentially allowing comparisons between the different specialisms involved in providing MACH.

A further limitation of this research is that it was not possible to explore in detail potential differences in how MACH has been implemented across different health boards. Conducting further research on the implementation and delivery of MACH, could enable exploration of the barriers and facilitators to service design and delivery within specific health boards and how they compare to one another.

[1] Bowling, Ann. *Research methods in health: investigating health and health services*. Open University Press McGraw Hill: Maidenhead, 2023.

How to access background or source data

☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact socialresearch@gov.scot for further information.

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