THRIVE Implementation Assessment Tool: [enter place name]

The purpose of this document is to provide a tool for sites implementing THRIVE to understand how ‘THRIVE-like’ their services are currently. The tool can be used as an assessment to support implementation plans, and has been developed to enable baseline and subsequent follow-up measurement for evaluation of the effectiveness of local transformation plans.

THRIVE is a whole system approach to delivering mental health care for children and young people within a locality. A set of principles that define what a ‘THRIVE-like’ system is have been developed and are described in the following tables. Implementation of THRIVE involves translating these principles into a model of care that fits a localities current context. For implementation to be successful, consideration needs to be given to all parts of the system, including commissioning and interagency work, the services that provide care for families, and the individual interactions with patients. Given this, the tool has been developed to consider each of these parts in the system separately.

The tables below include the details of the THRIVE principles. On the left there is a description of the THRIVE principle that would be delivered by successful implementation. Following this are four categories that indicate how successfully a service has achieved delivery of the principle in question. A score of 1 indicates there is considerable improvement required for their system to be considered to be ‘THRIVE-like’ and the principle is not currently being met. A score of 4 indicates that a locality is working in a fully THRIVE-like way and can be said to have successfully implemented this principle. For a site to be able to describe itself as ‘THRIVE-like’ in the delivery of this principle, it needs to achieve a score of at least 3 out of 4.

The principles are measured in different ways, for some there is a quantitative measure that can be used, for example the CollaboRATE measure, and the assessment of how THRIVE-like the service can be said to be is determined according to the score achieved. For others the scoring is qualitative and requires a variety of evidence to be sought in order to determine the score achieved.

**How to Score Services**

How the scoring is undertaken will differ according to what this tool is being used for. The tool has been designed for services to self assess as an aid to service transformation, and it can also be used to evaluate the effectiveness of the implementation of THRIVE within an academic setting.

In each case the score should be chosen that BEST FITS or IS MOST SIMILAR TO services in your locality. It may be that not every component of each description is met, but it is the description that overall fits your services best.

A separate table for scoring is included in this document and for each principle a score between 1 and 4 should be allocated on the likert scale.

***Self Assessment***: The assessment tool should be completed after discussion with a range of stakeholders in the system, including commissioners, managers, team leaders, professionals working with children & young people day to day. Each principle should be discussed in collaboration and the description that best fits where services are currently would be chosen.

***Evaluation***: An independent team of evaluators would assess a range of evidence provided by commissioners and providers and assess which description best fits where the services are currently. This may include undertaking interviews and focus groups, and reviewing for data.

# Macro System Considerations (Populations of young people, commissioning and interagency working)

| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | Level 2 | Level 3 | Level 4*Practice is very THRIVE-like* |
| --- | --- | --- | --- | --- | --- |
| MACRO PRINCIPLE 1: A locality’s mental health policy is interagency. | There are no specific measures relating to this principle.  | No policy on how a locality will deliver improved outcomes for CYP mental health. Child mental health is not included in the Sustainability & Transformation Plans (STPs) or Local Transformation Plans (LTPs). There is no implementation plan in place.  | There is a policy on how a locality will deliver improved outcomes for CYP mental health. However this is not jointly created with all agencies. There is no clear implementation plan in place sitting alongside this policy.Child mental health is included in either the LTP and STP, but this is not comprehensive. | There is a policy on how a locality will deliver improved outcomes for CYP mental health. Creation has involved some of the relevant agencies, but not all. Child mental health is included in both the LTP and STP.There is an implementation plan in place that sits alongside this, however this does not span all agencies in the locality. | There is a policy statement/ document that clearly articulates the localities’ approach to delivering improved outcomes for CYP mental health. This is jointly created between health, care and education, with clear 3rd sector input. Child mental health is included in both the LTP and STP. There is a clear plan for implementation associated with this.  |

# Rating

*Circle the rating level that best describes your service. Capture key points in the deliberation and note particular areas of strength or opportunities for improvement.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MACRO PRINCIPLE 1: A localities’ mental health policy is interagency. | 1 | 2 | 3 | 4 |  |

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| MACRO PRINCIPLE 2:All agencies are involved in commissioning care (education, health, social care, third sector) | There are no specific measures relating to this principle. | There are separate commissioning structures for local authority and health. Joint commissioning is not routine, or is confined to certain elements of the system. There is limited engagement with educational commissioners and the third sector is not considered routinely as part of commissioning decisions. There are no joint structures, outcome frameworks nor budgets.  | There is a limited amount of joint commissioning. This may relate to specific projects or services. There are separate governance boards that collaborate on the development of their commissioning plans, but no joint governance, strategy or budgeting at the most senior levels of the organisation. Each organisation has a separate outcome framework and manages their contracts separately.  | There is a joint commissioning board that is attended by all of the modality types. This is translated into a joint governance structure. There is a range of established projects that agencies collaborate on, however this collaboration does not include all services. There are joint budgets in some, but not all elements of the localities provision. There are no jointly owned outcome frameworks, but there is effort to align these and the board is working towards integration.  | Health, local authority, education and the third sector are actively involved in commissioning mental health care for the locality. They sit within one board with a common strategy and are jointly responsible and accountable for delivery of this strategy and the subsequent outcomes for their population. There is a governance structure that includes each of these and all agencies are regular attenders of joint commissioning board meetings. This governing body has developed joint outcome frameworks to manage their own performance and to support contracting. There are joint budgets in operation. (here an exemplar would be an effectively functioning devolved system or ACO, with joint governance, strategy, budget, performance framework. The responsibility for delivery of outcomes of the population is jointly owned between agencies). |

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| MACRO PRINCIPLE 3: Contracting of services, and the performance management of these, is informed by quality improvement information |  | There is no regular consideration of the contracts within a locality.There is little consideration of performance or quality data during the commissioning cycle. Providers do not have good systems in place to collate and report the quality data required to enable effective management of the contract.  | Commissioners have a schedule in place for reviewing contracts. There is some consideration of data and outcomes in the commissioning cycle, but there are problems in accessing the full range of data and quality improvement (QI) information that is needed. This is in part due to a lack of systems within the providers to enable collection and collation of this data. Although there is performance management of contracts using data, the relationship between the commissioners and providers is not always constructive, making the open sharing and use of data to inform commissioning cycles and contracting problematic at times.  | Commissioners have a schedule in place for reviewing contracts. Data and quality information is used well in developing the commissioning plans and contracts, however there is still some development to do in terms of the collection and reporting of data to support this. There are good relationships between the commissioners and providers, but there are not always established forums that enable the discussion of this data meaning that while it is used to support decisions and contracts, it is not utilised as fully to support QI as it could be. The approach is limited to one or two provider types and is not systematically used across all contracts. | Commissioners develop annual commissioning plans taking into account service performance and quality data. There are clear agreements about the use of data within contracts and on-going performance management of these. There are systems in place in providers to collate this data and it is routinely and comprehensively provided to commissioners. There are systems in place within commissioning structures to consider this and it is used to inform decisions in commissioning cycles. There are opportunities for commissioners and providers to jointly consider performance and quality data and a collaborative approach to using this to improve services and inform commissioning. This is not limited to health providers, but the approach is used across the full range of providers, with joint consideration of the impact of each service on the whole system’s performance.  |

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| MACRO PRINCIPLE 4: Use of population level preference data is used to support commissioning decisions. *Preference data is data that is collected on the preferred treatment option that has been agreed on as a result of a shared decision making process.* |  | Preference data is not collected, reported on or used by commissioners to make decisions about the effectiveness and value of services that are commissioned.  | Preference data is collected in some services. This is either not reported on, or is not used within the service to support improvement or commissioning decisions.  | Preference data is collected in most services. This is collated and reported on however it is not yet used within the commissioning cycle to support decision making.  | Preference data is collected routinely and utilised to support decision making. This includes resource allocation, contract management and the de-commissioning of services. Providers have systems in place to collect and report this.  |

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| MACRO PRINCIPLE 5: Services working closely together such that service users experience integration of care positively | InteGRATE: a four item scaleCHI ESQ | Average score for services is 20% <70% strongly endorse the service | Average score for services is 40%70% strongly endorse the service | Average score for services is 60%80% strongly endorse the service | Average score for services is 80%90% strongly endorse the service |

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