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 within 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.

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 1: Shared Decision Making (SDM) at the heart of all decisions | A: Measure of extent of implementation  | CollaboRATE has not been implemented. SDM is not articulated in the strategy.There is no SDM training available to staff.  | CollaboRATE has not been fully implemented.SDM is a part of what the locality aspires to deliver, but this has not been fully implemented and this is not measured.There is no SDM training available for staff currently.  | CollaboRATE has been implemented systematically in at least one setting. SDM is articulated in the strategy.There has been some training in SDM, although not all staff have attended.  | CollaboRATE has been implemented in Local Authority, Third sector and healthcare settings. SDM clearly articulated as a priority in the localities’ strategy. Staff have access to training in SDM.  |
| B: Scores achieved in CollaboRATE  | Average score of more than 5 achieved. Or less than half of the young people are given the opportunity to rate their experience of SDM within the service.  | Average score of more than 6 achieved, with at least 50% or more of CYP in a service having the opportunity to respond to the questionnaire | Average score of more than 7 achieved, with at least 50% or more of CYP in a service having the opportunity to respond to the questionnaire | Average score of more than 8 achieved, with at least 50% or more of CYP in a service having the opportunity to respond to the questionnaire |

# 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 |
| MICRO PRINCIPLE 1A: Shared Decision Making (SDM) at heart of all decisions | 1 | 2 | 3 | 4 |  |
| MICRO PRINCIPLE 1B: Shared Decision Making (SDM) at heart of all decisions | 1 | 2 | 3 | 4 |  |

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 2: People (staff, CYP and families) are clear about which needs based group they are working within for any one person at any one time and this explicit to all | Notes Audit: Explaining the THRIVE groups to CYP and families, and deciding on which is the most suitable for care are part of the assessment process. This should be explicitly discussed with CYP and families and the outcome of these decisions is recorded as part of assessment.  | 20% of notes have the THRIVE group recorded.  | 40% of notes have the THRIVE group recorded. | 60% of notes have the THRIVE group recorded. | 80% notes have the THRIVE group recorded. |

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 2: People (staff, CYP and families) are clear about which needs based group they are working within for any one person at any one time and this explicit to all | 1 | 2 | 3 | 4 |  |

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 3: People (staff, CYP and families) are clear about parameters for help and reasons for ending | A: Staff survey – 50% staff must have completed the survey.  | 20% staff agree that there are clear parameters for the length of treatment, and that clear reasons for ending are set out at the beginning of therapy. | 40% staff agree that there are clear parameters for the length of treatment, and that clear reasons for ending are set out at the beginning of therapy. | 60% staff agree that there are clear parameters for the length of treatment, and that clear reasons for ending are set out at the beginning of therapy. | 80% staff agree that there are clear parameters for the length of treatment, and that clear reasons for ending are set out at the beginning of therapy. |
| B: Reasons for ending proforma and information for patients. | 0-40% of notes have the reasons for ending proforma filled out and this confirms that there was explicit consideration of endings and that this was discussed with children and young people and their families at the beginning of therapy.  | 40% - 59% of notes have the reasons for ending proforma filled out and this confirms that there was explicit consideration of endings and that this was discussed with CYPAF at the beginning of therapy. | 60-79% of notes have the reasons for ending proforma filled out and this confirms that there was explicit consideration of endings and that this was discussed with CYPAF at the beginning of therapy. | 80-100% of notes have the reasons for ending proforma filled out and this confirms that there was explicit consideration of endings and that this was discussed with CYPAF at the beginning of therapy. |
| C:  | Staff do not have access to training on when to end therapy and it is not routinely addressed at the beginning of therapy. Not all staff recognise that this is an important part of all therapy sessions. | Some staff have access to training on when to end therapy and some are clear about how to address this at the beginning of therapy. Not all staff recognise that this is an important part of all therapy sessions. | Some staff have access to training on when to end therapy and are confident in how to address this at the beginning of therapy. Most staff are clear that this is an important part of all therapy sessions. | All staff have access to training on when to end therapy and are confident in how to address this at the beginning of therapy. All staff are clear that this is an important part of all therapy sessions.  |

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 3A: People (staff, CYP and families) clear about parameters for help and reasons for ending | 1 | 2 | 3 | 4 |  |
| MICRO PRINCIPLE 3B: People (staff, CYP and families) clear about parameters for help and reasons for ending | 1 | 2 | 3 | 4 |  |
| MICRO PRINCIPLE 3C: People (staff, CYP and families) clear about parameters for help and reasons for ending | 1 | 2 | 3 | 4 |  |

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 4: Outcome data is used to inform individual practice with the purpose of improving quality | *Routine outcome data refers to the clinical data identified as part of CYP IAPT* | Routine outcome data is not collected, and it is not used as part of a QI processes within providers. There are no systems in place to enable this – it is not an explicit part of the organisational strategy and QI is not really a part of the organisation’s culture.Many staff have not had QI training. | Routine outcome data is not collected routinely in most parts of the service. The organisation has plans to include the use of data routinely, and this practice does happen in isolated areas, however it is not yet a part of the organisation’s culture. Many staff have not had QI training. | Routine outcome data is collected and utilised to support QI processes within providers in most services. The systems in place to enable this exist in many services, but this is not multi-disciplinary or across all provider types. While the data is used to inform practice, this is not standardised across the service. Most staff are familiar with QI approaches and have some experience in the use of a standardised QI methodology. | Routine outcome data is collected and utilised to support QI processes within providers. There are systems in place to enable this – it is part of the organisational strategy and there are specific times and places (e.g., a team meeting, or during supervision) where outcomes and variations in these between teams or individuals are discussed. QI is a part of the approach of all provider types in the locality. Staff are familiar with QI approaches and feel confident in the use of a standardised QI methodology.  |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 4: Outcome data is used to inform individual practice and improve quality | 1 | 2 | 3 | 4 |  |

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

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| --- | --- | --- | --- | --- | --- |
| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 5: Any intervention would involve explicit agreement from the beginning about the outcome being worked towards and the likely timeframe. There would be a plan for what happens if it is not achieved. | A: Audit | 0-39% CYPAF are managed within the recommended number of therapy sessions according to THRIVE-group. | 40-59% CYPAF are managed within the recommended number of therapy sessions according to THRIVE-group. | 60-79% CYPAF are managed within the recommended number of therapy sessions according to THRIVE-group. | 80-100% CYPAF are managed within the recommended number of therapy sessions according to THRIVE-group. |
| B: Audit | In 0-39% of notes, the goals and expected outcomes for treatment are discussed with CYPAF and recorded in notes. There is a plan in place for what happens if this is not achieved. | In 40-59% of notes, the goals and expected outcomes for treatment are discussed with CYPAF and recorded in notes. There is a plan in place for what happens if this is not achieved. | In 60-79% of notes, the goals and expected outcomes for treatment are discussed with CYPAF and recorded in notes. There is a plan in place for what happens if this is not achieved. | In 80-100% of notes, the goals and expected outcomes for treatment are discussed with CYPAF and recorded in notes. There is a plan in place for what happens if this is not achieved.  |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 5A: Intervention involves explicit agreement about the outcome being worked towards and the likely timeframe. There would be a plan for what happens if it is not achieved | 1 | 2 | 3 | 4 |  |
| MICRO PRINCIPLE 5B: Intervention involves explicit agreement about the outcome being worked towards and the likely timeframe. There would be a plan for what happens if it is not achieved | 1 | 2 | 3 | 4 |  |

# Micro System Considerations (The relationships between professionals and CYP, and inter-professional relationships)

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| THRIVE Principle | Measure used (where relevant) | Level 1*Some way to go to achieving THRIVE-like Practice* | 2 | 3 | Level 4*Practice is very THRIVE-like* |
| MICRO PRINCIPLE 6: Most experienced practitioners inform advice and signposting |  | There is not a Grade 8 or above mental health practitioner involved in the signposting and advice provided across the service. There are multiple teams in different settings that provide advice and signposting, with no way for these teams to access expert supervision. There is no way to know how effective the advice and signposting across the system works.  | From a mental health point of view, at least one Grade 8 or above is involved in giving advice and supporting signposting. Individuals involved in advice and signposting are from a number of different teams. There is supervision for most of these, but some of the assessments in the community (e.g. LA or schools) are not routinely discussed with a senior practitioner. |  From a mental health point of view, at least one Grade 8 or above is involved in giving advice and supporting signposting. Most individuals across the system are linked into the Advice & Signposting Team and feel able to get support from the senior clinician in providing advice & signposting. There are systems in place through which the senior practitioner can be assured that the advice and signposting systems are operating effectively.  | From a mental health point of view, at least one Grade 8 or above is involved in giving advice and supporting signposting. While the team undertaking assessments would be expected to be multi-disciplinary and/or multi-agency, this should act as a coherent team and should be supervised by a senior team member with mental health expertise.  |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 6: Most experienced practitioners inform advice and signposting  | 1 | 2 | 3 | 4 |  |

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| MICRO PRINCIPLE 7: THRIVE plans used to help those managing risk | Audit | 0-39% of CYP in the GETTING RISK SUPPORT group have a THRIVE plan documented and up to date. | 40-69% of CYP in the GETTING RISK SUPPORT group have a THRIVE plan documented and up to date. | 60-79% of CYP in the GETTING RISK SUPPORT group have a THRIVE plan documented and up to date. | 80-100% of CYP in the GETTING RISK SUPPORT group have a THRIVE plan documented and up to date. |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MICRO PRINCIPLE 7: THRIVE plans used to help those managing risk | 1 | 2 | 3 | 4 |  |