THRIVE Implementation Assessment Tool

The purpose of this document is to provide a tool for sites implementing the THRIVE Framework for system change (Wolpert et al., 2019) 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.

The THRIVE Framework 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 the THRIVE Framework 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 principles of the THRIVE Framework. On the left there is a description of the principle of the THRIVE Framework 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 the THRIVE Framework 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 and 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 Framework 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 and 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 or 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 locality's approach to delivering improved outcomes for children and young people's mental health. This is jointly created between health, care and education, with clear third 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 Framework Principle	1	2	3	4	Notes
MACRO PRINCIPLE 1: **A locality's mental health policy is interagency.**	1	2	3	4	

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

THRIVE Framework 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 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. (Example: 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).

Rating

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THRIVE Framework Principle	1	2	3	4	Notes
MACRO PRINCIPLE 2: **All agencies are involved in commissioning care (education, health, social care, third sector)**	1	2	3	4	

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

THRIVE Framework 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 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	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	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

THRIVE Framework 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*
			commissioning cycles and contracting problematic at times.	and is not systematically used across all contracts.	the impact of each service on the whole system's performance.

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 Framework Principle	1	2	3	4	Notes
MACRO PRINCIPLE 3: **Contracting of services, and the performance management of these, is informed by quality improvement information**	1	2	3	4	

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

THRIVE Framework 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 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.

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 Framework Principle	1	2	3	4	Notes
MACRO PRINCIPLE 4: **Use of population level preference data is used to support commissioning decisions.**	1	2	3	4	

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

THRIVE Framework 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 5: **Services working closely together such that service users experience integration of care positively**	InteGRATE: a four item scale CHI ESQ	IntegRATE: Average score for services is 20% CHI ESQ: <70% strongly endorse the service	IntegRATE: Average score for services is 40% CHI ESQ: 70% strongly endorse the service	IntegRATE: Average score for services is 60% CHI ESQ: 80% strongly endorse the service	IntegRATE: Average score for services is 80% CHI ESQ: 90% strongly endorse the service

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 Framework Principle	1	2	3	4	Notes
MACRO PRINCIPLE 5: **Services working closely together such that service users experience integration of care positively**	1	2	3	4	

Meso System Considerations (the five needs based groupings of children and young people set out in the THRIVE Framework and the services that support them)

THRIVE Framework 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*
MESO PRINCIPLE 1: **A comprehensive network of community providers is in place**		There is little effective signposting that is undertaken between the services. Signposting may happen effectively in isolated cases but there are no effective systems in place to enable this to happen routinely as part of assessment or ongoing care planning. There is no way for CYP or their families to access information about services locally. Referrals are sent back to referrer with no way of enabling a more suitable option for care to be identified or referred to. There is evidence that the community provision is underused and CAMHS providers feel they are	Some effective signposting is undertaken, this is not systematised. The network does not include a full range of providers (e.g. it only considers commissioned services) and less than half of local third sector providers are included. There are no established relationships between community providers and those signposting. There is no detailed consideration of referral processes to community providers. Information about community providers is not kept up to date. There is an attempt to collate information about the range of services available, but this is not comprehensive, may sit in a number of different places and practitioners do not routinely use it to help CYP understand their options. CYP and their	There is an established approach to signposting to a network of non-NHS providers locally. The network includes the majority of providers and includes both commissioned and non-commissioned services. There is an attempt to build relationships with community providers, in particular those that are commissioned, but there is still work to be done in relation to third sector/other independent organisations. There is a basic understanding of the criteria for entry and referral processes of the providers most often signposted to. Information about community providers is maintained in a single place and is kept up to date. The database is digitally enabled and CYP and families	The full range of community providers is known about and actively signposted to. This includes commissioned and non-commissioned services provided by independent, third sector, local authority, primary care, education etc. There are good relationships with community providers and criteria for entry and referral processes to those services are known by professionals that are signposting. Professionals undertaking assessments fully understand the concept of 'Getting Advice and Signposting' and know that they are delivering that service – this is a core part of the assessment process. There is a single digitally enabled database of the full range of community services available that is maintained

THRIVE Framework 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*
		being asked to manage a large number of cases that 'don't meet their criteria'.	families are not currently able to access this information easily. There is some evidence of CYP re-presenting for CAMHS assessment due to ineffective signposting, or frustration from community providers due to a high number of inappropriate referrals to them.	are able to access this, or this is being planned currently. While the signposting is not perfect, there is some evidence that it is working effectively – referrers do not have their referrals returned without advice on what services are helpful, and community providers are not overwhelmed with inappropriate referrals due to lack of understanding of their service criteria.	(e.g. Youth Wellbeing Directory). CYP are able to access information to be able to support them to access these services themselves. Community providers don't feel that there are a large number of inappropriate referrals into their services as a result of ineffective signposting, and there are not a high number of re-presentations to CAMHS as a result of failed signposting.

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 Framework Principle	1	2	3	4	Notes
MESO PRINCIPLE 1: **Comprehensive network of community providers is in place**	1	2	3	4	

Meso System Considerations (the five needs based groupings of children and young people set out in the THRIVE Framework and the services that support them)

THRIVE Framework 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*
MESO PRINCIPLE 2: **Quality Improvement (QI) data used to inform decisions, and this involves multiagency consideration of the data**	MINDFUL approach (CORC mindfulness measure): The following elements of the measure are relevant to the Meso system and would ideally be present in a THRIVE-like system: 1. Outcome and process measures are collected routinely and used to help shape service provision. 2. There is an outcomes framework that addresses all the THRIVE-groups. 3. Data is collated and feedback to staff to support QI work. 4. There are systems in place that enable staff to discuss and explore variations in quality data. 5. QI projects are undertaken using recognised methodology (e.g. PDSA) to reduce variation and improve quality of services. 6. There are regularly (e.g. quarterly) learning forums in place that involve all sectors. 7. There is an annual review of services that is undertaken.	No elements of the Mindful approach are reliably in place to enable QI data to be used to inform service data.	Two areas of the Mindful approach are reliably in place to enable QI data to be used to inform service data.	Three areas of the Mindful approach are reliably in place to enable QI data to be used to inform service data.	Four or five areas of the Mindful approach are reliably in place to enable QI data to be used to inform service data.

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 Framework Principle	1	2	3	4	Notes
MESO PRINCIPLE 2: **Quality Improvement (QI) data used to inform decisions involving multiagency review**	1	2	3	4	

Meso System Considerations (the five needs based groupings of children and young people set out in the THRIVE Framework and the services that support them)

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*
MESO PRINCIPLE 3: **Help is delivered using the conceptual framework of five needs based groupings**	A: A THRIVE Framework needs based grouping would be classed as having been implemented if CYP managed in the locality are identified as being in one THRIVE Framework needs based grouping, and services are organised to deliver care according to the needs of CYP in the respective THRIVE Framework needs based groupings.	None or only one of the THRIVE Framework needs based groupings are fully implemented. There are plans to transform services according to principles of the THRIVE Framework but implementation is not yet underway. There are plans for the approach to be multi-agency but implementation has not reached all agencies as yet.	At least two THRIVE Framework needs based groupings are fully implemented. The implementation has not fully involved all agencies at this stage, although plans are in place to enable this. Informatics are not established within the services yet and so reporting according to THRIVE Framework needs based grouping remains problematic.	The THRIVE Framework needs based groupings are implemented for the most part and there are clear services that enable the delivery of care according to the needs identified in these groups. Implementation includes all agencies but it may not be fully mature in all of them. Assessment of need is established and CYP are able to access care according to the THRIVE Framework needs based groupings as a result of that assessment. The information systems are not fully in place which means that performance management according to THRIVE Framework needs	All of the THRIVE Framework needs based groupings are fully implemented. Implementation includes all agencies. Services are organised to deliver needs-based care according to the five needs based groupings. There is an effective assessment process that enables CYP to be signposted into the right THRIVE Framework needs based grouping for them. There is a way of recording this in electronic patient records. It is possible to report on the activity and outcomes for each of the THRIVE Framework needs based groupings.

				based groupings is currently being established.	
	B: Staff survey	The staff survey demonstrates that 20% staff across the locality agree that care is being delivered according to the THRIVE Framework needs based groupings.	The staff survey demonstrates that 40% staff across the locality agree that care is being delivered according to the THRIVE Framework needs based groupings.	The staff survey demonstrates that 60% staff across the locality agree that care is being delivered according to the THRIVE Framework needs based groupings.	The staff survey demonstrates that 80% staff across the locality agree that care is being delivered according to the THRIVE Framework needs based groupings.

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 Framework Principle	1	2	3	4	Notes
MESO PRINCIPLE 3A: **Help is delivered using the conceptual framework of five needs based groupings**	1	2	3	4	
MESO PRINCIPLE 3B: **Help is delivered using the conceptual framework of five needs based groupings**	1	2	3	4	

Meso System Considerations (the five needs based groupings of children and young people set out in the THRIVE Framework and the services that support them)

THRIVE Framework 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*
MESO PRINCIPLE 4: **There is a focus on strengths and family resources wherever possible**		There is no consistent consideration of the family and the wider support network. Self management within a family isn't included in care plans, and isn't consistently documented. It would not be possible to reliably audit this currently. Self management and patient activation are not an explicit part of the approach to supporting CYP. There is no opportunity for practitioners to develop these skills currently.	There is some consideration of the family and the wider support network. This is often included in care plans, but documentation is not consistent. It would not be possible to reliably audit this currently. Self management and patient activation are part of the approach to supporting CYP but there is no opportunity for practitioners to develop these skills currently.	There is active consideration of the family and the wider support network. This is routinely included in care plans, and documentation is of good quality. It would be possible to reliably audit this currently. Self management and patient activation are an explicit part of the approach to supporting CYP. There is some training available but not all practitioners have the opportunity to develop these skills currently.	There is systematic consideration of family and the wider support network. CYP and staff agree that this is implemented. The family is considered in decision-making and involved in developing care plans. This is routinely documented and can be audited. Self-management and patient activation is actively promoted and supported and clinicians are able to support CYP with this. Training programmes support practitioners in 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 Framework Principle	1	2	3	4	Notes
MESO PRINCIPLE 4: **Focus on strengths and family resources wherever possible**	1	2	3	4	

Meso System Considerations (the five needs based groupings of children and young people set out in the THRIVE Framework and the services that support them)

THRIVE Framework 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*
MESO PRINCIPLE 5: **Evidence based practice is available and aligned to need using the 19 sub categories of needs as set out in the payment systems work**		Evidence of alignment of therapy with NICE-based guidance, where clearly relevant (e.g. CBT for anxiety) is achieved for at least 20% of relevant cases.	Evidence of alignment of therapy with NICE-based guidance, where clearly relevant (e.g., CBT for anxiety) is achieved for at least 40% of relevant cases.	Evidence of alignment of therapy with NICE-based guidance, where clearly relevant (e.g., CBT for anxiety) is achieved for at least 60% of relevant cases.	Evidence of alignment of therapy with NICE-based guidance, where clearly relevant (e.g., CBT for anxiety) is achieved for at least 80% of relevant cases.

Rating

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THRIVE Framework Principle	1	2	3	4	Notes
MESO PRINCIPLE 5: **Evidence based practice is available and aligned to need using the 19 sub categories of needs as set out in the payment systems work**	1	2	3	4	

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

THRIVE Framework 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 of the local area. 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 strategy of the local area. Staff have access to training in SDM.
	B: Scores achieved in CollaboRATE	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.	CollaboRATE: 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.	CollaboRATE: 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.	CollaboRATE: 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 Framework 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 (relationships between professionals and CYP and inter-professional relationships)

THRIVE Framework 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 grouping they are working within for any one person at any one time and this explicit to all**	Notes Audit: Explaining the THRIVE Framework needs based groupings 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 Framework needs based grouping recorded.	40% of notes have the THRIVE Framework needs based grouping recorded.	60% of notes have the THRIVE Framework needs based grouping recorded.	80% notes have the THRIVE Framework needs based grouping recorded.

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

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

THRIVE Framework 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.	Staff survey (min. 50% completion rate): 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.	Staff survey (min. 50% completion rate): 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.	Staff survey (min. 50% completion rate): 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.	Staff survey (min. 50% completion rate): 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.	Reasons for ending proforma: 0-40% of case 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 CYP and their families at the beginning of therapy.	Reasons for ending proforma: 40% - 59% of case 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 CYP and their families at the beginning of therapy.	Reasons for ending proforma: 60-79% of case 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 CYP and their families at the beginning of therapy.	Reasons for ending proforma: 80-100% of case 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 CYP and their families at the beginning of therapy.
	C:	Staff do not have access to training on when to end treatment and it is not routinely addressed at the beginning of therapy. Not all staff recognise that this is an	Some staff have access to training on when to end treatment and some are clear about how to address this at the beginning of therapy. Not all staff recognise that this is an	Some staff have access to training on when to end treatment and are confident in how to address this at the beginning of therapy. Most staff are clear that this is an	All staff have access to training on when to end treatment 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.	important part of all therapy sessions.	important part of all therapy sessions.	important part of all therapy sessions.

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 Framework 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 (relationships between professionals and CYP and inter-professional relationships)

THRIVE Framework 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 QI processes within providers. There are no systems in place to enable the collection of routine outcome data – 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 regularly in most parts of the service. Services have plans to collect data routinely and use this to inform individual practice. This does happen in isolated areas but 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 data collection exist in many services, but this is not multi-disciplinary or across all provider types. Data is used to inform individual practice but this is not standardised across services. 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 any variations in outcomes 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.

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 Framework 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 (relationships between professionals and CYP and inter-professional relationships)

THRIVE Framework 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	Case audit: 0-39% CYP and their families are managed within the recommended number of therapy sessions.	Case audit: 40-59% CYP and their families are managed within the recommended number of therapy sessions.	Case audit: 60-79% CYP and their families are managed within the recommended number of therapy sessions.	Case audit: 80-100% CYP and their families are managed within the recommended number of therapy sessions.
	B: Audit	Case audit: in 0-39% of notes, the goals and expected outcomes for treatment are discussed with CYP and their families and recorded in notes. There is a plan in place for what happens if this is not achieved.	Case audit: in 40-59% of notes, the goals and expected outcomes for treatment are discussed with CYP and their families and recorded in notes. There is a plan in place for what happens if this is not achieved.	Case audit: in 60-79% of notes, the goals and expected outcomes for treatment are discussed with CYP and their families and recorded in notes. There is a plan in place for what happens if this is not achieved.	Case audit: in 80-100% of notes, the goals and expected outcomes for treatment are discussed with CYP and their families and recorded in notes. There is a plan in place for what happens if this is not achieved.

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 Framework 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 (relationships between professionals and CYP and inter-professional relationships)

THRIVE Framework 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: **The 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 services. 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.	There is at least one Grade 8 or above mental health practitioner involved in giving advice and supporting signposting. Individuals involved in advice and signposting are from a number of different teams. There is mental health practitioner supervision for most of these, but some of the assessments in the community (e.g. local authority teams or schools) are not routinely discussed with a senior mental health practitioner.	There is at least one Grade 8 or above mental health practitioner involved in giving advice and supporting signposting. Most individuals across the system are linked into the advice and signposting services and feel able to get support from the senior clinician when they are providing advice and signposting to CYP and their families. There are systems in place through which the senior mental health practitioner can be assured that the advice and signposting systems are operating effectively.	There is at least one Grade 8 or above mental health practitioner involved in giving advice and supporting signposting. The team undertaking assessments is multi-disciplinary and/or multi-agency but acts as a coherent team and is supervised by a senior team member with mental health expertise. There are systems in place through which the senior mental health practitioner can be assured that the advice and signposting systems are operating effectively.

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 Framework Principle	1	2	3	4	Notes
MICRO PRINCIPLE 6: **The most experienced practitioners inform advice and signposting**	1	2	3	4	

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

THRIVE Framework 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 7: **Multi-agency THRIVE/Risk Support plans are used to help those managing risk**	Audit	Case audit: 0-39% of CYP in the 'Getting Risk Support' needs based grouping have a multi-agency THRIVE/Risk Support plan documented and up to date.	Case audit: 40-69% of CYP in the 'Getting Risk Support' needs based grouping have a multi-agency THRIVE/Risk Support plan documented and up to date.	Case audit: 60-79% of CYP in the 'Getting Risk Support' needs based grouping have a multi-agency THRIVE/Risk Support plan documented and up to date.	Case audit: 80-100% of CYP in the 'Getting Risk Support' needs based grouping have a multi-agency THRIVE/Risk Support plan documented and up to date.

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 7: **Multi-agency THRIVE/Risk Support plans are used to help those managing risk**	1	2	3	4	