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.

# Meso System Considerations (Groups of CYP with similar needs, and the services that provide care for 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 1: Comprehensive network of community providers is in place |  | There is little effective signposting that is undertaken between the services. Young people should be effectively signposted to appropriate services that might benefit them. While this may happen effectively in isolated cases, there are no effective systems in place in the locality to enable this to happen routinely as part of assessment or ongoing care planning. There is evidence that the community provision in underused and CAMH providers feel they are being asked to manage a large number of cases that ‘don’t’ meet their criteria’. 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 no way for CYP or families to access information about services in a locality.  | ‘Getting Advice & Signposting’ does undertake some signposting but this is not systematized in that: - The network does not include full range of providers. E.g. only considers commissioned services.- Less than half of the 3rd sector providers are included in the database. - While signposting may happen, there are no established relationships between assessment & signposting service and the services signposted to. - No detailed consideration of referral processes to different services.- The information about services that are signposted to 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 within a locality and practitioners do not routinely use this service to help CYP understand their options. CYP and their families are not able to access this information easily. - There is some evidence of patients re-presenting for assessment due to ineffective signposting, or frustration within the community due to a high number of inappropriate referrals to them. | There is an established approach to signposting to a network of non-NHS providers within the locality. - The network includes the majority of providers and includes both commissioned and non-commissioned services. - There is an attempt to build relationships between 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 to 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 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 – referrer s(e.g. primary care) do not have their referrals returned without advice on what services are helpful, and the community providers are not overwhelmed with inappropriate referrals due to lack of understanding of the criteria for their services.  | Full range of community providers is known about and actively signposted to. This includes commissioned and non-commissioned services provided by the full range of providers (independent, 3rd sector, LA, primary care, educational settings and health). - There are good relationships between providers and in particular the assessment services. Criteria for entry to services are known by professionals to enable effective signposting, and they understand/ have ready access to the referral processes for each. Getting signposting and advice is established with professionals undertaking assessment able to include this into the assessment process and signpost to these services effectively. There is a database of the full range of services available within a community that is maintained (e.g. Youth Wellbeing Directory). CYP are able to access information to be able to support them to access these services themselves. This is digitally enabled and collated in one place. Non-health services do not feel 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 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 Principle | 1 | 2 | 3 | 4 | Notes |
| MESO PRINCIPLE 1: Comprehensive network of community providers is in place | 1 | 2 | 3 | 4 |  |

# Meso System Considerations (Groups of CYP with similar needs, and the services that provide care for 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 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 arereliably in place to enable QI data to be used to inform service data. | Three areas of the Mindful approach arereliably in place to enable QI data to be used to inform service data. | Four or five areas of the Mindful approach arereliably in place to enable QI data to be used to inform service data. |

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| --- | --- | --- | --- | --- | --- |
| THRIVE 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 (Groups of CYP with similar needs, and the services that provide care for 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 delivered using conceptual framework of five needs based groups | A: A THRIVE Group would be classed as having been implemented if CYP managed in the locality are identified as being in one THRIVE group, and services are organised to deliver care according to the needs of CYP in the respective THRIVE-groups.  | None or only one of the THRIVE groups are fully implemented. Although a locality has plans to transform their services according to THRIVE principles, implementation is not yet underway.Although there are plans for the approach to be multi-agency, implementation has not reached all agencies as yet.  | At least two THRIVE groups are fully implemented. The implementation has not fully involved all agencies at this stage, although plans are in place to enable this. Informatics is not established within the services yet and so reporting according to THRIVE group remains problematic.  | The THRIVE groups 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 will include all agencies, but may not be fully mature in all of them. Signposting is established and patients are able to access care according to the THRIVE groups.The information systems are not fully in place which means that performance management of the services is currently being established.  | All the THRIVE groups are fully implemented. Implementation includes all agencies. Services are organised to deliver needs-based care according to these groups. There is an effective assessment process that enables CYP to be signposted into the right THRIVE group 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-groups.  |
| B: Staff survey | Demonstrates that 20% staff across the locality agree that care is being delivered according to the THRIVE needs groups.  | Demonstrates that 40% staff across the locality agree that care is being delivered according to the THRIVE needs groups.  | Demonstrates that 60% staff across the locality agree that care is being delivered according to the THRIVE needs groups.  | Demonstrates that 80% staff across the locality agree that care is being delivered according to the THRIVE needs groups.  |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MESO PRINCIPLE 3A: Help delivered using conceptual framework of five needs based groups | 1 | 2 | 3 | 4 |  |
| MESO PRINCIPLE 3B: Help delivered using conceptual framework of five needs based groups | 1 | 2 | 3 | 4 |  |

# Meso System Considerations (Groups of CYP with similar needs, and the services that provide care for them)

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| 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 4: Focus on strengths and family resources wherever possible |   | There is no consistent consideration of the family & wider support network. Self management 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 management. There is no opportunity for practitioners to develop these skills currently. | There is some consideration of the family & 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 management but there is no opportunity for practitioners to develop these skills currently. | There is active consideration of the family & 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 management. 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. Patients and staff agree this is implemented. The family is considered in decision-making and involved in developing care plans. This is routinely documented and can be audited. Patient activation and self-management is actively promoted and supported and clinicians are able to support patients in this. Training programmes support practitioners in this.  |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MESO PRINCIPLE 4:Focus on strengths and family resources wherever possible | 1 | 2 | 3 | 4 |  |

# Meso System Considerations (Groups of CYP with similar needs, and the services that provide care for them)

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| MESO PRINCIPLE 5: Evidence based practice available and aligned to need using the 19 sub categories of Needs based groups as relevant e.g. from Payment Systems |  | 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. |

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| THRIVE Principle | 1 | 2 | 3 | 4 | Notes |
| MESO PRINCIPLE 5: Evidence based practice available and aligned to need using the 19 sub categories of Needs based groups as relevant e.g. from Payment Systems | 1 | 2 | 3 | 4 |  |