

Putting NICE guidance into practice

Costing statement: Violence and aggression

Implementing the NICE guideline on violence and aggression (NG10)

Published: May 2015

Summary

NHS organisations are advised to assess the resource implications of this guidance locally. Potential areas for additional costs locally are:

- staff training
- increased staffing levels
- increased multidisciplinary liaison

Potential areas for savings locally are:

- avoiding violent or aggressive incidents through prevention and de-escalation, which may reduce the costs of service users harming themselves, endangering others or compromising the therapeutic environment
- reduced staff sickness absence, which may reduce the need for bank and agency staff
- more efficient use of hospital beds
- reduced costs for litigation.

1 Introduction

- 1.1 This costing statement considers the cost implications of implementing the recommendations made in [Violence and aggression: the short-term management of violent and physically threatening behaviour in mental health, health and community settings](#) (NICE guideline NG10).
- 1.2 The guideline might have resource implications at a local level as a result of variation in current practice across the country. Therefore, we encourage organisations to evaluate their own practices against the recommendations in the NICE guideline and assess costs locally. Some of the resource effects to be considered locally are discussed in this statement.
- 1.3 The commissioners for this topic are: NHS England for secure settings, Tier 4 children and adolescent mental health services (CAMHS) and primary care; clinical commissioning groups for mental health inpatient units, acute hospitals (including emergency departments), ambulance trusts and community services (including community mental health services); and local authorities for social care.

2 Background

- 2.1 Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.
- 2.2 Violence and aggression are common and serious occurrences in health and social care settings. Between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England: 69% in mental health or learning disability settings; 27% against ambulance staff, 25% involving primary care staff and 26% involving acute hospital staff. Violence and aggression in mental health settings occur most frequently in inpatient

psychiatric units and most assaults in acute hospitals take place in emergency departments.

- 2.3 In psychiatric wards in England, the estimated annual cost of assaults, verbal abuse and damage to objects is £20.5 million per year (2013/14 prices) (Flood et al. 2008). These estimates are based on the staff time taken and resources directly used to manage the incidents. They do not include fixed costs.

3 Recommendations with potential resource impact

Staff training

Recommendations

- [Recommendation 1.2.1](#)
- [Recommendation 1.3.12](#)
- [Recommendation 1.4.1](#)
- [Recommendations 1.5.3, 1.5.4 and 1.5.5](#)
- [Recommendations 1.6.2 and 1.6.3](#)
- [Recommendations 1.7.1, 1.7.2 and 1.7.3](#)

Background

- 3.1 Training covered in the recommendations includes legal issues, restrictive interventions, de-escalation techniques, immediate life support and communication.
- 3.2 The Guideline Development Group advised that the staff training currently given by health and social care provider organisations may not be in line with the recommendations in this guideline. Effective staff training might help to improve outcomes for service users and increase staff safety.
- 3.3 Currently training for violence management typically, but not always, consists of a 5-day course, followed by annual refresher courses. These courses are often provided in house. Where training is commissioned from external private providers there are a range of courses with different

content. In house courses are often linked to private providers via a 'train the trainer' scheme. Currently there are no detailed national guidelines on the content of violence management courses.

Costs

- 3.4 If health and social care provider organisations are not providing training in line with the guideline's recommendations, there may be additional costs to implement the recommendations. These will include the costs of staff time needed to provide cover for staff having training.
- 3.5 If staff working in CAMHS have not been given a training programme specifically designed for staff working with children and young people, in line with recommendation 1.7.1, there may be additional costs to implement this recommendation.
- 3.6 When staff work with children and young people as well as adults there may be additional costs because of the need to provide training specific to each age group.

Savings and benefits

- 3.7 Improving staff training should result in fewer violent or aggressive incidents, because staff will be better equipped to anticipate and prevent or de-escalate potential incidents.
- 3.8 Improving the management of violence and aggression may reduce the incidence of staff sickness absence and result in savings from lower bank and agency staff costs.
- 3.9 Staff morale may improve because staff feel safer if incidents of violence and aggression are reduced.
- 3.10 The safety of service users during restraint or rapid tranquillisation will be increased when staff have been trained in immediate life support.
- 3.11 The risk of litigation for injury to service users and staff may reduce as the number of violent or aggressive incidents reduces.

- 3.12 When violent or aggressive incidents happen, there should be less risk of harm to the service user, staff and others, because staff will be able to use effective techniques to deal with the incident. This may reduce the risk of litigation for injury to service users and staff, reduce staff sickness absence and may improve outcomes for service users.

Staffing

Recommendations

Immediate life support

- [Recommendation 1.4.4](#)

Observation

- [Recommendations 1.4.10 and 1.4.11](#)

Manual restraint

- [Recommendation 1.4.23](#)

Background

- 3.13 Observation uses nursing time because it is a 2-way relationship between the service user and the nurse. The costs of observation are estimated to be £88 million annually (2013/14 prices) ([Flood et al. 2008](#)).
- 3.14 Manual restraint is used to safely immobilise a service user to prevent them from harming themselves, endangering others or compromising the therapeutic environment. The costs of manual restraint are estimated to be £6.1 million annually (2013/14 prices) ([Flood et al. 2008](#)).

Costs

- 3.15 Additional nursing staff may be needed if there are not enough staff to implement the recommendations on observation and manual restraint.
- 3.16 Additional staff may be needed to ensure that there are enough staff available at all times to work together as a team when carrying out manual restraint, in line with recommendation 1.4.23.

- 3.17 There should be staff trained in immediate life support and a doctor trained to use emergency equipment immediately available to attend an emergency if restrictive interventions (such as manual restraint) may be used. This may necessitate training for staff or recruiting additional trained staff, including doctors.
- 3.18 The Guideline Development Group expect that some organisations providing inpatient units might need changes in staffing levels to implement the recommendations on levels of observation and manual restraint. It has not been possible to calculate the cost because of local variation and lack of data.
- 3.19 NICE is developing a [safe staffing guideline](#) for mental health inpatient settings (publication expected October 2015).

Savings and benefits

- 3.20 If violent or aggressive incidents are avoided because of improved observation, there may be a lower risk of litigation for injury to service users and staff, reduced staff sickness absence and improved outcomes for service users.
- 3.21 Manual restraint by a team rather than on a one-to-one basis reduces the risk of injury to both service users and staff. Staff can ensure that the service user's airways and circulation are protected.

Multidisciplinary liaison

Recommendations

- [Recommendations 1.5.1 and 1.5.2](#)

Background

- 3.22 Most people who frequently re-attend emergency departments do so because of untreated mental health problems, according to the Joint Commissioning Panel for Mental Health's 2013 report [Acute care – inpatient and crisis home treatment](#).

3.23 Most of the 17,900 violent incidents in 2013/14 in acute hospitals happened in emergency departments.

Costs

3.24 Many emergency departments work with liaison mental health teams. If liaison mental health services for emergency departments are not currently implementing the recommendations in the guideline, including being able to carry out a full mental health assessment within 1 hour of alert from the emergency department, there may be additional staff costs to implement these recommendations.

Savings and benefits

3.25 Mental health assessment in emergency departments will allow service users to be directed to suitable services. This is likely to reduce frustration for the service user and avoid violent or aggressive incidents.

3.26 If liaison mental health teams are available in line with the recommendations in the guideline, the overall costs of care could be lowered, through a reduction in time spent in emergency departments and general hospital beds.

3.27 Effectively assessing mental health conditions may reduce medical investigations and the use of medical and surgical outpatient facilities that do not relate to the service user's health problems.

4 Other considerations

4.1 If violence and aggression are effectively managed, organisations may reduce litigation and compensation costs.

4.2 [Recommendation 1.3.14](#) suggests using quiet areas to segregate agitated service users as part of a violence prevention strategy. In facilities without access to quiet areas there may be one-off expenditure needed to provide these areas.

4.3 If violence and aggression are not effectively managed there may be problems with staff recruitment and retention.

5 Conclusion

5.1 NHS organisations are advised to assess the resource implications of this guidance locally. Potential areas for additional costs locally are:

- staff training
- increased staffing levels
- increased multidisciplinary liaison

Potential areas for savings locally are:

- avoiding violent or aggressive incidents through prevention and de-escalation, which may reduce the costs of service users harming themselves, endangering others or compromising the therapeutic environment
- reduced staff sickness absence, which may reduce the need for bank and agency staff
- more efficient use of hospital beds
- reduced costs for litigation.

About this costing statement

This costing statement accompanies [Violence and aggression](#) (NICE guideline NG10).

Issue date: May 2015

This statement is written in the following context

This statement represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. It should be read in conjunction with the NICE guideline. The statement is an implementation tool and focuses on those areas that were considered to have potential impact on resource utilisation.

The cost and activity assessments in the statement are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.

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