Royal College of Nursing

2025 Employment Survey

Health, safety and wellbeing

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1. Introduction

The RCN's **2025 Employment Survey report** (RCN, 2025) summarises findings from over 20,000 RCN members, offering detailed insights into their working lives, looking at pay and pensions, working hours, workplace abuse and bullying as well as attitudes to nursing as a career. This separate report concentrates on working hours, patterns, pressures and experiences of abuse among nursing staff, and further examines how these vary by employment sector, contract type, demographics and workplace context.

Concentrating on the health, safety and wellbeing of nursing staff, this report highlights substantial variation across sectors, settings, and roles. It also shows that personal characteristics play a crucial role in shaping how people experience their working lives. Yet these experiences are not formed in isolation – they are deeply influenced by broader societal norms and workplace cultures. Factors such as ethnicity, age, gender, sexuality, and social class affect how individuals and groups are viewed and treated at work, as well as the decisions they make about their roles and career paths.

These detailed findings reveal a workforce experiencing significant strain, shaped by structural pressures within health and social care and by the personal circumstances of nursing staff. Working hours and patterns vary widely across roles and settings, reflecting both organisational demands and individual needs. While many staff work full time; part-time and fixed hours arrangements are common in certain sectors such as general practice and education. In contrast, shift working remains central in acute, urgent and hospital-based care, where service intensity is greatest. These differences intersect with demographic factors: women, older staff and disabled staff frequently occupy roles with more fixed hours or part time work, while younger staff are more likely to work full time and undertake shift work.

Across the workforce, a clear theme emerging from the report is the prevalence of working beyond contracted hours. Most staff regularly put in additional time, often several times a week, indicating a culture in which long hours are normalised. The extent of this varies considerably depending on the setting. Some areas, particularly further and higher education, community services, and hospital management roles, experience chronic and sustained additional workloads. Others, such as independent care homes and some hospital specialties, face intense but less frequent spikes. This pattern underscores the extent to which overtime is driven not only by individual choice or contract type but by the organisational pressures embedded in specific parts of the health and social care system.

The findings also point to a workforce under significant pressure. A majority of respondents report feeling stretched or unable to provide the level of care they would like. High acuity hospital settings, along with call centre based environments such as NHS 111/24, appear to be particular pressure points. Work-life balance remains a challenge for many, and satisfaction with working hours is mixed. Choice and autonomy over working patterns are unevenly distributed; staffing levels and service demands can limit flexibility, especially in hospitals and care homes. Younger and full time staff tend to have more nominal control over their hours, yet this often coincides with higher levels of stress. Conversely, part-time or shift-based work can offer staff better balance but may come with reduced autonomy – revealing a paradox at the heart of contemporary nursing work.

The report also highlights widespread levels of presenteeism. Many staff continue working when they believe they should be on sick leave, especially those working for agencies, criminal justice settings and care homes. This behaviour appears closely tied to workplace pressure, job insecurity and the nature of employment arrangements.

Experiences of abuse form another significant part of the findings. Verbal abuse is widespread, and physical abuse is a persistent risk, particularly in hospital settings such as acute, urgent, older people's care and mental health. Staff in independent care homes, NHS 111/24 services and agency roles also face heightened exposure. Younger staff, male and non-binary respondents, and internationally educated nurses report especially high rates of abuse. Much of this behaviour originates from individuals experiencing health-related conditions such as dementia, delirium or mental health crises, although dissatisfaction with delays or care also contribute. While most staff know how to report abuse, confidence that reporting leads to meaningful action remains low, and many feel incidents are minimised or treated as an unavoidable part of the job.

Bullying and harassment from colleagues is also common. The report identifies GP practices as a prominent hotspot, with smaller teams and limited oversight potentially contributing to challenging workplace cultures. Disabled staff face especially high levels of bullying, and many believe the behaviour is linked to their disability. Unlike other forms of abuse, bullying does not show strong sectoral patterns beyond this; rather, it appears rooted in local workplace culture and interpersonal dynamics.

Sexual harassment – primarily from patients, relatives or members of the public – disproportionately affects younger staff and students. Hospitals, particularly acute and urgent care, are the main environments where such incidents are reported. While demographic factors such as age and ethnicity influence risk, workplace setting remains a central driver.

Taken together, the findings paint a picture of a workforce shaped by complex interactions between organisational structures, workforce distribution, and individual identity. High-pressure environments, staffing shortages, and cultural norms around overtime and abuse create uneven experiences across the profession. While many staff continue to deliver care with dedication despite these challenges, the report underscores the need for structural changes – more supportive organisational cultures, better staffing levels, and greater recognition of the pressures faced by nursing staff across all sectors.

2. Working hours and patterns

Respondents were asked about their working hours and patterns, and whether they work full-time, part-time or occasional/various hours. They were also asked whether they work shift patterns or fixed hours. The survey results show that patterns of working in health and social care are highly differentiated, heavily shaped both by the prevalence of part-time contracts and by the divide between shift-based and fixed-hour roles.

2.1 Working hours

- 66.5% work full-time.
- 30.8% work part-time.
- 2.7% work occasional or various hours.

Working patterns

- 54.1% work fixed hours.
- 41.4% work shift hours.
- 4.5% work a different pattern.

2.1.2 Sectoral variation

Working hours and contracts vary across different organisational settings, reflecting service needs and workforce structures.

Full-time vs part-time working

- Overall, 30.8% of respondents are employed part-time.
- Highest prevalence: general practice (60.6%), followed by NHS 111/24 (44.2%) and hospices (42.1%).
- Lowest prevalence: independent sector care homes (19.7%), criminal justice settings (21.6%) and NHS hospital mental health settings (17.7%).

Shift vs fixed hours

- Fixed hour working dominates in further education (FE)/higher education (HE), general practice, and NHS education, development, management, leadership, and outpatient roles.
- Shift-based working is prevalent in NHS acute and urgent care, hospital-based older people care and surgical settings, NHS 111/24, and independent sector hospitals.

2.1.3 Demographic variation

- **Gender:** Figure 1 shows clear differences across female and male respondents, with women more likely to work part-time than men (33.1% compared to 14.3%). Women are also more likely to report working fixed hour patterns (58.1%) than men (47.2%).
- **Disability:** Respondents with disabilities report little difference in full time vs part time working, but are slightly more likely to work fixed hours than those without disabilities (60.6% vs 55.9%).
- **Age:** Figures 2 and 3 show a clear age gradient, with younger staff much more likely to work full-time hours and shift patterns and older staff more likely to work part-time and fixed hours.

Figure 1: Working hours and patterns by gender

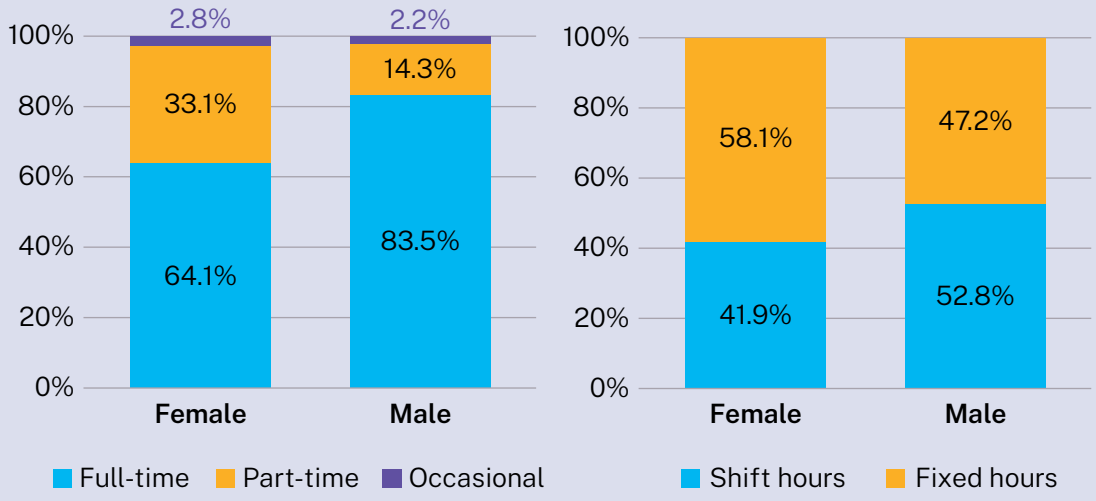


Figure 2: Working hours by age

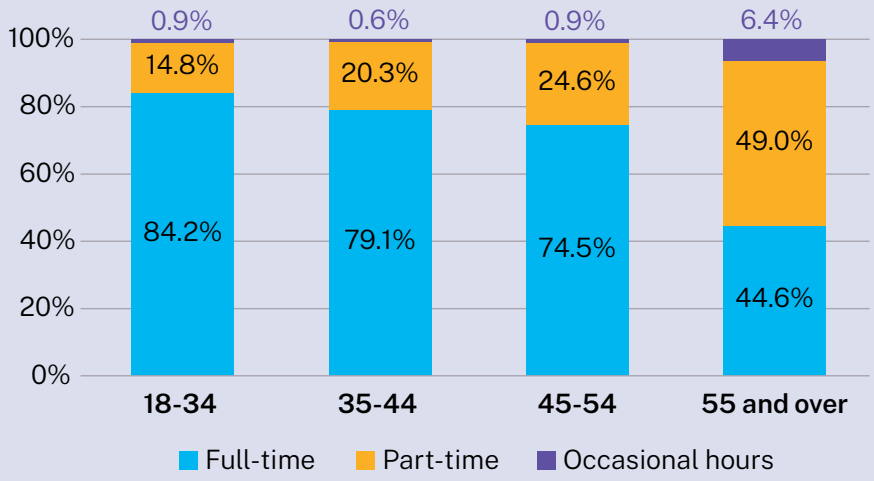
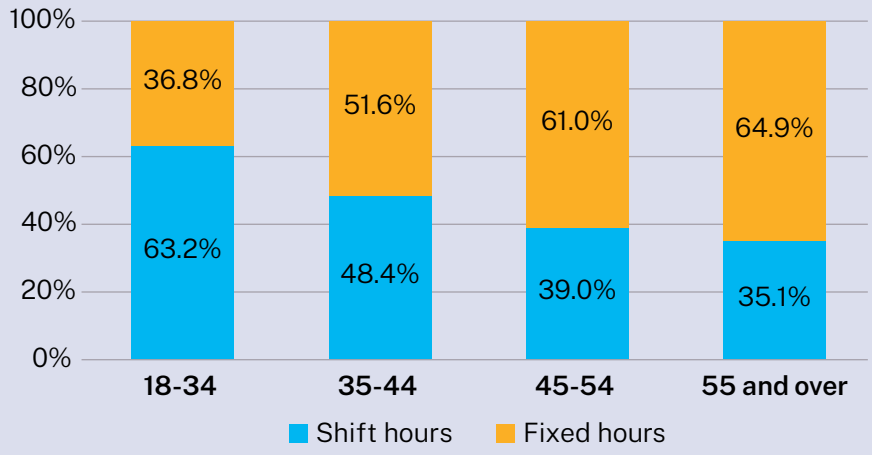


Figure 3: Working pattern by age



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2.2 Additional hours working

Respondents were asked about the extent to which they worked beyond their contracted hours, focusing on both the regularity of this additional working and the typical duration involved.

Prevalence:

- 70.4% reported working additional hours at least once a week.
- 34.8% do so several times a week.
- 13.5% work extra hours on every shift.

Duration (among those working extra at least once a week)

- 1–2 hours: 32.4%
- 3–6 hours: 41.6%
- 7–10 hours: 11%
- Over 10 hours: 11%

Figure 4: Working additional hours

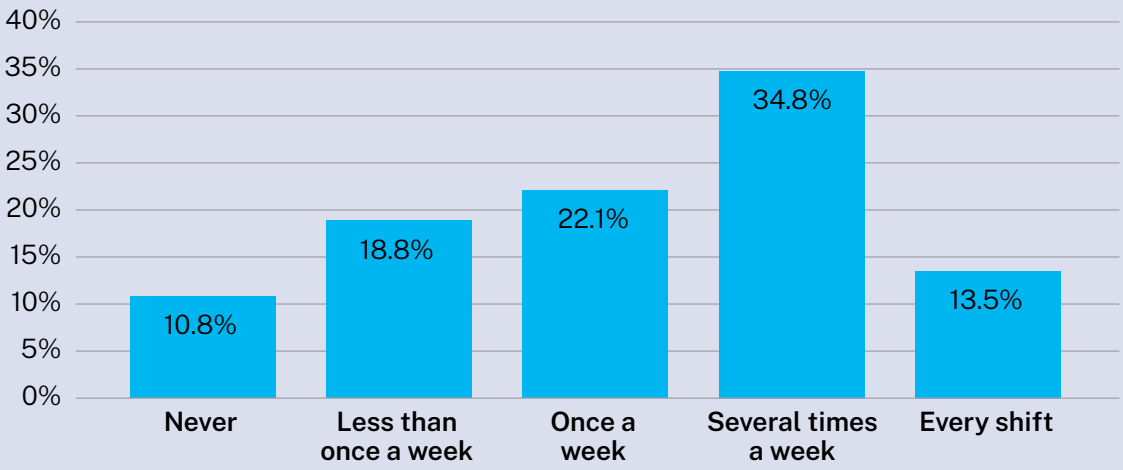
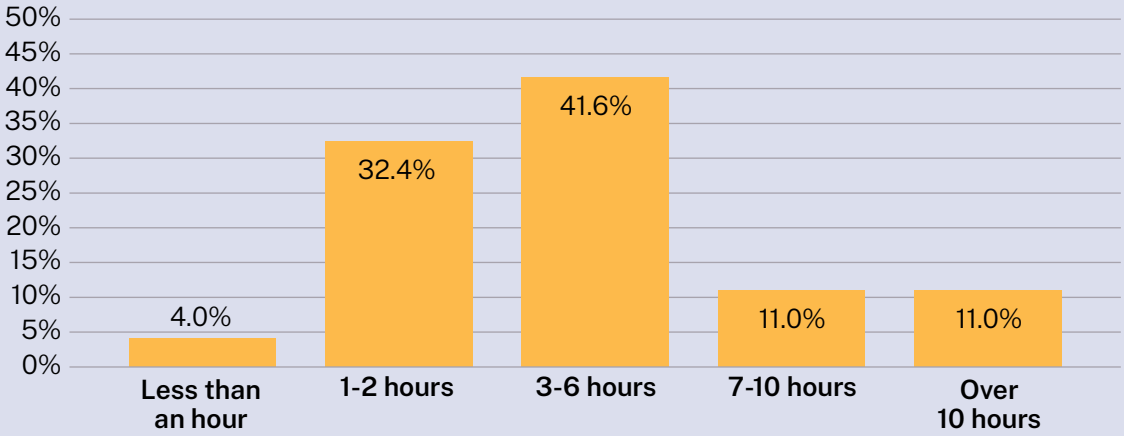


Figure 5: Length of additional working hours



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2.2.1 Sectoral variation

Looking across different settings in the health and social care sector, patterns of additional hours working vary significantly, in terms of both regularity and length.

- **Highest incidence of regular overtime:**
  - FE/HE (63.9%).
  - NHS community (59.1%).
  - NHS management/governance (52.2%).
- **Lowest incidence:**
  - Private sector industry (43.2%).
  - Independent hospitals (40.2%).
  - o Independent care homes (41.4%).

Intensity of additional hours working

Looking at those who most regularly work long additional hours (at least 6 hours extra every shift or several times a week):

- **Highest intensity:** FE/HE (33.1%), independent sector community providers (19.1%), NHS management/governance (17.1%).
- **Lowest intensity:** hospices (8.3%), bank/agency staff (7.6%), general practice (5.0%).

2.3 Working patterns and contract type

Looking at the incidence of additional hours working in more detail shows that the likelihood of nursing staff working longer than their contracted hours is closely linked to their working patterns and contractual arrangements, as well as the organisational context in which they are employed.

Working hours and patterns are shaped by both service requirements and individual choice. For instance, certain hospital wards may operate entirely on shift-based schedules, while other areas, such as outpatient services typically run on fixed-hour models. Meanwhile, individual nursing staff may also express preferences for particular patterns, balancing professional responsibilities with personal circumstances.

These factors combine to influence working patterns, workloads and pressure to work beyond contractual hours.

Variation by contract type

The survey responses show that contractual arrangements strongly influence the frequency of additional hours:

- **Full-time staff:** 51.8% report working additional hours on every shift/working day or several times a week.
- **Part-time staff:** 42.6% report doing so.
- **Occasional/variable hours staff:** Only 23.7% report regularly working additional hours.

These contrasts illustrate how organisational context drives working patterns and, in turn, influences additional hours working.

Typology of additional hours working

The findings in section 2.2.1 showed that working patterns vary markedly across different areas of the health and social care economy. We can see that, for example, part-time working is prevalent in general practice while shift working is the dominant contractual pattern in NHS acute and urgent care, NHS 111/24, and independent hospitals.

Therefore, in order to take into account the different pattern working patterns across the range of organisational setting, we analysed the prevalence of additional hours working, controlling for these factors. This analysis, which allows us to identify where additional hours working is most prevalent regardless of these variations, reveals four distinct overtime typologies[1]:

1. **Chronic overload** – frequent and long additional hours working
    - FE/HE, public sector (including criminal justice), NHS community, NHS hospital management/leadership/policy, NHS hospital mental health settings.
2. **Acute spikes** – less frequent but heavy additional hours working when it occurs
    - Independent sector care homes and hospitals, bank/agency staff, NHS hospital older people's care.
3. **Routine extension** – frequent but lighter additional hours working
    - Hospices, NHS hospital cancer care, long-term conditions, children and young people.
4. **Minimal burden** – lowest incidence and intensity
    - General practice, NHS 111/24, private sector employers, NHS outpatients, NHS hospital education and development, women's health, surgical.

2.3.1 Conclusion on additional hours working

Additional hours working is widespread across nursing staff, cutting across contract types and working patterns. While those working fixed hours and full-time report the highest rates of regular additional hours working, part-time and shift-based staff are not far behind. The burden is systemic, driven less by individual factors than by organisational context, sectoral norms, service demands, and workforce structures.

By controlling for working patterns this shows that overtime intensity is not simply a matter of being full time vs part time, or shift vs fixed. Instead, it is the organisational context that is decisive.

1 Analysis for this report was conducted using logistic regression models that controlled for key factors including working pattern, contract type, organisational setting and relevant demographic characteristics. Controlling for these variables enabled us to isolate differences in survey findings that are not simply the result of variations in workforce composition or employment context.

2.4 Nursing staff views about working patterns and workload

Respondents were asked a range of questions about their workload, work-life balance, satisfaction with the length of their working day and choice over working hours.

- 62.9% agree or strongly agree with the statement 'I feel under too much pressure at work', while just one in ten (11.9%) disagreed.
- 38.1% disagreed or strongly disagreed that they were able to balance home and work lives, while a similar proportion (36.9%) agreed with the statement.
- 50.4% reported feeling happy with their working hours.
- 59.3% agreed or strongly agreed with the statement that 'I am too busy to provide the level of care I would like' with just 18.1% disagreeing with the statement.
- 45% of respondents agreed that they were satisfied with the choice they had over the length of shifts of working days.

Figure 6: I feel I am under too much pressure at work

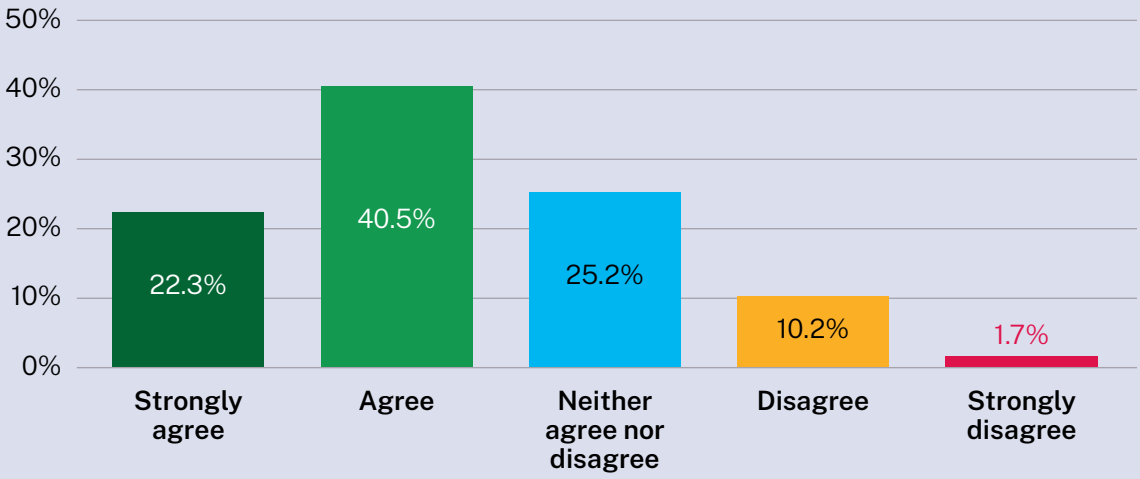

Figure 7: I feel able to balance my home and work lives

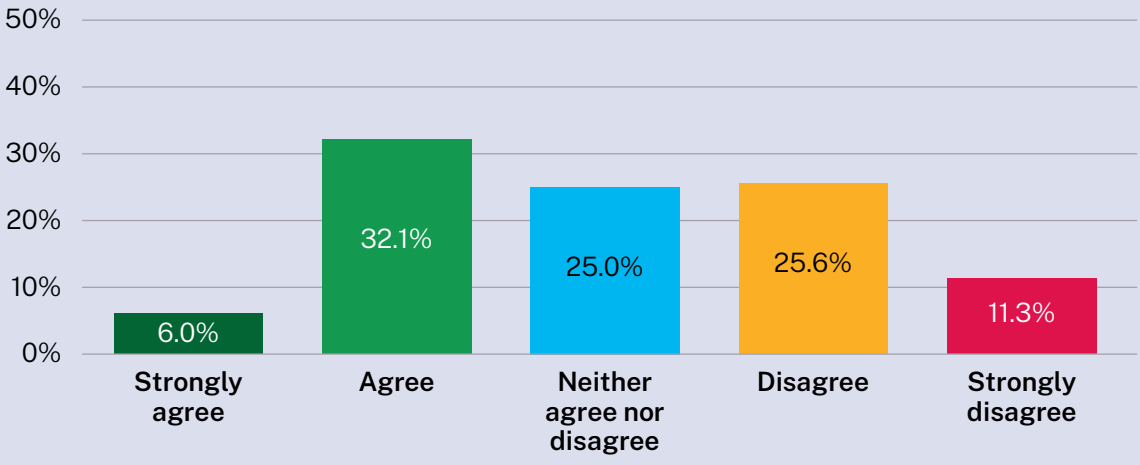

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Figure 8: I am happy with my working hours

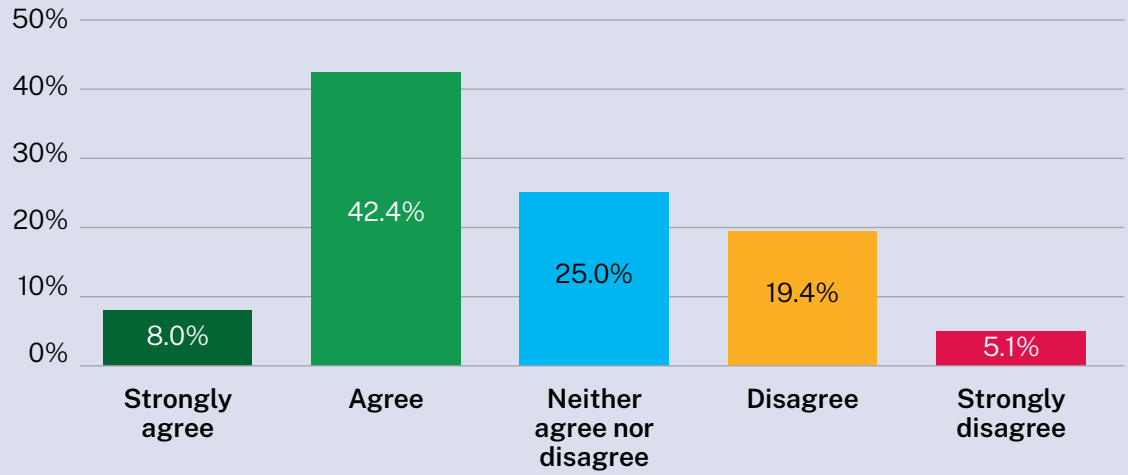
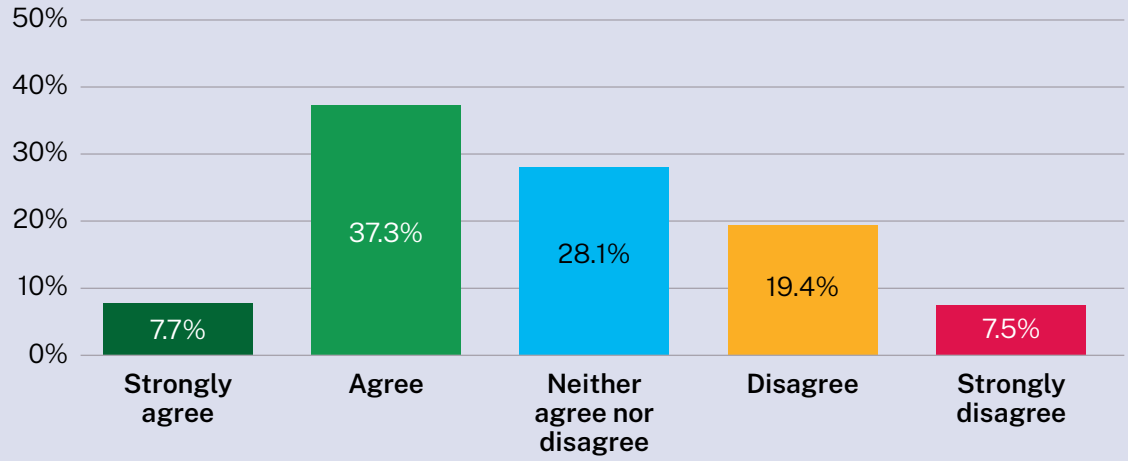


Figure 9: I am satisfied with the choice I have over the length of shifts/working hours I work



2.4.1 Workplace pressure

Further analysis of survey questions on working hours and workplace pressure was undertaken to explore differences across respondents, focusing on age, employer type, and mode of working (ie whether staff work shifts or fixed hours). The findings reveal that workplace pressure, perceived choice over working hours, and work life balance are shaped by distinct structural and individual factors, creating a complex and sometimes contradictory landscape of workforce experiences.

Workplace pressure is structurally concentrated in hospital-based NHS roles, particularly in acute and urgent care, cancer and palliative care, long-term conditions, and surgical practice areas. These high acuity areas translate into consistently higher odds of staff reporting that they feel too busy or under strain. NHS 111/24 and other call centre and digital health roles also stand out, reflecting the intensity of demand and the rigid nature of service delivery. By contrast, staff in hospices, NHS education and development roles, and independent sector hospitals report lower levels of pressure, suggesting that organisational setting and patient acuity are key drivers of strain.

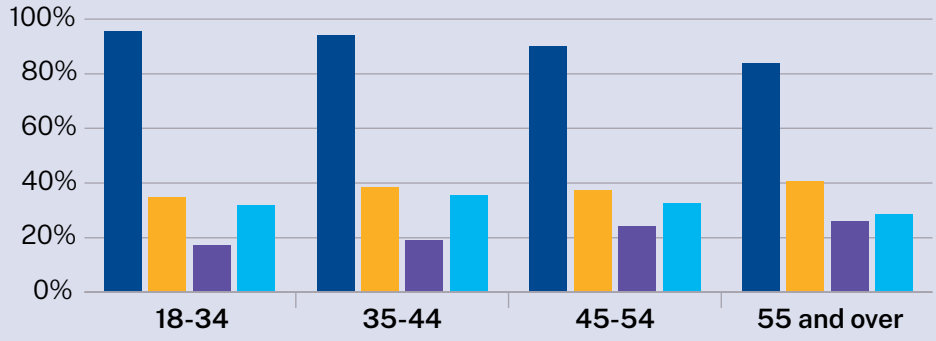
2.4.2 Choice and autonomy over working hours and length

Perceived choice over working hours follows a different pattern. Autonomy is most constrained in independent care homes and NHS hospitals, where staffing levels and service demands limit flexibility. However, choice is shaped more by contract type, shift type, age, and disability than by employer type or NHS practice area.

Both older and disabled staff consistently report less autonomy. In contrast, younger staff as well as those working full-time and those on fixed-hours contracts report more choice, but this is often accompanied by higher pressure and dissatisfaction with work-life balance.

Respondents were also asked to choose from a list of options which aspect of their working lives would make most difference to them. Figure 10 shows that overwhelmingly, the majority of respondents stated a pay rise would make most difference, and while pay remains the clear top priority at all life stages, there is a gradual decline with age, with 83.8% of those aged 55 or over stating this was their priority, compared to 97.7% of those aged 34 and under. The preference for more holiday and shorter working hours increases steadily with age, with older respondents more likely to indicate this a priority than younger colleagues. Interest in more flexible working arrangements follows a different pattern, with those aged between 35 and 44 most likely to express this as a preference, likely reflecting work–life pressures associated with caring responsibilities.

Figure 10: What would make most difference to your working life? by age



	18-34	35-44	45-54	55 and over
Pay rise	95.7%	94.1%	90.0%	83.8%
More holiday	34.6%	38.6%	37.2%	40.6%
Shorter working hours	17.4%	19.2%	24.2%	25.9%
More flexible working arrangements	31.8%	35.6%	32.8%	28.5%

2.4.3 Work life balance

Work life balance is shaped less by employer type or practice area, and more by working patterns and individual characteristics:

- shift work is somewhat protective, with staff working shift patterns more likely to report good balance compared to those on fixed hours
- part-time and occasional contracts are strongly associated with better balance, offering staff greater control over their lives
- older nurses consistently report higher odds of balance, reflecting career stage and accumulated experience
- disabled staff also report better balance, even though they face higher pressure and less autonomy. This suggests that accommodations or flexible arrangements may support balance, even where systemic inequities remain.

Taken together, the results show that:

- pressure is concentrated in high-acuity NHS roles and practice areas
- work-life balance is most strongly shaped by working patterns and individual characteristics
- choice/autonomy is constrained by personal characteristics and contractual arrangements, with older and disabled staff particularly disadvantaged
- employer type and practice area drive pressure, while contract type, shift type, age, and disability drive choice and balance.

2.4.4 The paradox

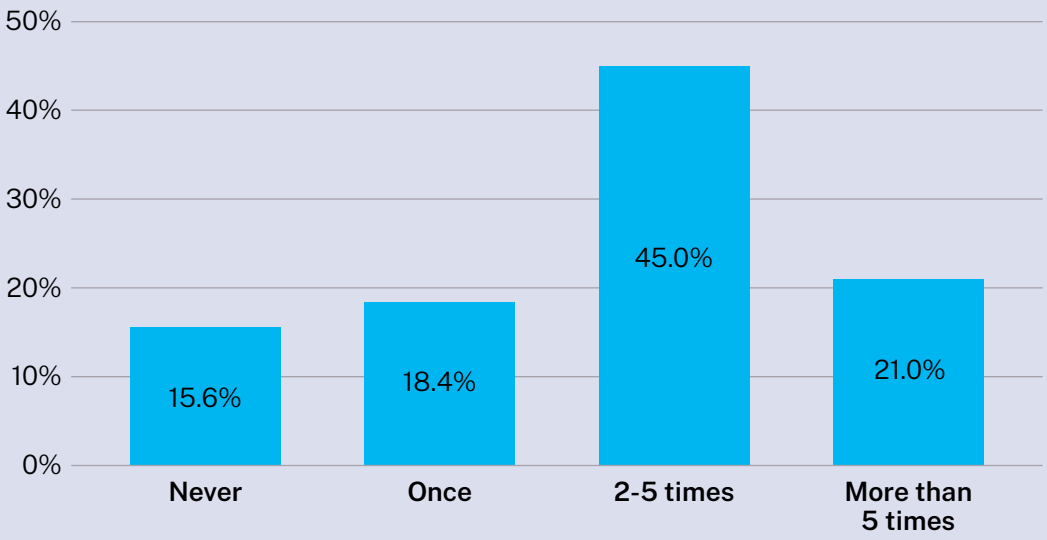
Working arrangements such as part-time and shift working are seen to protect wellbeing but are also associated with less control. Meanwhile, those working arrangements which are associated with more control (full-time, fixed-hours working) face higher pressure and dissatisfaction. Wellbeing and autonomy do not align: staff may feel healthier and more balanced under arrangements that limit their control, while those with more control experience greater strain.

2.5 Working when sick

Survey respondents were asked how many times they had worked when they really should have taken sick leave over the previous 12 months. Over eight in ten (84.5%) reported having worked when unwell on at least one occasion and 21% had done so on over five occasions.

Respondents employed by nursing agencies, in criminal justice settings and in independent sector care homes were most likely to report working at least five times, despite being unwell. A third of all respondents employed by agencies said they had done so, reflecting their limited access to paid sick leave and pressure to maintain income streams.

Figure 11: How many times have you worked in the last 12 months when you should have taken sick leave?



Further analysis of the survey data shows a consistent and strong association between feeling under high pressure at work and working while sick. Regardless of employer type, staff who report feeling they work under high pressure are more than twice as likely to report presenteeism compared to those under low pressure. This strongly indicates that pressure is a central driver of presenteeism across the workforce.

2.5.1 Sectoral differences

- Hospitals and NHS 111/24 roles combine structural demand with clinical intensity, making pressure especially likely to translate into presenteeism.
- Agency staff face compounded risk: pressure interacts with insecure contracts and income dependence, producing the highest odds of working while sick.
- GP practices also show elevated odds, reflecting small team sizes and limited cover.
- Hospices show lower levels of pressure and presenteeism

These findings highlight that organisational setting shapes how pressure is experienced, but the underlying mechanism of pressure driving presenteeism is consistent.

Working patterns

- Full-time staff and those working shift patterns are most vulnerable, as pressure interacts with workload intensity and rigid scheduling.
- Part-time and occasional contracts, and fixed hours arrangements, provide protection, showing how flexibility reduces the likelihood of presenteeism.

This demonstrates that working arrangements can either amplify or buffer the impact of pressure.

2.5.2 Individual characteristics

Further analysis of the results suggests that presenteeism is not just about where someone works – it is also about who they are and how their work is structured.

- Pressure is universal, but its impact depends on context (employer, practice area), working pattern (contract type, shift vs fixed), and individual characteristics (age, disability).
- The highest risks occur where structural demand, clinical acuity, and insecure or rigid working arrangements overlap: NHS 111/24, agency work, and high acuity hospital areas.
- Protective factors include part-time or occasional contracts, fixed hours, and career maturity.

2.5.3 Workplace sickness policies, processes and culture

Respondents' accounts reveal that many nursing staff living with disabilities or long term health conditions often experience workplace systems and sickness absence policies as an added source of strain. While the survey's quantitative findings describe the broader prevalence of pressure and presenteeism, further feedback shows how such pressures are experienced in practice. Staff frequently reported that sickness absence processes felt rigid, inconsistently applied, or insufficiently sensitive to their individual circumstances. This contributes to feelings of scrutiny rather than support, suggesting that organisational cultures and policy implementation can undermine wellbeing, particularly for those already managing chronic or fluctuating health needs.

> My own health needs and disabilities are used against me. They don't understand the correlation between work stress and how this impacts staff on a personal, emotional, physical and socio-economic level. Holistic care is preached yet when it comes to staff nobody cares. I have experienced micromanagement, bullying that is hard to prove, unfair and unprofessional treatment and want to leave my career due to this. I have chronic physical and mental health issues and when off sick I get "reminded" of how my absence affects the service and my team – I stress about this enough and don't need it."
>
> *Clinical nurse specialist, NHS community setting, West Midlands*

> I wish to drop a half day to make life more manageable due to work/life balance and disability, but work keep refusing."
>
> *NHS Health visitor, Scotland*

> Disability discrimination is horrendous. If you have a long-term chronic illness, you get penalised for being off sick. The policy has recently changed to allow managers to use their discretion. However, they use bullying tactics such as threatening of dismissal, unprofessionalism with dealing with sensitive issues. Occupational Health input just gets ignored. They cause increased anxiety and stress, but they treat all staff the same when it comes to sickness."
>
> *Assistant practitioner, NHS acute/urgent hospital unit, East of England*

> As an occupational health nurse, I see that most workplace sickness policies are awful. Putting blame and guilt onto staff for having chronic illness. Attendance policies need to change towards disability or chronic conditions. I want to leave the profession."
>
> *Occupational health nurse, private provider*

Respondents' accounts also highlighted the experiences of older nursing staff, many of whom described needing greater recognition and support as their roles become more physically and emotionally demanding with age.

A significant number of female respondents also emphasised that menopausal symptoms were poorly understood or insufficiently accommodated within workplace policies and practice.

> Not enough done to support nurses who have been nursing for a long time. The job takes its toll physically and mentally, especially when getting older and sustaining numerous workplace injuries. Sickness policy does not recognise or support this."
>
> *Deputy sister/charge nurse, NHS hospital unit, East Midlands*

> Nursing has lost managerial support. There are no benefits within the NHS for example doctors appointments or operations as I'm getting older. I'm needing more time due to menopause and older age. Previously I would be retired and to be quite honest I'm not sure how I can continue without the support of management but there is a huge lack of care and consideration for an aging nursing population."
>
> *Senior nurse/matron, NHS hospital unit, South East England*

> I work compulsory long days which are extremely tiring and makes it difficult to eat healthier and at regular times. Also, more thought needs to be given to those of us who are experiencing a bad menopause."
>
> *NHS mental health nurse, North West England*

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3. Physical and verbal abuse

Respondents were asked whether they had experienced physical or verbal abuse in their workplace from a patient, service user or relative in the previous 12 months.

- 27.3% of all respondents reported they had experienced physical abuse.
- 64% reported they had experienced verbal abuse.
- Non-binary and male respondents are more likely to report having experienced verbal and physical abuse than female respondents.
- Younger respondents are more likely to report having experienced verbal and physical abuse than older colleagues.

Figure 12: Experience of physical or verbal abuse in the last 12 months, by gender

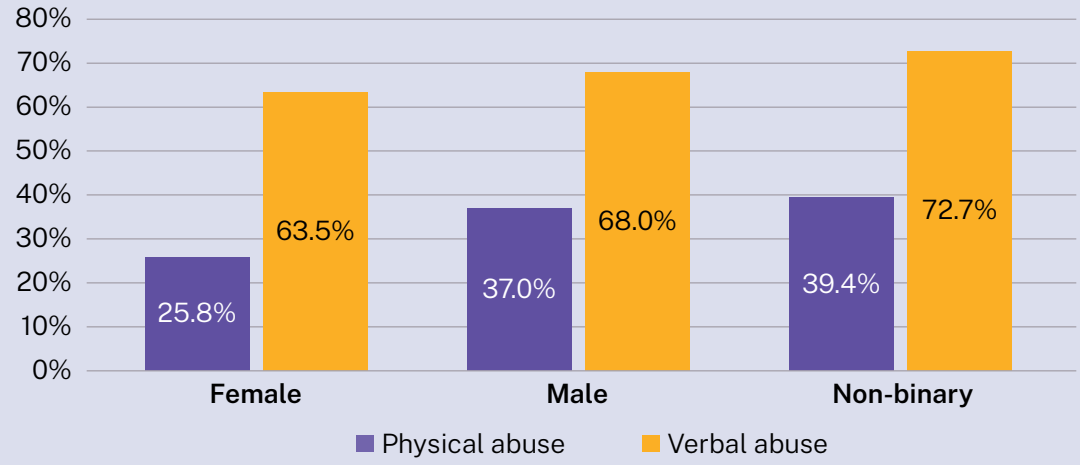
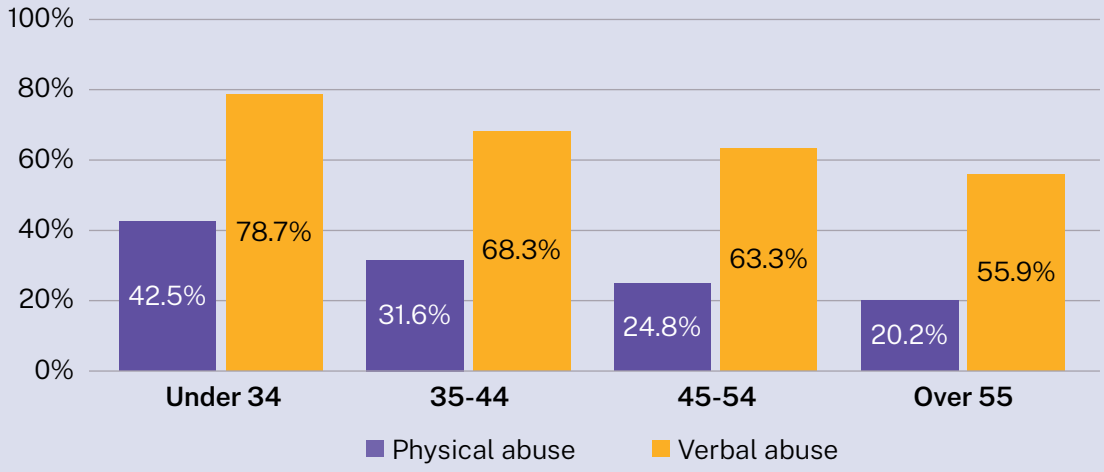


Figure 13: Experience of physical or verbal abuse in the last 12 months, by age



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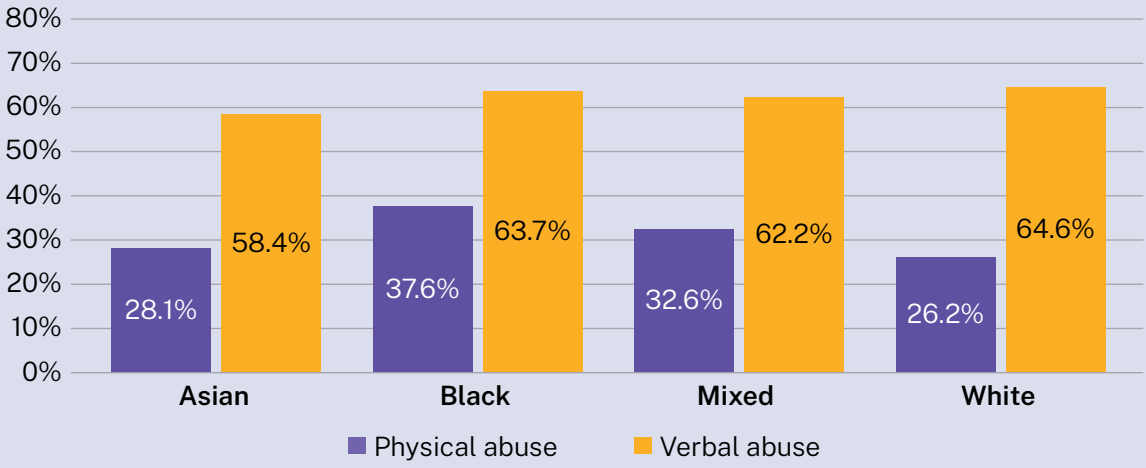
3.1 Ethnicity and international registration

Figure 14 indicates that black respondents and those of a mixed ethnic background were most likely to state they had experienced physical abuse in the previous 12 months. Around a third of these groups of members stated they had experienced physical abuse.

We also found that among registered nurse respondents, 29.9% of internationally educated nurses reported they had experienced physical abuse compared to 25.5% of those educated in the UK.

Reports of verbal abuse are high among all respondents, with over half stating they had experienced abuse in the previous 12 months. Looking at the experiences of internationally educated nurses, we found that 60% of these respondents reported they had experienced verbal abuse, compared to 64.1% of those educated in the UK.

Figure 14: Experience of physical or verbal abuse in the last 12 months, by ethnicity



3.2 Employer contexts and risk

Further analysis of the data on physical and verbal abuse reveals stark contrasts across different sectors of the health and social care system.

Employers

- NHS hospitals are the central hotspot for both physical and verbal abuse.
- Independent sector care homes show elevated risk.
- NHS 111/24 and other call centre services report high levels of verbal abuse.
- Agency staff face high risk of both physical and verbal abuse.
- GP practices also report elevated abuse.

NHS hospital practice areas

- Physical abuse: highest prevalence in older people's care, acute/urgent care, and mental health/learning disability.
- Verbal abuse: most elevated in older people's care and children/young people. Outpatients, surgical, and long-term conditions show significantly lower odds compared to acute care.

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3.3 Structural and demographic drivers

Once the varying risks across employers and practice areas are accounted for, several factors consistently amplify risk:

- **Shift work:** staff on shifts are more than twice as likely to report physical and verbal abuse compared to fixed hours staff.
- **Age:**
  - Physical abuse: odds rise steadily with age, with staff aged 55 and over 2.4–3.2 times more likely to report abuse than younger groups.
  - Verbal abuse: staff aged 55 and above are 2.3 times more likely.
- **Disability:** disabled staff are more likely to report verbal abuse than those without disabilities, but not physical abuse.
- **Ethnicity and international registration:**
  - In absolute terms, Black and Asian nurses – especially those first registered outside the UK – report higher exposure to both verbal and physical abuse than White nurses overall.
  - However, once employer type, practice area, and working patterns are taken into account, this gap appears to be largely structural. Black and Asian nurses first registered outside the UK are more likely to be employed into high-risk contexts (hospitals, care homes, frontline practice areas) where abuse is most common.
  - The elevated prevalence reflects the environments in which these nurses are concentrated, rather than ethnicity itself being an independent driver of abuse.

The data reveals that context matters most – certain areas of NHS hospitals, care homes, NHS 111/24 and agency roles are the highest risk settings. But beyond context, structural factors such as shift work, age, disability, and international registration amplify vulnerability. Disparities in absolute terms across nursing staff of different ethnic backgrounds are largely explained by employment patterns in these higher risk contexts. Abuse is therefore not only a function of where people work, but also of who they are and how they are positioned within the system.

3.4 Reasons for abuse

Table 1 shows responses relating to the reasons or explanations for the physical or verbal abuse they had experienced.

The main reason respondents felt that they endured physical and verbal abuse was that patients/service users had health related or personal problems. In most cases, this relates to mental health problems, delirium or dementia, with many respondents stating such incidents are simply part of the job.

A high number of respondents (60.3%) also felt they had endured verbal abuse was that patients/service users or relatives were dissatisfied with the service provided. In particular, many cited long waiting times and delays as common flashpoints.

Table 1: Reasons attributed to physical abuse and verbal abuse

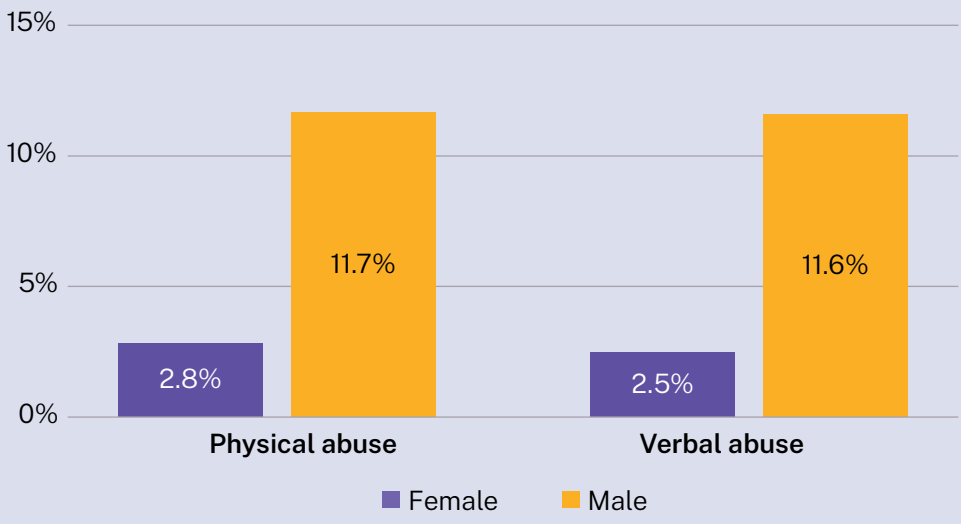
	Physical abuse	Verbal abuse
Health related/personal problems	69.4%	62.6%
History of violence/abuse	39.1%	29.6%
Intoxicated with alcohol/drugs	31.3%	26.0%
Dissatisfied with service provided	30.0%	60.3%
Discriminatory (in relation to gender, ethnicity, sexuality, age, disability or other factor)	19.2%	17.7%
Reacting to bad news	7.1%	15.2%

3.4.1 Discriminatory abuse

Sexuality and gender

Overall, 10% who stated they had experienced physical abuse and 12% who exerienced verbal abuse said it was discriminatory and related to sexuality. Figure 15 indicates that male respondents were at least four times more likely than female respondents to state that abuse was linked to their sexuality. In contrast, there was little difference between female and male respondents who reported abuse as discriminatory based on gender, with around 10% of both groups stating this.

Figure 15: Abuse understood as gender based



Ethnicity

About one in seven respondents who experienced physical or verbal abuse in the past year said the abuse was discriminatory and based on ethnicity. Among black and Asian respondents, this proportion is significantly higher – especially for verbal abuse. Nearly two-thirds (67.4%) of black respondents and almost six in ten (58%) Asian respondents who reported verbal abuse stated that it was discriminatory based on their ethnicity.

Respondents described experiences of verbal and physical abuse that they perceived as directly linked to their ethnicity. Many reported an increase in microaggressions in recent years. Alongside this, we heard harrowing accounts of racist and violent behaviour by patients, service users or their relatives, often compounded by inadequate support from colleagues.

> I experienced racism in the workplace that deeply affected me. My headscarf seemed to be a factor in how I was treated. I was spat at and called offensive names. On one occasion, a patient became violent after I removed his dressings. He threw something at me and pushed his table forcefully in an attempt to hurt me. I reported this to the nurse in charge, but she showed no concern whatsoever. This lack of support left me feeling vulnerable and unsafe. When I escalated it to my manager, she recognised that I was visibly upset and informed the medical team who handled the patient. Despite these serious incidents, I never received any reassurance or support from my manager or the team. It seemed that this was not treated as a significant concern. I felt completely let down. I didn't feel like I was part of a team or even seen as a person, just someone who was there to fill a shift."
>
> *Staff nurse, NHS hospital surgical ward, East Midlands*

In many cases, respondents reported that incidents of abuse were not sufficiently addressed, with reference to the perpetrator's mental health often limiting or preventing meaningful organisational action.

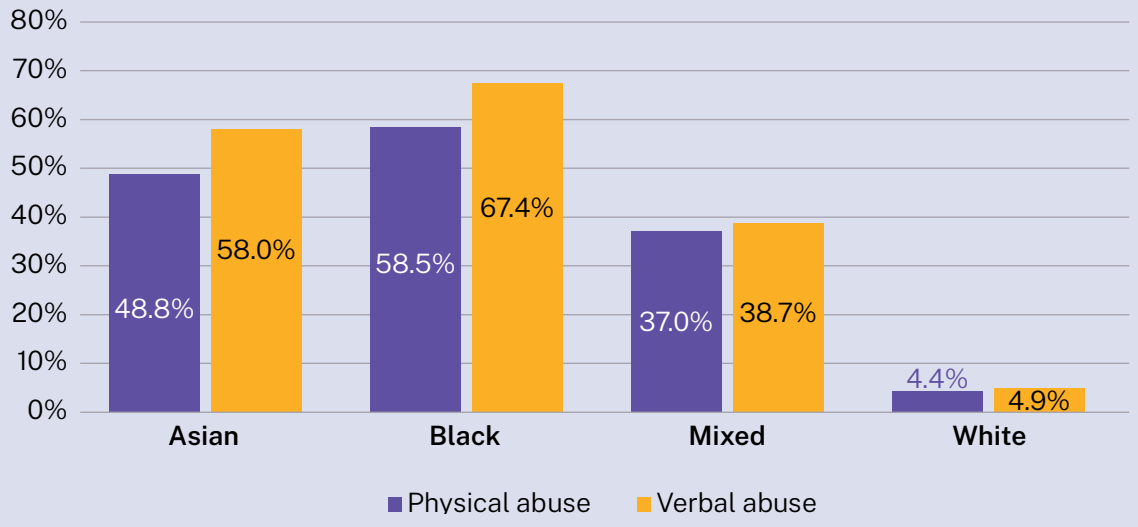
> This is an ongoing issue, but nothing gets done because I am always told that the patients have mental health problems. Even when the patient has got mental capacity of knowing that what they are doing is wrong. Because they know that they are in a mental hospital and they know that no action will be taken against them. I experience racial abuse every day in my workplace, not just myself but every black person that I work with. It is normal to be racially abused and expected to get on with your work."
>
> *Health care assistant, NHS mental hospital unit, North West England*

We also heard accounts of nursing staff witnessing discriminatory behaviour and abuse directed at colleagues by patients, service users or their relatives, highlighting the wider impact of such incidents on teams.

> I witness racial discrimination daily from patients to other staff. I often step in as I am white British so they don't take the brunt of it."
>
> *Deputy sister, NHS hospital surgical ward, East Midlands*

> Although patients have not been discriminatory towards me, I have heard and reported patients discriminating against other members of staff from different ethnic backgrounds."
>
> *Deputy sister, NHS acute/urgent hospital unit, Wales*

Figure 16: Abuse understood as ethnically motivated



3.5 Reporting of physical and verbal abuse

Respondents who stated they had experienced physical or verbal abuse in the previous 12 months, were asked whether they reported the last occasion they had been abused to their employer.

- 75.6% reported physical abuse
- 63.9 reported verbal abuse

Among these groups, Figure 17 shows that less than three in ten were satisfied with the response to this reporting of either physical or verbal abuse.

At least six in ten of who reported abuse did not express satisfaction with the response - either actively dissatisfied or disengaged – indicating a high level of unhappiness or at least ambivalence to their attempt to report abuse. A common response we received is that reports of abuse are too often 'swept under the carpet' reinforcing perceptions of organisational indifference and a lack of accountability.

> Learning disability nurses face the risk of physical assault almost daily but this is now seen as an expected side effect of the job role and very little support is given. It's an ongoing issue that appears to be very hush hush and because of it staff are being burnt out easily and not staying in a role."
>
> *Learning disability nurse, NHS residential home, Northern Ireland*

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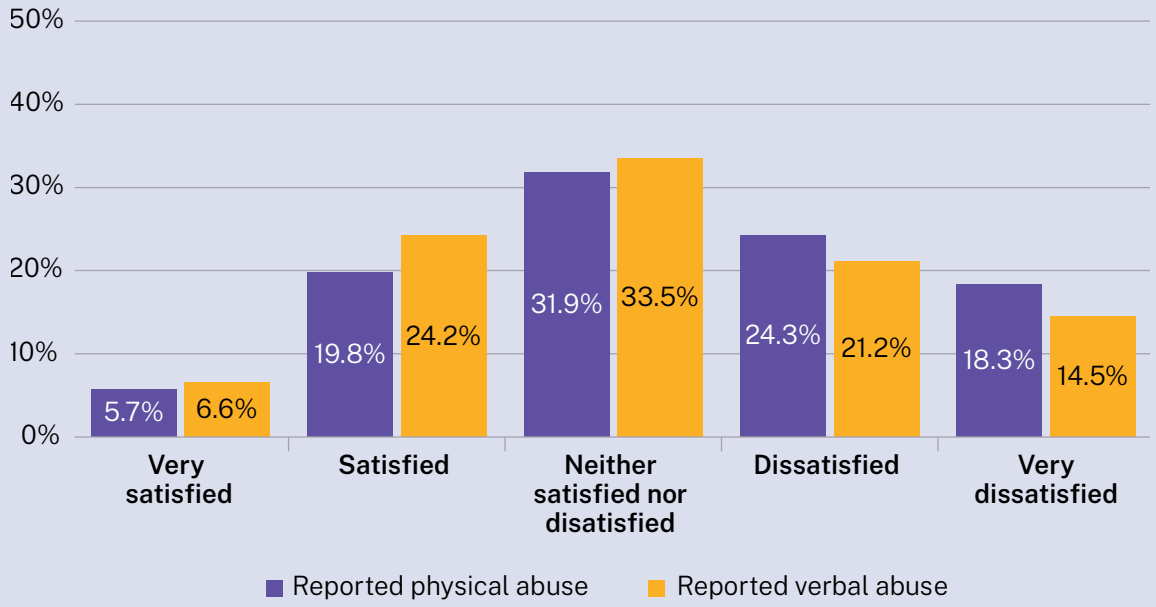
> NHS says it's not okay to be abusive to staff and that it has zero tolerance, but when someone is continually abusive (apart for justified reasons such as disability/post op delirium etc) it is tolerated, nothing is done. We have to continue providing care and ignore until they are discharged. Makes me feel like I really don't want to come into work sometimes because there is someone hard to care for because of their attitude on ward."
>
> *Staff nurse, NHS surgical ward, Greater London*

> I work in elderly care. The consensus is our patients are unpredictable and physical outbursts are "part of the job" I have been hit, bitten, spat at, kicked so many times. I have seen multiple events where colleagues are attacked and hurt. It's reported. Nothing ever happens."
>
> *Staff nurse, NHS older people's hospital ward, North East England*

Figure 17: Thinking about the last time you experienced abuse, how satisfied were you with the response to your reporting of the incident?



Among those who stated they did not report the physical or verbal abuse, respondents reported a mix of reasons for not reporting. Just under three in ten said that physical and verbal abuse is often seen as part of the job, while two in ten said they didn't think the incident was serious enough to warrant reporting.

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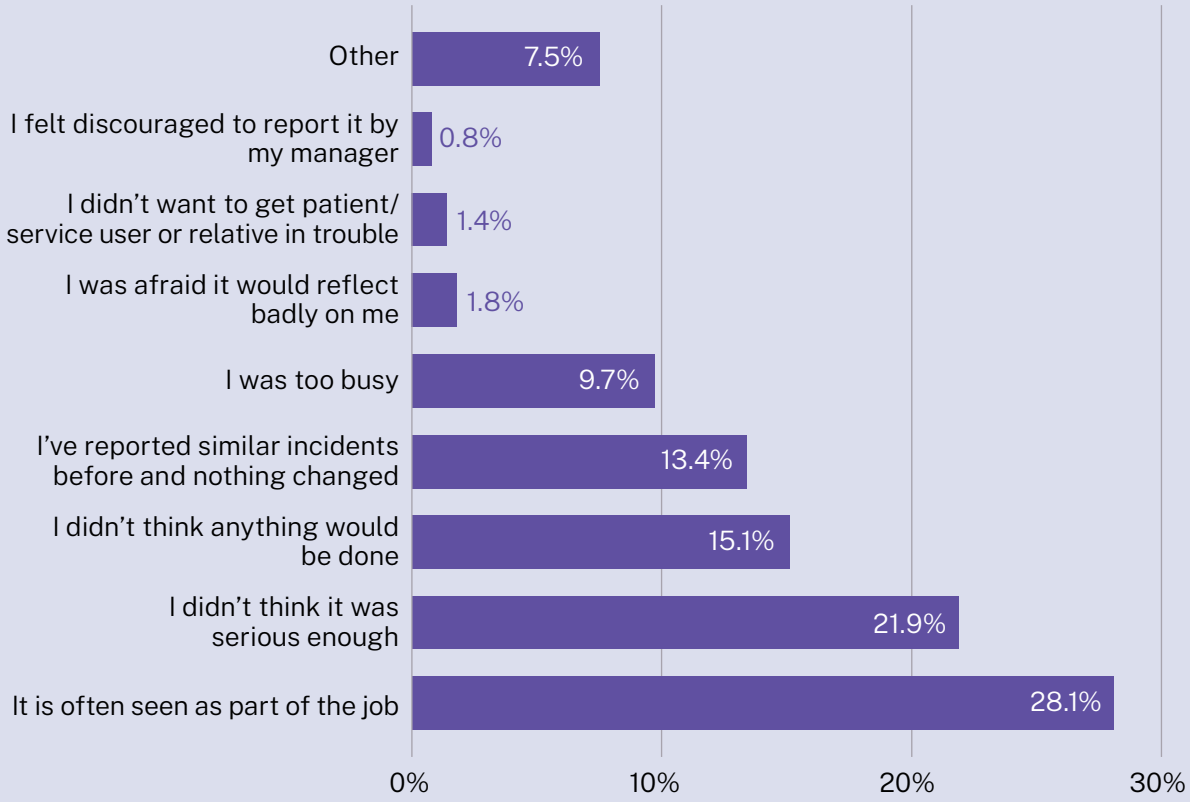
Figure 18: Thinking about the last time you experienced physical or verbal abuse, why did you not report it?



3.6 Impact of physical and verbal abuse

Respondents' accounts made clear that the impact of physical and verbal abuse extended well beyond the incidents themselves. Many described the emotional toll of trying to deliver care under severe pressure, and the added distress when organisational responses focused on process rather than support. These experiences often left staff feeling unheard, undervalued and morally strained.

> All you get told was how could we have de-escalated? Was there a trigger warning? Never asked how do we feel! What could we have done better. Never worry about the staff! Most patient aggression is frustration that we are unable to provide the care that all patients deserve in a timely manner. Unfortunately this is often not the case due to staff shortages and high acuity. It's not acceptable. Not only are you physically unable to get all tasks completed which morally makes you feel inadequate, to then get patients also reminding you how inadequate we are at times. Some patients are empathetic and see the strain we are under. Doesn't make it any more acceptable. Raise concerns and all you get back is, "Well, all wards are struggling right now." Not the feedback you want when you are seeking support
>
> *Health care assistant , NHS hospital acute/urgent unit, East of England*

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> Vast majority of my patients are very grateful for the service I am part of. They make me feel that my efforts in supporting them in chronic illness' care are worth it. The patients who are abusive you cannot dismiss as it is part of our duty of care to try to do the best for them. I just wish there was a way of enforcing minimal expectations of behaviour from patients and co-workers that will not make you feel like it is your word against theirs, which gives me the sense that I will never win if I report verbal abuse."
>
> *Clinical nurse specialist, NHS outpatients, South West England*

> No one cares from management. You just fill in an incident report. No one asks if you are alright."
>
> *Staff nurse, NHS acute/urgent hospital unit, South East England*

3.7 Organisational support

All respondents, regardless of whether they had recently experienced physical or verbal abuse, were asked about the broad organisational culture around support and reporting.

Responses reveal a mixed picture of organisational culture around reporting of abuse. While the majority of staff (93%) stated they know how to report an incident and six in ten (61.8%) said they have received relevant training, confidence in the organisation's response is markedly lower. Fewer than four in ten (37.6%) said they believe incidents are taken seriously, and only 26.8% feel that reporting leads to meaningful action or change.

This disconnect between awareness and trust suggests that procedural knowledge is much stronger than the perceived impact of reporting. Staff may be reluctant to come forward if they believe their concerns will not be acted upon, particularly in environments where abuse is normalised or minimised.

Figure 19: Thinking about physical and verbal abuse from patients, service users or their relatives, how well supported do you feel in your workplace?

Other responses were neither agree/disagree or don't know.

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3.7.1 Incident reporting and follow up

Many respondents' accounts described a reporting culture that felt procedural rather than supportive. Staff often felt that incident systems prioritised closure over learning, and that feedback was limited or absent. Several noted that reporting could even result in blame, reinforcing a sense that concerns were minimised rather than addressed.

> We are encouraged to report incidents but the main priority is to close the incidents before the end of the month."
>
> *Senior nurse/matron, independent sector community care provider, North West England*

> Although the datix is being submitted, no feedbacks are being provided. So unsure what the outcome is as it is not being shared with the reporter."
>
> *Nursing associate, NHS acute/urgent hospital unit, South East England*

> The response from Datix was rather indifferent and placed the blame for the lack of care on the nursing staff as usual. It failed to acknowledge that the patient has a history of attacking staff and exhibiting verbal and racial abuse. To be honest, there's little point in completing these reports, as the staff are always blamed."
>
> *Health care assistant, NHS surgical ward, Greater London*

Many respondents' accounts also highlighted that the reporting process itself could feel overly burdensome. Staff described systems that were time consuming and complicated, making it difficult to report incidents during already pressured working schedules. Those employed in the NHS frequently referred to the Datix system which is a risk management and incident reporting software, allowing staff to log adverse events, near misses, and safety concerns.

> We have to datix on each occasion and they take so long to fill in or you don't have the time you end up not doing it. We need a more simple reporting system."
>
> *Staff nurse, NHS cancer care hospital unit, East Midlands*

> We have a system to report incidents but no one really does them as they take too long, they are ridiculously complicated and nothing is ever chased, resolved or answered. So we all say - what is the point, nothing ever gets done."
>
> *Health care assistant, NHS acute/urgent hospital unit, East of England*

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3.7.2 Police response

We received many accounts from respondents working in mental health settings relating to the police response to violence and aggression from patients. A common theme related to their perception of a reluctance to follow up these cases and fail to fully verify whether perpetrators lack capacity or not.

> Police ignore reports of violent conduct from patients saying they lack capacity without checking their mental status."
>
> *Trainee nursing associate, NHS mental health hospital unit, Yorkshire and Humberside*

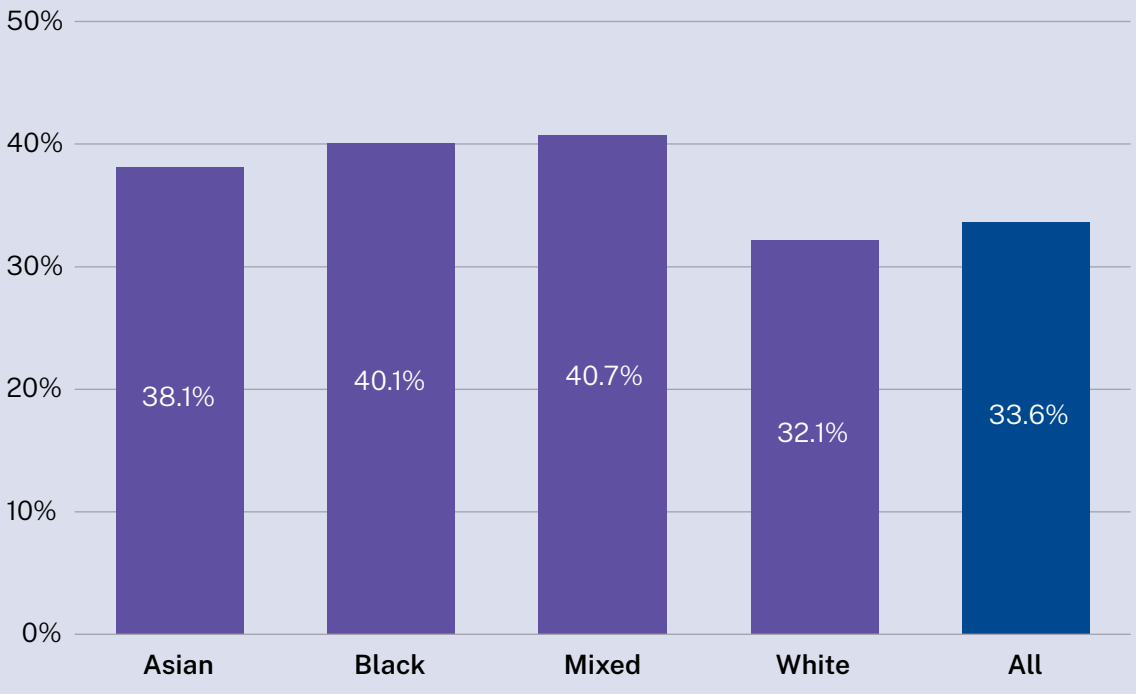
> We frequently have patients who are not psychotic or manic but who are violent and aggressive towards us. These individuals have full capacity and are the same as anyone assaulting someone else in the community - they know what they're doing - and in those many instances the police should attend, arrest, and hold that individual to account. This does not happen. We call the police and 9 times out of 10 they refuse to attend because it's 'mental health'. This leaves us at significant risk from the individual and allows them to believe that they can do what they want because there are no repercussions. Why is it different in an acute mental health ward to an emergency department? Do we as nurses not deserve the same protection?"
>
> *NHS mental health nurse, East of England*

4. Bullying and harassment from colleagues

Just over one third of respondents (33.6%) reported experiencing bullying or harassment from a colleague in the past 12 months. These behaviours appear widespread, cutting across gender and age groups, but certain staff are disproportionately affected. Disabled respondents were particularly vulnerable: half (49.5%) reported bullying or harassment, and among them, one in three (34.6%) believed the behaviour was directly related to their disability.

Figure 20 highlights disparities across ethnic background groups. Respondents identifying as Black, Asian, or of mixed ethnic background were significantly more likely to report bullying or harassment compared to their white colleagues. While nearly a third of White respondents also reported such experiences– pointing to broader cultural or organisational issues – among Black, Asian, and respondents from a mixed ethnic background who had experienced bullying, nearly six in ten (56.6%) believed the behaviour was discriminatory and related to their ethnicity.

Figure 20: Experience of bullying or harassment, by ethnicity



4.1 Structural and demographic drivers of bullying and harassment from colleagues

The analysis shows that bullying and harassment from colleagues is shaped by workplace context but more by individual characteristics, and the profile differs from other forms of abuse.

Employer context

- The analysis highlights GP practices as a distinctive hotspot. Staff in GP practices are around twice as likely to report bullying and harassment compared to NHS hospital staff, even after controlling for other factors. This suggests that small team dynamics and limited organisational oversight may create environments where interpersonal conflict escalates into bullying.
- Other employer categories do not show consistent independent effects once controls are applied, reinforcing that bullying is less about large institutional settings and more about specific workplace cultures.

Demographics

- **Gender:** Unlike sexual harassment, where women are disproportionately affected, bullying and harassment from colleagues is more often reported by men. Male staff face odds about 25% higher than women. This reversal highlights that bullying is not gendered in the same way as sexual harassment; it reflects broader workplace dynamics where men may be more exposed to peer conflict or targeted differently.
- **Disability:** Disabled staff are more than twice as likely to report bullying compared to non disabled colleagues. This is one of the strongest independent effects in the analysis, suggesting that disability remains a significant point of vulnerability in for nursing staff
- **Age:** Younger staff (18–34) are slightly more exposed, but the age gradient is weaker than for sexual harassment. Older age groups show modestly lower odds, indicating that bullying is less sharply age stratified.
- **Ethnicity:** Once employer and practice area are controlled, there is very little difference in the incidence of bullying across nursing staff of different ethnic backgrounds

4.2 Patterns and drivers of bullying

Bullying and harassment from colleagues is less about structural employment patterns in high-risk settings and more about workplace culture and interpersonal dynamics. GP practices stand out as a distinctive hotspot, while demographic factors reveal a different profile than sexual harassment: men and disabled staff are more exposed, with weaker age and ethnicity effects.

4.3 Reporting and organisational response to bullying

Many respondents' accounts also highlighted significant challenges in reporting bullying and harassment. Staff described environments where raising concerns felt risky or futile, with limited confidence that issues would be taken seriously or lead to meaningful action. In some cases, reporting was perceived to escalate tensions or result in repercussions for the individual rather than the perpetrator, reinforcing a culture of silence.

> It's difficult to report bullying in my workplace. Myself and my colleagues have raised concerns to senior management regarding our direct manager making inappropriate comments and gaslighting, but I do not feel our concerns are taken seriously. We are told we need to make a formal complaint, but we don't want to do that because it will cause tension and make matters worse in our small team."
>
> *NHS clinical research nurse, Wales*

> Bullying in health is under reported by nurses as when they complain about bullying – particularly by medical colleagues – the nurse is very often silenced by moving them from their role and sweeping the issue under the carpet."
>
> *Senior nurse/matron, Northern Ireland*

> I have been subjected to bullying and harassment quite often by ward matron. Unable to report it due to fear of judgement. Some of my colleagues reported to Freedom to Speak Up team however, nothing has been done or investigated. Those who reported, received discrimination at my workplace. Due to bullying, a few colleagues left our ward/moved to another department.
>
> *Staff nurse, NHS acute/urgent hospital unit, North West England*

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5. Sexual harassment

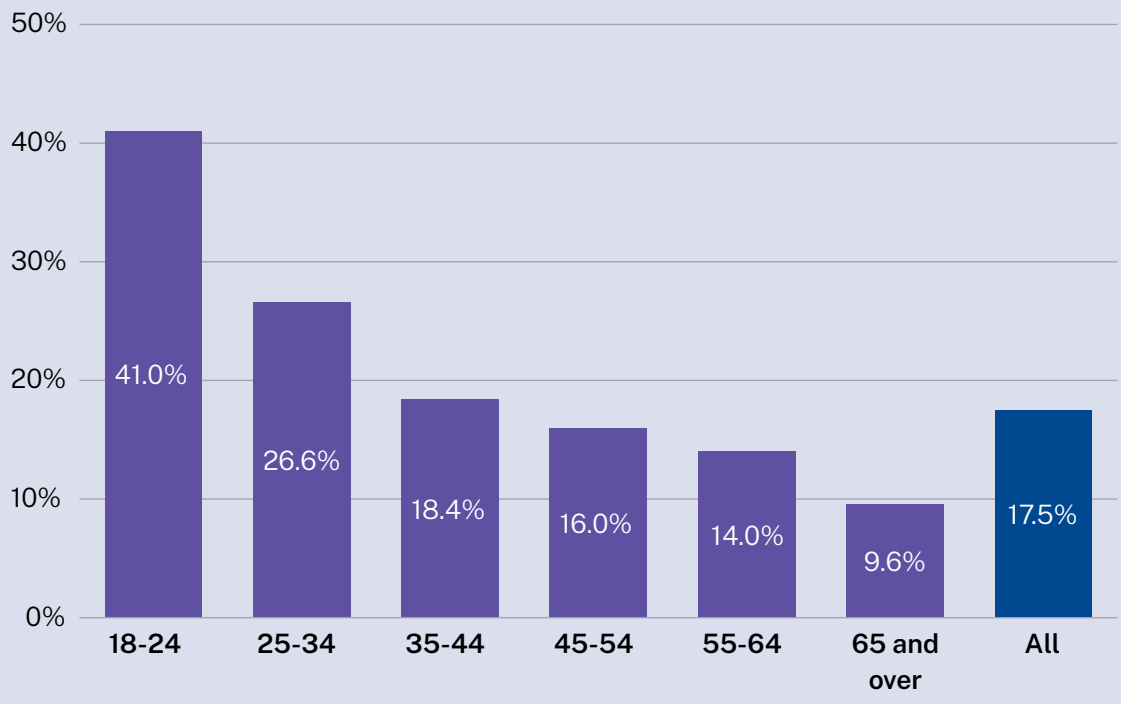
Respondents were asked whether they had, in the previous 12 months, been the target of unwanted behaviour of a sexual nature in the workplace. This was defined as including offensive or inappropriate sexualised conversation (including jokes), touching or assault.

Patients/service users, their relatives or other members of the public

- 10.3% stated they had experienced sexual harassment from patients/service users, their relatives or other members of the public (10.8% of female; 6.4% of male and 18.2% of non-binary respondents).
- Of all respondents who said they had been the target of such behaviour, 41.9% stated they had reported it the last time it had happened.
- Among those who did report the last incident, 90% did so to their manager and 16.7% logged it through organisational reporting procedures

Reports of sexual harassment from patients are much more common among younger members of the nursing workforce, with four in ten of those aged 18 to 24 stating they had received unwanted behaviour of a sexual nature in the previous 12 months. Further findings show that students are the largest group to report having received unwanted behaviour of a sexual nature., suggesting that younger members of the workforce and particularly students on placement are the most targeted in the workplace.

Figure 21: Experience of sexual harassment, by age



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5.1 Employer contexts

NHS hospitals are the central setting where sexual harassment is most reported and within NHS hospital settings, risk varies sharply by area of practice with the highest risk in acute and urgent care. Lower risk is reported in NHS hospital based older people's care, children/young people, and long-term conditions.

Structural and demographic factors

Controlling for employer type and practice area, several factors shape risk:

- **Age:** Younger staff (18–34) are at much higher risk; odds decline steeply with age.
- **Shift work:** Unlike physical/verbal abuse, shift workers are less likely to report harassment than fixed hours staff.
- **International registration:** Nurses first registered outside the UK are less likely to report harassment compared to UK registered nurses.
- **Ethnicity:** Asian and mixed ethnicity groups show significantly higher odds compared to white nursing staff

Respondents' accounts of sexual harassment highlighted inconsistencies and gaps in workplace policies and organisational support, raising questions about how sexual safety is understood and enacted in practice. While some organisations have formally committed to sexual safety standards, respondents described limited guidance on managing incidents involving patients or service users, and reported being left without adequate protection or support after experiencing harassment or assault.

> We have no policy addressing sexual safety, despite signing the [NHS Sexual Safety Charter]. Staff have been told they must return to care for the same patient (1:1) who assaulted them the previous day. We have no guidance on managing this. I have raised with HR several times over the last year. They initially said a policy would be developed, but now say it is up to individual areas."
>
> *NHS educator/trainer, Greater London*

> My trust runs sessions on sexual safety in the workplace which is solely aimed at colleague relationships/interactions. I don't think ever acknowledge that the highest risk of sexual contact is from patients. I have been touched inappropriately on shift by patients and relatives, and there is no guidance/ support given around this."
>
> *Staff nurse NHS cancer ward, East of England*

Appendix: Results tables

Employment Status		%
Employed and working (including self employed)	18,133	86.2%
Retired, but still in paid employment	1,650	7.8%
Employed, on sick leave	757	3.6%
Employed, on maternity/paternity leave	314	1.5%
Student	181	0.9%
Total	**21,035**	**100%**

Country		%
England	17,204	81.8
Scotland	1,883	9.0
Wales	1,208	5.7
Northern Ireland	616	2.9
Channel Islands	65	0.3
Isle of Man	46	0.2
Across the UK	13	0.1
Total	**21,035**	**100**

England Region		%
East of England	1,685	9.8
East Midlands	1,503	8.8
Greater London	1,776	10.4
North East	1001	5.8
North West	2,588	15.1
South East	2,736	16.0
South West	2,419	14.1
West Midlands	1,719	10.0
Yorkshire and Humberside	1,712	10.0
Total	**17,139**	**100**

Main employment sectors		%
NHS Trust/Board (including Channel Islands and Isle of Man)	15,710	74.7%
NHS commissioning/arm's length body	832	4.0%
NHS Bank	404	1.9%
NHS 111/NHS 24/Helpline	54	0.3%
General Practice	1,164	5.5%
Independent sector care home	844	4.0%
Independent sector hospital	455	2.2%
Hospice/charity	388	1.8%
Independent sector community provider	220	1.0%
Student	181	0.9%
Further/Higher Education	147	0.7%
Public sector organisation	108	0.5%
Private company/industry	106	0.5%
Self employed	100	0.5%
Nursing agency	98	0.5%
Social enterprise	83	0.4%
Criminal justice	74	0.4%
Other	67	0.3%
Total	**21,035**	**100%**

Gender		%
Female	18,185	86.9%
Male	2.481	11.8%
Non-binary	33	0.2%
Prefer not to say	220	1.1%
Prefer to self-describe	8	0.1%
Total	**20,927**	**100%**

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Do you consider yourself to have a disability?		%
Yes	3,326	15.8%
No	17,534	83.4%
Total	**20,860**	**100%**

Ethnicity		%
Asian/Asian British: Bangladeshi	30	0.1%
Asian/Asian British: Indian	685	3.3%
Asian/Asian British: Pakistani	59	0.3%
Asian/Asian British: other	592	2.8%
Black/Black British: African	1229	5.9%
Black/Black British: Caribbean	236	1.1%
Black/Black British: other	40	0.2%
Chinese	46	0.2%
Filipino	97	0.5%
Mixed: White and Asian	76	0.4%
Mixed: White and Black Caribbean	81	0.4%
Mixed: White and Black African	42	0.2%
Mixed: other	108	0.5%
White: British, English, Welsh, Scottish, Northern Irish	15,428	73.9%
White: Irish	513	2.5%
White: other	1,070	5.1%
Prefer not to say	442	2.1%
Total	**20,883**	

Age		%
18-24	294	1.4
25-34	2753	13.2
35-44	4627	22.2
45-54	5934	28.4
55-64	6320	30.3
65 and over	942	4.5
Total	**20,870**	**100**

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