



Individual Report

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Student name: Carbelis Mayela Carrillo Guevara

Student ID: 2516436

Lecturer's Name: Shaila Hussain

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Research Topic: Workforce shortages in UK health and adult social care (2024/25)

Introduction

This report explores workforce shortages across the UK National Health Service (NHS) and adult social care, a current challenge affecting service quality, staff wellbeing and long-term sustainability. It summarises the scale of vacancies and turnover, key drivers such as pay competitiveness, workload, ageing demand and reliance on international recruitment, and the consequences for patients, unpaid carers and provider organisations. It then proposes an appropriate research design by explaining the chosen methodology and data sources. The overall purpose is to justify why research is needed to support evidence-based workforce planning, improved retention and safer care delivery.

Problem Statement

Workforce shortages are a persistent problem in UK health and social care and continue to shape service delivery in 2024/25. In the NHS, the Long Term Workforce Plan reported over 112,000 vacancies in March 2023 (around an 8% vacancy rate) and highlighted that the UK has fewer doctors and nurses per head than many comparable countries (NHS England, 2023). Shortages span acute, community and primary care roles, contributing to long waiting lists and reduced capacity for prevention and long-term condition management. In adult social care, Skills for Care estimated a 7.0% vacancy rate in 2024/25, equivalent to around 111,000 vacant posts, and turnover of 23.1% (approximately 335,000 leavers) (Skills for

Care, 2025). Although rates have improved since the post-pandemic peak, they remain high and create instability in care provision.

The issue affects multiple groups. People who use services may experience delays, reduced continuity and safety risks when teams are understaffed. Staff experience increased workload, stress and burnout when vacancies are covered through overtime or short-staffed shifts. Organisations face higher costs through agency staffing and repeated recruitment, while struggling to meet quality and regulatory standards. The problem also increases pressure on unpaid carers; Carers UK estimates 5.8 million unpaid carers across the UK (Carers UK, 2025).

Recent evidence suggests recruitment and retention pressures remain acute. A DHSC workforce survey found that 71% of adult social care provider locations reported recruitment as challenging and 37% were concerned about sustaining service delivery over the next six months; providers also identified better pay outside the sector as a leading barrier (DHSC, 2025). Overall, the evidence points to a system-level workforce problem that requires investigation into drivers, impacts and sustainable responses across the health and social care system.

Justification

Research is needed because workforce shortages have clinical, ethical and economic implications. Staffing levels influence whether services can deliver safe, timely and person-centred care. When staffing is inadequate, organisations may prioritise urgent tasks and reduce time for prevention, rehabilitation, training and supervision, which can lower quality over time. Persistent vacancies can also create a negative feedback loop: pressure on existing staff increases stress and burnout, which in turn raises intentions to leave and deepens the shortage. Evidence from a nationwide UK survey study links workforce attrition to wellbeing and workplace experience (Martin et al., 2024), and professional commentary warns that without improved retention, long-term reform plans will be harder to deliver (Gautam and Johnson, 2025).

Workforce shortages are also a whole-system issue. Limited social care capacity contributes to delayed hospital discharge and avoidable use of acute beds, reducing NHS efficiency and increasing costs (CQC, 2025). Policy context matters: improvements in adult social care vacancy rates have been partly supported by international recruitment, and tighter immigration rules could increase future shortages if domestic recruitment does not rise (Institute for Government, 2025). Research can test which drivers matter most in different settings (for example pay, workload, supervision, flexible contracts, career progression, and safe staffing levels) and which interventions provide value.

This topic also aligns with the module learning outcomes. First, analysing workforce data and service indicators demonstrates competence in workplace data handling (e.g., interpreting vacancy rates, turnover and survey results). Second, the study requires identifying and evaluating credible information sources across government, regulators and peer-reviewed literature. Third, the research can evaluate contemporary technologies that may improve efficiency and employability, such as e-rostering, digital workforce analytics, electronic care records and automation of administrative tasks, which may free clinician time and support retention by reducing workload. Overall, robust research can inform evidence-based interventions at organisational and national levels, supporting retention, recruitment and quality of care for an ageing population with complex needs (NHS England, 2023).

Information Sources and Justification

1) ****NHS England (2023) – NHS Long Term Workforce Plan.**** This national workforce strategy provides official data on NHS vacancies and models workforce supply and demand to 2036/37. It also sets out proposed actions such as expanding training places, new roles and retention initiatives. It was selected because it is the authoritative NHS planning source and frames workforce shortages as a strategic risk to safety, access and transformation.

2) ****Skills for Care (2025) – The state of the adult social care sector and workforce in England (2025).**** This annual workforce intelligence report uses the Adult Social Care Workforce Data Set to estimate vacancies, turnover, pay and workforce composition in 2024/25. It supports analysis of how staffing pressures differ by job role and employer type, and it documents trends over time. It was selected because it provides the most detailed and

transparent evidence base for adult social care staffing at national scale.

3) **Department of Health and Social Care (2025) – Adult social care workforce survey: April 2025 report.** This official statistical report summarises provider perceptions of recruitment, retention and capacity pressures in the lead up to winter 2024, including the impact of changing international recruitment conditions. It identifies key barriers such as better pay outside the sector and helps interpret routine vacancy statistics. It was selected because it adds timely, practice-facing evidence to complement administrative workforce data.

Task 2: Research Methodologies

Give a brief overview of quantitative and qualitative research.

Quantitative research uses numerical data to measure patterns, relationships or change. It often uses structured tools such as closed-question surveys and analysis of routinely collected datasets (for example vacancy rates, sickness absence or staff turnover).

Quantitative designs typically use larger samples and statistical techniques to enable comparison across regions, provider types or time periods.

Qualitative research explores meanings, experiences and processes. It commonly uses purposive sampling and methods such as semi-structured interviews, focus groups or document analysis. Findings are analysed thematically to explain how and why an issue occurs, capturing context such as workplace culture, perceived support, discrimination or barriers to progression.

In summary, quantitative methods are strong for estimating scale and testing associations, whereas qualitative methods are strong for understanding lived experience and explaining mechanisms behind observed trends.

What type of research methodology will you use for your research and why?

This research will adopt a mixed-methods methodology. First, secondary quantitative data (for example NHS workforce statistics, Skills for Care vacancy and turnover estimates, and DHSC survey outputs) will be analysed to describe the size, distribution and trends in shortages and to support basic comparisons across settings. Second, a small qualitative component (semi-structured interviews with a sample of NHS and adult social care staff or managers) would explore why people stay or leave, and how shortages affect continuity and quality of care. Mixed methods are justified because the topic is both structural (measurable gaps in staffing) and experiential (workload, morale and organisational culture). Triangulating findings improves validity and supports practical recommendations for workforce planning.

Task 3: Data Collection

Overview of primary and secondary data collection

Primary data are collected first-hand for a specific study, such as interviews with staff, questionnaires administered to care workers, or observations of staffing and workflow. Primary data can be tailored to the research question and may capture current experiences and local context, but they require time, ethical approval and careful sampling.

Secondary data are collected by others for a different purpose and then re-used for research. In health and social care this includes national workforce statistics, regulatory reports, policy documents, published research and routinely collected operational data. Secondary sources can offer large-scale coverage and trend information, but they may not answer every local question and can reflect limitations of the original data collection.

What form of data will be used to address your research problem, and why?

To address this research problem, the study will mainly use secondary data linked to the quantitative strand of the mixed-methods design. Secondary datasets and reports (for example NHS planning statistics, Skills for Care workforce estimates, CQC assessments, and DHSC survey findings) allow analysis of vacancy rates, turnover and provider-reported capacity pressures at national scale. This is appropriate because workforce shortages are system-wide and cannot be understood from a single organisation alone.

A limited amount of primary qualitative data may be collected through interviews to add depth and improve interpretation of secondary indicators (for example, understanding how pay, workload, supervision or visa policy changes influence decisions to stay or leave). Using mostly secondary data is justified on feasibility grounds and supports comparison across settings, while the primary component strengthens interpretation by linking statistics to lived experience.

Conclusion

Workforce shortages in the UK NHS and adult social care remain a current and significant problem in 2024/25. National planning documents, workforce intelligence and regulatory assessments show large numbers of vacant posts and continued instability from turnover, even where some indicators have improved since the post-pandemic peak. These shortages affect people who use services through delays and reduced continuity, place pressure on staff through workload and morale challenges, and increase organisational costs and performance risk. The issue also shifts care onto families and unpaid carers when formal services cannot meet demand.

Because the problem is both measurable and experienced at the frontline, a mixed-methods approach is appropriate. Secondary quantitative data can describe the scale and distribution of shortages, while targeted qualitative work can explain why staff stay or leave and how shortages influence care quality. Overall, research can support better workforce planning, retention strategies and sustainable policy responses.

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