Cystic Fibrosis Trust

UK Cystic Fibrosis Service Resourcing 2023 to 2025

Based on findings from the annual Cystic Fibrosis Trust staffing tool

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Uniting for a life unlimited

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Cystic Fibrosis Trust

UK Cystic Fibrosis Service Resourcing

2023 to 2025

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Section 6

Summary

Participation

In October 2025, 48 of 58 CF centres across the UK completed the staffing tool. This included 23 paediatric and 25 adult CF centres. Staffing information, which is submitted by centre staff themselves, provides us with a snapshot of CF service staffing levels each year. This report summarises the staffing tool findings from three data collections (October 2023, 2024 and 2025), focused mainly on the most recent data.

Key insights

- Overall staff time available in many participating CF centres was lower than what is recommended in the Standards of Care. While some variation is warranted based on models of care in use, several CF centres continued to report gaps in certain professions and staffing challenges:
  - 13 of 25 adult and 15 of 23 paediatric centres lacked a CF social worker.
  - 1 of 25 adult and 5 of 23 paediatric centres did not include a CF pharmacist.
- A larger proportion of paediatric CF services appear to lack roles for CF social workers or pharmacists in their team compared to adult services.
- Some CF teams include additional roles that are not funded from CF budgets but deliver care for people with CF. Access to such roles varies and does not address the gaps in social work and pharmacy staffing. However, diabetes and research staff are frequently funded this way.
- Overall staff time available to the CF population across participating centres fluctuates, and it will be vital to keep monitoring this in future, particularly with the adult CF population expected to grow.
- Services for adults have more vacant staff time year-on-year compared to paediatric services, but a higher proportion of vacancies in paediatrics were open long term.
- Similar to the NHS overall, CF services are facing issues with vacancies and recruitment. In October 2025, the vacancy rate in participating CF centres was higher than the NHS vacancy rate overall at 10.1% versus 6.7%.
- More than a third of uncovered vacancies in participating CF services remained unfilled for six months or longer.
- More than half of participating CF services say they are not satisfied with their staffing levels year-on-year.
- CF teams face several staffing challenges, with many citing inadequate provision as a key issue, alongside staff shortages, recruitment challenges, and high workloads.
- CF services across the UK continue to adapt and innovate to mitigate staffing challenges and meet the needs of their patients. Key innovations include developing existing staff and enhanced collaboration. Despite these innovations, staffing often remains a challenge.

Introduction

Specialist multidisciplinary teams (MDTs) are central to the care of people living with cystic fibrosis (CF) across the UK. These MDTs are made up of CF specialists from different professions, including doctors, nurses, dietitians, physiotherapists and other staff, so that they can holistically manage the physical as well as mental health and wellbeing of people with CF under their care. Cystic Fibrosis Trust's Standards of Clinical Care of children and adults with cystic fibrosis[1] and the NHS RightCare CF Toolkit[2] provide consensus guidance on the composition of CF MDTs and care delivery.

The multidisciplinary, specialist approach to CF care has resulted in huge improvements in care and, most importantly, the health outcomes and experiences of people with CF and their families. In the decade from 2014 to 2024, the proportion of people with CF aged 16 or over steadily increased, with the median age of the CF population in 2024 at 23 years[3]. Furthermore, in 2024, median predicted survival for babies born with CF today increased to 66 years.

To continue this trend of ongoing improvement, it is essential to ensure that CF centres have sufficient staff and resources to meet the evolving and diversifying needs of the population and provide safe, high-quality care. This care must be accessible in a timely manner to those who need it. CF increasingly needs to be treated as a multisystem condition, as lung function improvements from modulator therapies are shifting the focus of many patients' concerns onto other aspects of their physical and mental health and wellbeing. Additionally, cost of living pressures could result in increased demand for financial and benefits advice, as well as mental health and crisis support. There also remains a sizeable minority of people with CF who cannot benefit from modulator therapies and may need more traditional CF care. High-quality care, therefore, requires appropriate resourcing for all professions in the CF MDT, access to suitably qualified staff, and effective recruitment and retention of such staff (low vacancy rates), all of which are key priorities for the NHS generally, as well as the UK government[4,5,6].

Cystic Fibrosis Trust wants everyone with CF to be able to access the expertise and support they need to live a fulfilled life. We monitor this in several ways, including collecting and publishing information on patient outcomes (via the UK CF Registry), staffing levels, and patient experiences, feeding this information back to clinical teams to stimulate Quality Improvement (QI), and sharing our findings more widely to increase reach and impact.

1 Cystic Fibrosis Trust, Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK. 3rd edition, August 2024: **www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals/consensus-documents**

2 NHS England, RightCare cystic fibrosis toolkit; 2024: **www.england.nhs.uk/long-read/rightcare-cystic-fibrosis-toolkit/**

3 UK CF Registry Annual Report 2024, published Nov2025: **www.cysticfibrosis.org.uk/registryreports**

4 The King's Fund, Securing the NHS workforce for the future: our recommendations for action, Dec 2025: **www.kingsfund.org.uk/insight-and-analysis/long-reads/securing-nhs-workforce-future-recommendations-action**

5 Gov.uk, Government to tackle NHS workforce crisis with refreshed plan, Dec 2024: **www.gov.uk/government/news/government-to-tackle-nhs-workforce-crisis-with-refreshed-plan**

6 HSJ, Government delays new NHS workforce plan; 2025: **www.hsj.co.uk/workforce/government-delays-new-nhs-workforce-plan/7040250.article**

Scope of this report

This report presents an overview of staffing information collected from participating CF centres across the UK once annually via the Cystic Fibrosis Trust staffing tool (in October 2023, 2024 and 2025). It is specifically focused on staff time funded from CF budgets and spent delivering cystic fibrosis care.

This summary report is designed to stimulate discussion about CF service resourcing within participating centres and beyond. We also hope that the insights from this work will be useful to understand how staffing levels in CF services in the UK change over time. This is especially important as modulator therapies are transforming the health and needs of many in the CF population[7], alongside dramatic changes in digital health offerings[8] and the wider NHS funding landscape, with persistent staffing challenges continuing to impact on services.

Information within this report is drawn from three years of staffing data. The most recent findings from October 2025 are presented, alongside data from preceding years, where relevant, to facilitate comparisons and to enable early identification of any changes that may positively or negatively impact CF care delivery.

Services can use the information in this report alongside their own staffing data to review staffing levels and reflect on how their service compares. However, when exploring staffing levels, it is important to consider the local service model in use, the needs and preferences of the local patient population, and access to primary care and other healthcare teams, as well as additional factors that could impact on staff cover needed. In adult care, workforce planning also needs to account for the diversifying needs of a growing and ageing adult population with CF.

Data collection and participation

Each year since 2019, Cystic Fibrosis Trust invites all specialist CF centres and their networks to complete our dedicated staffing tool to share information about roles in CF teams, contract types, banding, vacancies, and satisfaction with staffing levels. The tool collects this information directly from CF services via the UK CF Registry system each October; as such, it provides an annual snapshot.

While services are not required to complete the staffing tool, most specialist CF centres/networks have contributed data in the last three years. The number of participating services and the size of the populations they care for vary year-on-year. Smaller services, such as shared care clinics, can individually contribute to the staffing tool, but their responses are combined with their network centre in analyses. There are very few networks in adult settings, but these are common in paediatric care, where shared care patients may attend a local clinic but also be looked after by the specialist CF team at the main centre.

This report is based on data collected from 48 of 58 CF centres/networks in the UK (83%) in October 2025 and also draws on staffing data from previous years, which were based on slightly different numbers and combinations of centres (Table 1). Over 70% of CF specialist centres in the UK contribute to the staffing tool each year, but participation is voluntary. While there is overlap in samples from the past three years (41 centres consistently contributed), the number of participating services varied, and some services submitted data in just one or two years.

7 Gov.uk, Cystic fibrosis drugs Kaftrio and Kalydeco licensed for patients aged two to five years old, Nov 2023: **www.gov.uk/government/news/cystic-fibrosis-drugs-kaftrio-and-kalydeco-licensed-for-patients-aged-two-to-five-years-old**

8 Calthorpe, RJ, Smith, S, Gathercole, K et al. (2020) **Using digital technology for home monitoring, adherence and self-management in cystic fibrosis: a state-of-the-art review**. Thorax, 75 (1). pp.72-77

Table 1: Participation in staffing tool by centre type, year and total population*

	2023	2024	2025
Paediatric centres and population	**71.9% (23 of 32)** Full care: 2,155 Shared care: 1,051	**86.7% (26 of 30**)** Full care: 2,383 Shared care: 1,537	**76.7% (23 of 30)** Full care: 2,129 Shared care: 1,428
Adult centres and population	**82.1% (23 of 28)** Full care: 5,828 Shared care: 151	**89.3% (25 of 28)** Full care: 6,423 Shared care: 143	**89.3% (25 of 28)** Full care: 6,778 Shared care: 121
Total centres	**76.7% (46 of 60)** Full care: 7,983 Shared care: 1,202	**87.9% (51 of 58**)** Full care: 8,806 Shared care: 1,680	**82.8% (48 of 58)** Full care: 8,907 Shared care: 1,549

* Population figures show full care as well as shared care (SC) numbers; shared care patients were proportionally attributed in staff time calculations (Section 2) based on information provided by centres as to the proportion of care SC patients receive from CF staff declared in the staffing tool.

** In 2024, the number of paediatric CF centres reduced from 32 to 30 due to mergers.

Considerations

The Standards of Care[9] recommend that the minimum size for designation as a Specialist CF Centre should be 100 children or 200 adults with CF, including any shared care or outreach clinic patients. Staff time in this publication is therefore usually shown as Whole-Time Equivalents (WTEs) per 100 paediatric or 200 adult patients to align our reporting with the current Standards. This allows easier comparison of staffing levels between CF centres of differing sizes, but it does not adjust for any other factors such as the service model in use or population needs. Use of WTE per 200 adults may result in seemingly high staffing levels for adult centres that are currently smaller than the recommended size. This should be considered when reviewing WTE tables.

Data presented in this publication are based purely on staffing tool data submitted to Cystic Fibrosis Trust by participating CF services and reflect actual staffing levels across these services. Average WTE levels across our sample do not indicate a recommended or desired level of staffing and do not imply that services at or above the average WTE level are adequately staffed.

Findings within this report can be reviewed in the context of recommendations within the new Standards of Care[9]. However, it should be considered that some differences between our data and staffing level recommendations in tables 1 and 2 of the Standards may be warranted. The new Standards acknowledge the need for CF teams to continuously adapt and innovate to ensure services best meet their local populations' needs. Therefore, staffing levels observed in the staffing tool may differ from recommended levels for core MDT roles in the Standards due to:

- different models of care in place; for example, nurse-led services may have more nursing time and less consultant time in their CF MDTs compared to the model outlined in table 1 and 2 of the Standards;
- services introducing new and emerging roles to complement other professions in the CF MDT; for example some services now include youth workers, occupational therapists and CF practitioners;
- other local factors, including shared care arrangements and access to non-CF services within hospitals, as well as community services and primary care.

9 Cystic Fibrosis Trust, Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK. 3rd edition, August 2024: www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals/consensus-documents

Limitations

The data collected constitute a snapshot of staffing resources available within CF centres at one point in time (once per year, in October). Staffing levels can fluctuate throughout the year as staff leave or as vacancies are filled, and readers are encouraged to keep this in mind when reviewing the findings, particularly the impact of temporary vacancies on staff availability.

The staffing tool is mainly focused on CF budget-funded roles. This is because funding for CF teams should be at a level sufficient to employ a qualified core MDT of appropriate size to deliver the CF service. CF teams should not need to rely on funding from other budgets to secure core staff for their MDT. However, some CF teams will have access to staff not funded from CF budgets. **Sections 1** and **1.1** include some information about the number of CF centres that have additional staff, and in which professions such roles are available.

Collecting accurate CF team staffing information is complex due to the different ways in which CF teams are set up and how roles are funded. While we endeavour to check that the staffing information provided by participating services only focuses on the number of staff and time available for CF care (including patient-facing and non-patient-facing), we rely on centres to report these accurately. There can be great variation in the way that CF teams describe their structures and resources, making it difficult to pool data together and compare configurations across services. For example, attribution of staff time where staff work across several different departments, including but not limited to CF, can be complex, which is why the staffing tool tries to focus solely on CF time. Another issue is the attribution of patients under shared care arrangements because these individuals may receive varying proportions of care from their central specialist CF teams while also receiving some care from local teams.

The primary purpose of the staffing tool is to provide bespoke centre-level data feedback to help CF centres explore their staffing levels in context. To enable this, all participating CF centres are issued with a bespoke summary showing their staffing information against the latest findings from the full staffing tool sample with references to the current Standards of Care. To ensure a centre's staffing tool summary is as useful as possible to the CF team, all participating centres can decide if and how they wish to include network clinic staff and/or shared care patients, depending on their service's setup. As a result, some centres have chosen to focus only on their centre's core CF MDT staff, while others also include clinic staff. Centres may also occasionally change how they complete the staffing tool to ensure their bespoke summary is as useful to their local service as possible, which can impact the full sample findings.

To make our staffing information more accurate, we continuously work to improve how we capture and report information on staffing resources, bed availability and shared care patients. For example, we attribute shared care patients proportionately, where possible, and encourage services to agree on a consistent approach to how network clinics are included in staffing submissions. We have also followed up with services to ensure the information we have is as complete and accurate as it can be and only reflects time dedicated to cystic fibrosis. Data published within this report may therefore vary slightly from that in previous publications as it incorporates retrospective amendments submitted by services. The latest publication in the series should be referred to for the most up-to-date information.

We will continue to develop and improve our staffing tool and reports in future and we welcome feedback at **QI@cysticfibrosis.org.uk**

Section 1
Professions available in CF MDTs

The staffing tool collects details about members of CF multidisciplinary teams (MDTs) to better understand which professions are providing input and are available to support people with CF. CF budgets should be sufficient to employ a core CF team with relevant skills and expertise; this section focuses on such staff. However, section 1.1 provides an overview of roles funded via other budgets.

Tables 2 and 3 show the proportion of participating centres each year that said they had at least one active member of staff in each profession. "Active staff" include substantive post holders funded from the CF budget, or cover staff, available to input into the CF MDT. This does not mean centres with active staff were adequately staffed in these professions; it merely confirms whether input from the respective profession was available in a centre's CF MDT. Section 2 provides further detail on available staff time across the different professions.

Table 2: Participating paediatric centres with active staff funded by CF budgets

The below is based on currently available staff only; vacant roles are not included, but covered roles are.

	October 2023		October 2024		October 2025	
	Percent	Centres	Percent	Centres	Percent	Centres
Medical (Doctors)	100%	23 of 23	100%	26 of 26	100%	23 of 23
Nursing	100%	23 of 23	100%	26 of 26	100%	23 of 23
Physiotherapy	100%	23 of 23	96.2%	25 of 26	100%	23 of 23
Dietetics	100%	23 of 23	100%	26 of 26	100%	23 of 23
Psychology	87.0%	20 of 23	84.6%	22* of 26	95.7%	22* of 23
Social Work	39.1%	9 of 23	34.6%	9* of 26	30.4%	7* of 23
Pharmacy	73.9%	17 of 23	76.9%	20* of 26	73.9%	17* of 23
Administrative	91.3%	21 of 23	96.2%	25 of 26	95.7%	22 of 23
Research	34.8%	8 of 23	34.6%	9* of 26	39.1%	9 of 23
Other[10]	30.4%	7 of 23	34.6%	9 of 26	26.1%	6 of 23

* Additional centres with non-CF budget funded active staff in 2025: 1 extra for psychology, social work, and pharmacy, 2 for 'other'; in 2024: 1 extra for social work and pharmacy, 2 for psychology, 3 for research.

10 "Other" group includes roles such as: welfare advisers, youth workers, CF practitioners, physiologists, and exercise therapists

Table 3: Participating adult centres with active staff funded by CF budgets

The below is based on currently available staff only; vacant roles are not included, but covered roles are.

	October 2023		October 2024		October 2025	
	Percent	Centres	Percent	Centres	Percent	Centres
Medical (Doctors)	100%	23 of 23	100%	25 of 25	100%	25 of 25
Nursing	100%	23 of 23	100%	25 of 25	100%	25 of 25
Physiotherapy	100%	23 of 23	100%	25 of 25	100%	25 of 25
Dietetics	100%	23 of 23	100%	25 of 25	100%	25 of 25
Psychology	91.3%	21 of 23	92.0%	23* of 25	100%	25 of 25
Social Work	52.2%	12 of 23	44.0%	11 of 25	48.0%	12 of 25
Pharmacy	91.3%	21 of 23	88.0%	22* of 25	96.0%	24 of 25
Diabetes	43.5%	10 of 23	48.0%	12* of 25	48.0%	12* of 25
Administrative	100%	23 of 23	100%	25 of 25	96.0%	24 of 25
Research	56.5%	13 of 23	56.0%	14* of 25	52.0%	13* of 25
Other[10]	60.9%	14 of 23	72.0%	18 of 25	60.0%	15* of 25

* Additional centres with non-CF budget funded active staff in 2025: 2 extra for diabetes, research, and 'other'; in 2024: 1 extra for psychology, pharmacy, and research, 4 for diabetes.

All participating CF centres confirmed their MDT included doctors, nurses, physiotherapists and dietitians funded from CF budgets. Furthermore, in October 2025, at least one role for psychology funded from CF budgets was available at all CF centres except one, which funded theirs differently. While some centres were impacted by vacancies, all had input from doctors, nurses, physiotherapists, dietitians, and psychologists. This is crucial because these are also the professions that people with CF say they need to access the most[11].

However, other expertise important for holistic CF care was not always available. Not all children and adults with CF had access to CF specialist social workers and pharmacists, whose availability could change year-on-year and varied between centres. Limited availability of CF specialist pharmacists is concerning as they can support with accessing medications, managing complex treatment regimens, medicines optimisation, and more.

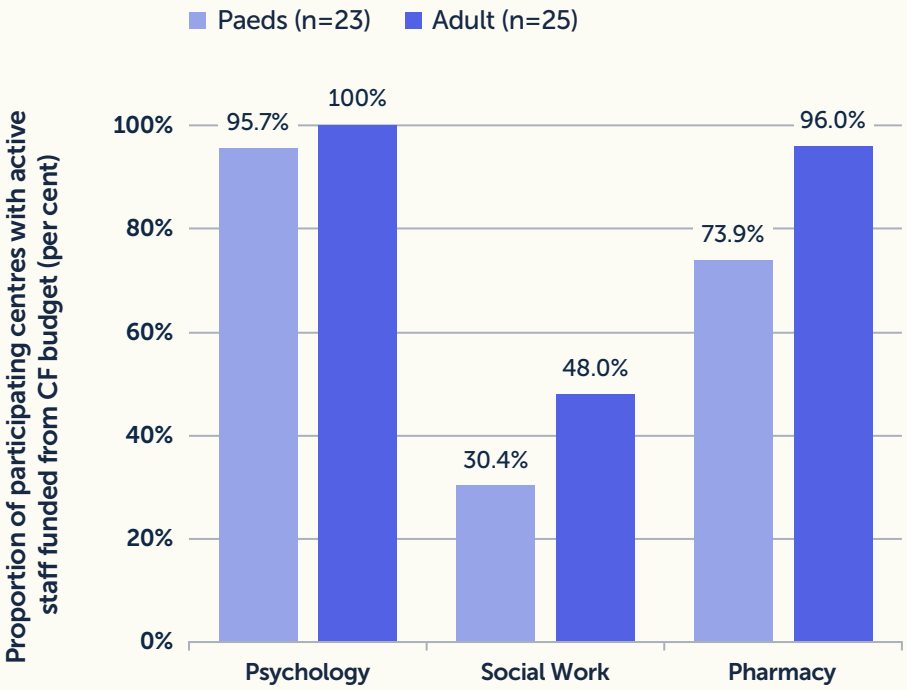
Access to social workers was also limited. The proportion of paediatric centres with specialist CF social worker input was particularly low year-on-year. This does not necessarily mean that patients under the care of centres without a specialist CF social worker cannot access social support. Centres may have welfare advisers or similar roles, or they may refer to services in the community. However, specialist CF social workers bring expertise and knowledge of the condition that is valued by people with CF and critical to high quality holistic care as they help with tailored advice on benefits, housing, finances, education, employment and more[12].

Access to CF specialist pharmacists and social workers was also variable in adult services, though better than in paediatric settings. 12 of 25 adult CF centres (48%) said they funded dedicated diabetes staff.

11 Cystic Fibrosis Trust, Patient-Reported Experience Measures; 2024 **www.cysticfibrosis.org.uk/QI**

12 Cystic Fibrosis Trust, **Support in crisis: the unseen cost of living with cystic fibrosis**; October 2023

Figure 1: CF MDTs with active psychology, social work, and pharmacy staff funded from CF budgets



Insight: Not all people with cystic fibrosis consistently have access to a full multidisciplinary team at their CF centre, particularly when it comes to CF specialist social work and pharmacy.

Even when psychologists, social workers, and pharmacists are available within a team, these roles are often only part time and people with CF may still be unable to access them in a timely manner, even where roles exist. This also means availability of these professions is more easily impacted by vacancies because there is usually only one role in each of these professions in a team. This offers limited resilience when staff leave, retire, or take time off.

While some services reported that they did not have such roles within their CF MDT, others had a temporary gap due to a vacancy, and yet others sourced funding for these roles from outside the CF budget (see section 1.1).

It is important to understand whether apparent gaps in staffing are due to open vacancies or a lack of provision for such roles. Figure 2 provides an overview of the proportions of participating CF centres that had each specialist profession available in the MDT, alongside the proportion that lacked input from these professions. The latter group is split into whether roles were available but vacant or whether there were no roles available in a centre at all. It also shows where centres included such staff but were funding them from other budgets.

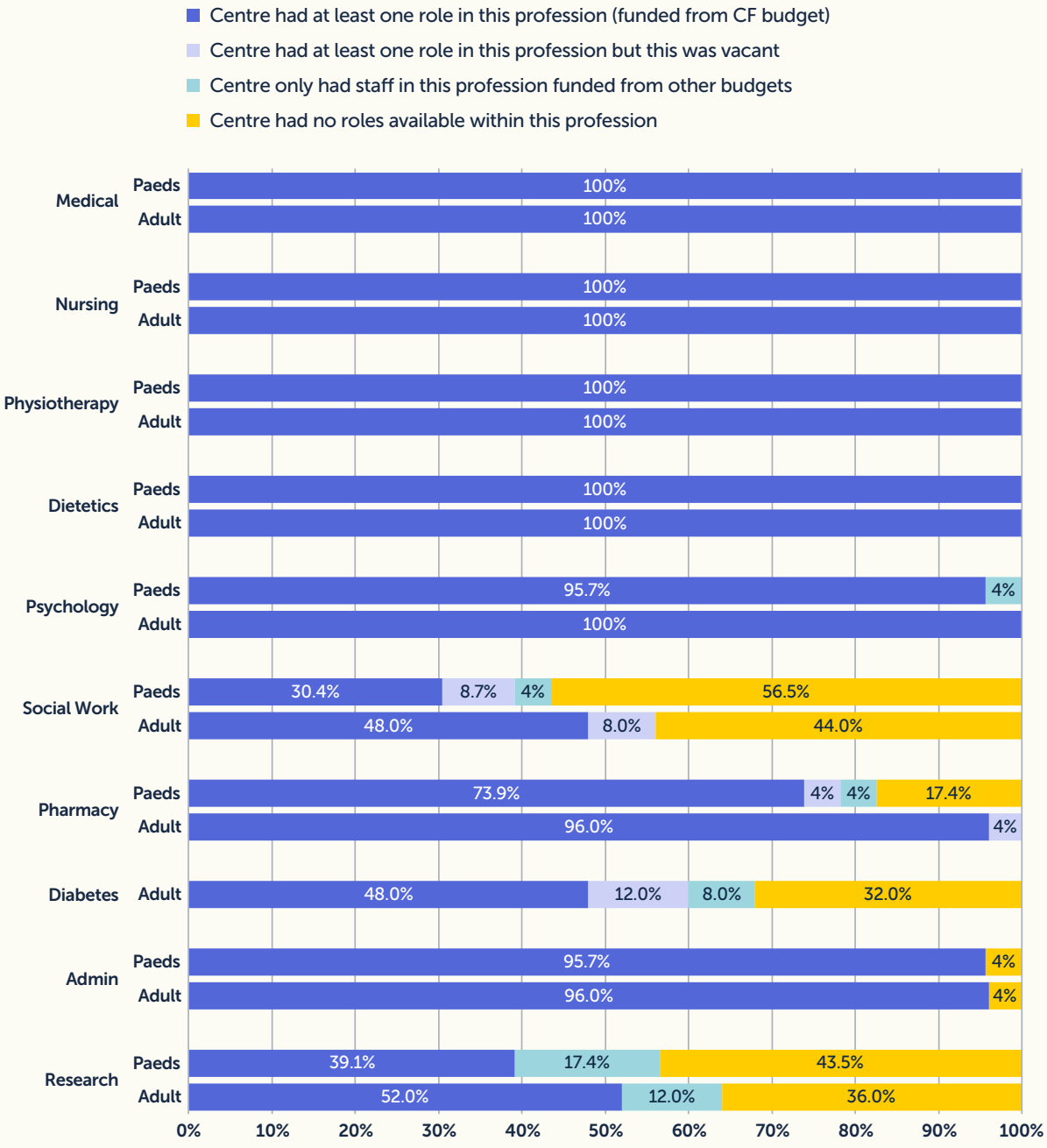
This analysis shows improved access to CF psychologists in our October 2025 sample compared to previous years, as all participating centres in 2025 had at least one active psychologist in their CF MDT, although one paediatric centre funded this role from a budget other than the CF budget.

Figure 2 also shows that two paediatric and two adult centres lacked specialist CF social worker input in the short term due to vacancies. However, half of all participating centres (24 of 48 in October 2025) had no roles for specialist CF social workers available at all. In adult care, this was the case for 11 of 25 centres (44%). Services for children were even less likely to have any such roles available, with 13 paediatric services (56.5%) not having any roles for social workers, and one service funding their social worker from another budget.

All adult CF centres in our October 2025 sample included a pharmacist funded from the CF budget, but one centre was impacted by a vacancy and had no pharmacist available short term. In contrast, four paediatric centres (17.4%) did not have roles for pharmacists in their CF MDT in October 2025, and one children's service sourced this role from another budget.

Figure 2: Availability of professions in CF services

The below is based on data from participating paediatric (n=23) and adult (n=25) CF centres/networks in October 2025; small numbers have been rounded in the graph below; percentages may add up to slightly more/less than 100% due to rounding.



Insight: A larger proportion of paediatric CF services appear to lack roles for CF social workers and pharmacists in their MDT compared to adult services.

1.1 Additional staff

Occasionally, CF teams include additional staff not funded from CF budgets. Where this is the case, the staffing tool explores which additional professions are feeding into CF MDTs, though no further detail about these roles is captured.

Eighteen of 48 participating centres (38%) had additional staff available in at least one profession: 10 of 23 paediatric centres (44%) and 8 of 25 adult centres (32%). Sixteen of these centres had additional roles in more than one profession. These roles can sit alongside CF-funded roles or be standalone.

Table 4: Participating centres with at least one non-CF budget funded role

The below shows the number of participating centres with staff who were not funded from the centre's CF budget by profession. These roles may be in addition to CF-funded staff in the same profession and centre.

Profession	Paediatric centres with non-CF-funded staff	Adult centres with non-CF-funded staff
Medical (Doctors)	2 of 23	3 of 25
Nursing	2 of 23	1 of 25
Physiotherapy	2 of 23	1 of 25
Dietetics	3 of 23	0 of 25
Psychology	2 of 23	0 of 25
Social Work	1 of 23	1 of 25
Pharmacy	3 of 23	1 of 25
Diabetes	6 of 23	4 of 25
Administrative	3 of 23	1 of 25
Research	6 of 23	4 of 25
Other	3 of 23	3 of 25

Staff within diabetes, research, and medicine were the most likely to be funded from budgets other than the CF budget. Social workers and pharmacists were rarely funded this way. While access to additional staff will often be beneficial to CF teams and patients, such staff do not appear to fill the gaps in social work and pharmacy (see Figure 2).

Insight: Some CF teams include additional roles that are not funded from CF budgets but deliver care for people with CF. Access to such roles varies and does not address the gaps in social work and pharmacy staffing.

Section 2
Staffing configurations

The make-up of CF teams can differ between paediatric and adult settings, and even between the same types of services. This variation may be appropriate, depending on service size, patient population, model of care in use, and other factors such as access to non-CF services in the community. However, as staffing configurations can impact the ability to meet professional standards and deliver high quality care, information in this section provides important insights to help CF teams explore their staffing in context.

Table 5a: Median centre-level staff time available per 100 children with CF

Median WTE available per 100 children in sample of 23 participating paediatric centres/networks in October 2025; vacant roles are not included unless they were covered; where a vacant role was covered at a different level to the usual role, the WTE of the cover arrangement was used. Oct 2024 results shown for comparison.

Paediatric Care	WTE per 100 paediatric patients			
	Median* October 2025	**Range**** Lowest - Highest	**Median/Range** October 2024	**Standards of Care**[13]
Overall	**8.7**	**(4.8 – 12.6)**	8.2 (5.0-12.6)	9.25
Medical (Doctors)	1.1	(0.4 – 2.7)	1.0 (0.4-3.1)	1.50
Nursing	2.1	(1.3 – 3.8)	2.0 (0.9-3.8)	1.75
Physiotherapy	1.8	(0.6 – 3.0)	1.4 (0.0-2.7)	2.00
Dietetics	0.8	(0.3 – 1.3)	0.9 (0.5-2.1)	1.00
Psychology	0.6	(0.0 – 1.4)	0.4 (0.0-1.3)	0.75
Social Work	0.0	(0.0 – 1.1)	0.0 (0.0-1.1)	0.75
Pharmacy	0.3	(0.0 – 1.7)	0.4 (0.0-1.7)	0.75
Administrative	0.9	(0.0 – 1.5)	0.8 (0.0-1.5)	0.75
Research	0.0	(0.0 – 0.8)	0.0 (0.0-0.8)	N/A
Other	0.0	(0.0 – 1.2)	0.0 (0.0-1.2)	N/A

* A median of zero means that half or more of participating services reported not having any available staff within the respective profession (they may have had vacant posts in these professions).

** The range shows the lowest and highest staffing level seen among participating centres for each profession; it gives an idea of the differences in level of cover between different centres but does not take fully into account differences in patient population complexity, nor external/other factors.

The different levels of staff time available in participating centres (see ranges in Tables 5a and b) show that there appears to be variation in staffing levels between services and professions. Staff time here is defined as funded from the CF budget and contracted for CF care, including patient-facing and other activities.

For most professions, the median staff time in our paediatric and adult service samples was below the level recommended in the Standards of Care, indicating that more than half of participating centres had less time available from these professions than is recommended. Where the median is zero, more than half of responding services did not have any active CF budget-funded staff in the profession. For example, 29 of 48 participating centres had no time available from CF budget-funded social workers.

13 Cystic Fibrosis Trust, Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK. 3rd edition, August 2024: www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals/consensus-documents, Table 1, page 13

Table 5b: Median centre-level staff time available per 200 adults with CF

Median WTE available per 200 adults in sample of 25 participating adult centres/networks in October 2025; vacant roles are not included unless they were covered; where a vacant role was covered at a different level to the usual role, the WTE of the cover arrangement was used. Oct 2024 results shown for comparison.

Adult Care	WTE per 200 adult patients			
	Median* October 2025	**Range**** Lowest - Highest	**Median/Range** October 2024	**Standards of Care**[14]
Overall	**12.6**	**(6.7-20.6)**	13.8 (6.3-23.4)	18.5
Medical (Doctors)	1.6	(0.6 – 3.6)	1.8 (0.7-3.5)	3.0
Nursing	2.7	(1.3 – 7.4)	2.8 (1.4-7.1)	3.5
Physiotherapy	2.6	(1.2 – 4.2)	3.0 (0.9-5.8)	4.0
Dietetics	1.2	(0.4 – 2.3)	1.2 (0.6-2.4)	2.0
Psychology	0.5	(0.0 – 1.5)	0.7 (0.0-3.7)	1.5
Social Work	0.0	(0.0 – 1.5)	0.0 (0.0-1.8)	1.5
Pharmacy	0.8	(0.0 – 2.0)	0.9 (0.0-2.1)	1.5
Diabetes	0.0	(0.0 – 1.1)	0.0 (0.0-0.1)	N/A
Administrative	1.4	(0.1 – 2.6)	1.7 (0.1-3.5)	1.5
Research	0.2	(0.0 – 3.3)	0.3 (0.0-2.0)	N/A
Other	0.3	(0.0 – 2.1)	0.6 (0.0-2.3)	N/A

* A median of zero means that half or more of participating services reported not having any available staff within the respective profession (they may have had vacant posts in these professions).

** The range shows the lowest and highest staffing level seen among participating centres for each profession; it gives an idea of the differences in level of cover between different centres but does not take fully into account differences in patient population complexity, nor external/other factors.

Insight: In October 2025, available staff time in many participating CF centres was below the Whole-Time Equivalents (WTE) recommended in the Standards of Care. While some variation is warranted based on models of care in use, several CF centres reported vacancies or gaps in certain professions and staffing challenges.

Some variation may be warranted due to differences in location, population, and models of care in use. However, given that many services fed back they were not satisfied with their staffing levels (**section 4**), it is likely that some variation in staff time available is due to vacancies and gaps in provision, rather than adjustments to the needs of the population or model of care in use.

In addition to exploring and comparing staff time available at centre level, it is useful to consider how much staff time was planned and available across the whole population that was being cared for by participating CF centres each year. This gives an indication of CF professionals' availability across our sample populations in paediatric and adult care, and how these change over time.

14 Cystic Fibrosis Trust, Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK. 3rd edition, August 2024: **www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals/consensus-documents**, Table 2, page 13

Figure 3a: Average WTE per 100 children; October 2023, 2024, 2025

Average staff time was calculated based on all posts in participating centres and the total population in our sample (with shared care patients attributed proportionately); where a vacant post was covered at a different level to the usual role, the WTE of the available cover was included in 'covered time'; any remaining vacant time is included in 'vacant time' (striped).

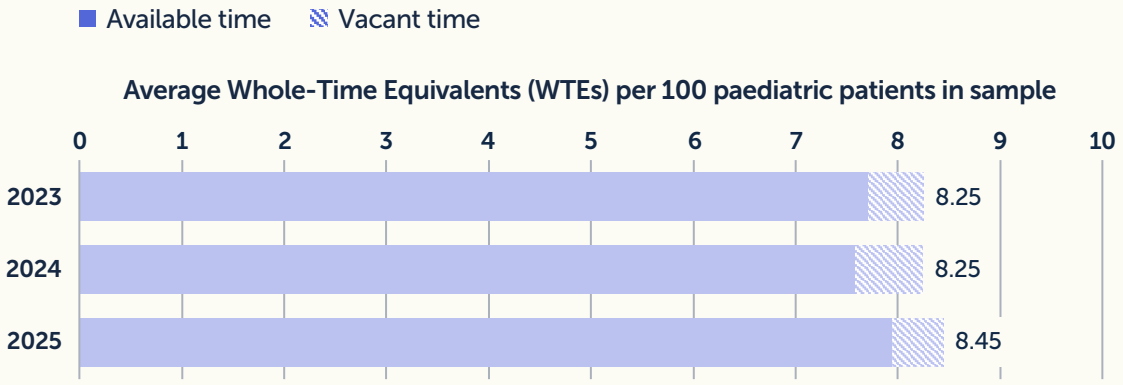
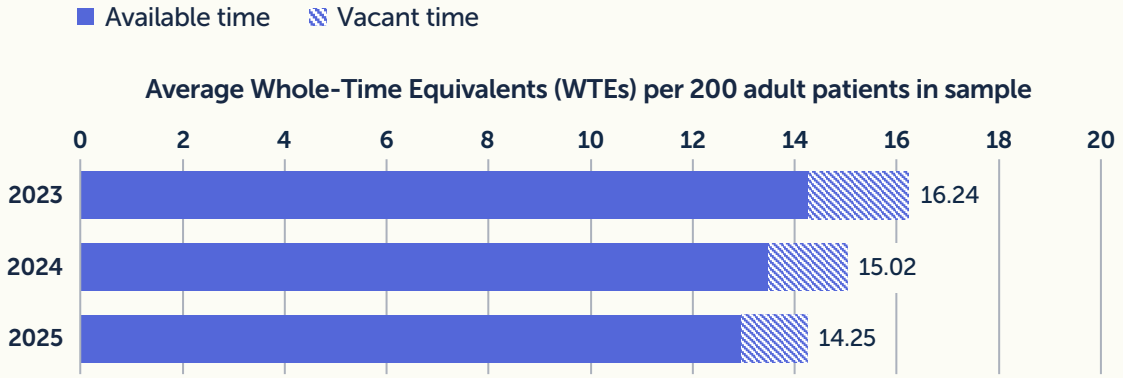


Figure 3b: Average WTE per 200 adults; October 2023, 2024, 2025

Average staff time was calculated based on all posts in participating centres and the total population in our sample (with shared care patients attributed proportionately); where a vacant post was covered at a different level to the usual role, the WTE of the available cover was included in 'covered time'; any remaining vacant time is included in 'vacant time' (striped).



Average staff time for the paediatric population has remained relatively stable in our samples, with a slight increase in 2025. In contrast, average staff time for 200 adults with CF appears to be decreasing year-on-year in our samples. Fluctuations in average staff time from one year to the next could be driven by several factors, including changes in the number of roles or the time they are contracted for CF, but also changes in the number of patients. In adult care, it is likely that increasing patient numbers are affecting average staff time more than in paediatric settings.

Vacancies can also impact available staff time each year, as a proportion of funded time remains uncovered and is not available to CF patients. There was a higher proportion of vacant time in adult care year-on-year compared to paediatric settings (also see section 3).

Insight: Overall staff time available to the CF population across participating centres fluctuates, and it will be vital to keep monitoring this in future, particularly with the adult CF population expected to grow.

Insight: Services for adults have a higher proportion of vacant staff time year-on-year compared to paediatric services.

To explore how staff time is distributed across different professions in CF MDTs, Figures 4 and 5 show staff time for each profession in our samples from 2023, 2024 and 2025 (as average WTE per 100 children or 200 adults, respectively).

Figure 4: Average staff time for paediatric population, by profession

Average staff time was calculated based on all posts in a profession (incl. vacant/covered posts) and total population in the sample (with shared care patients attributed proportionately); as per Figure 3a .

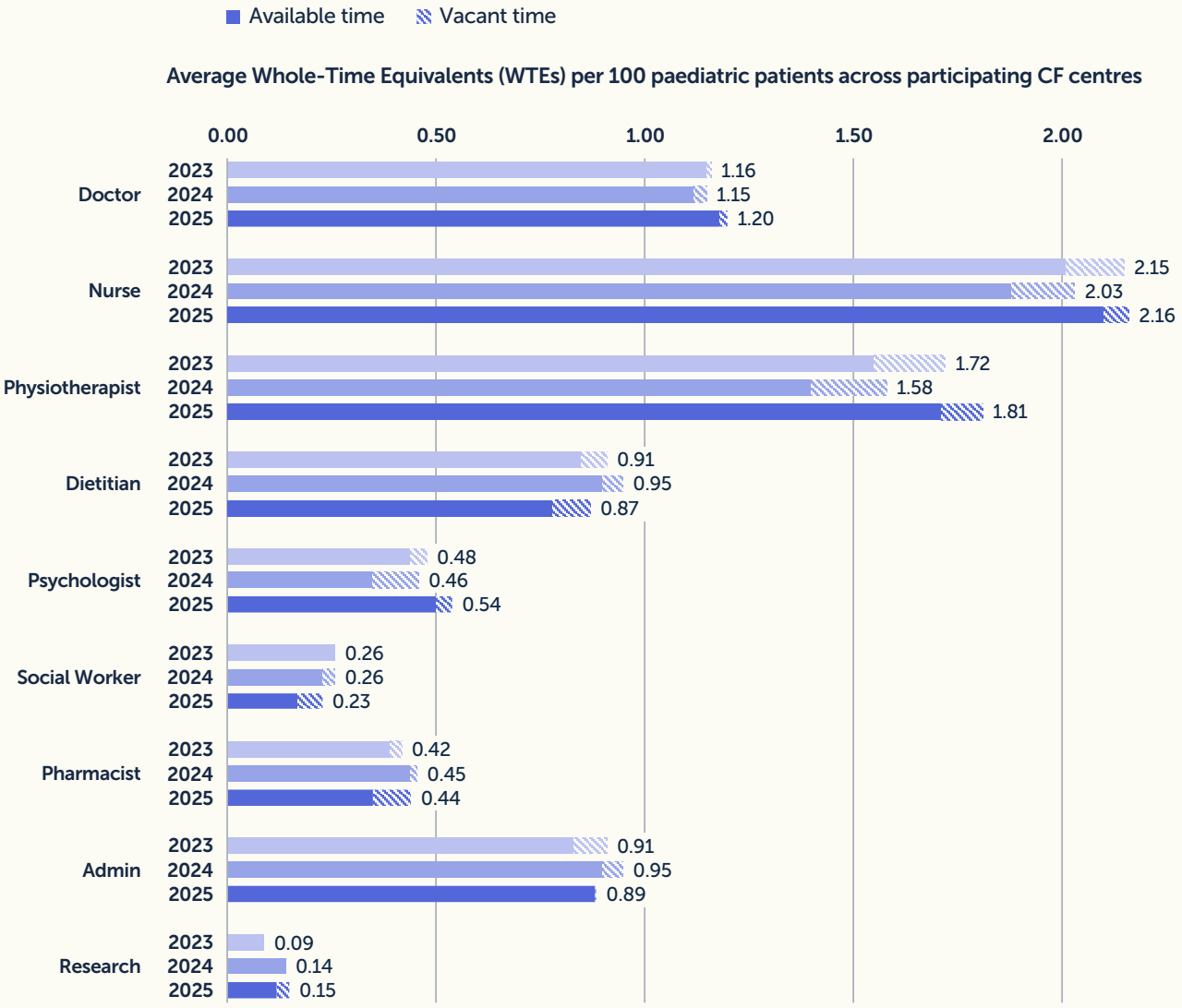
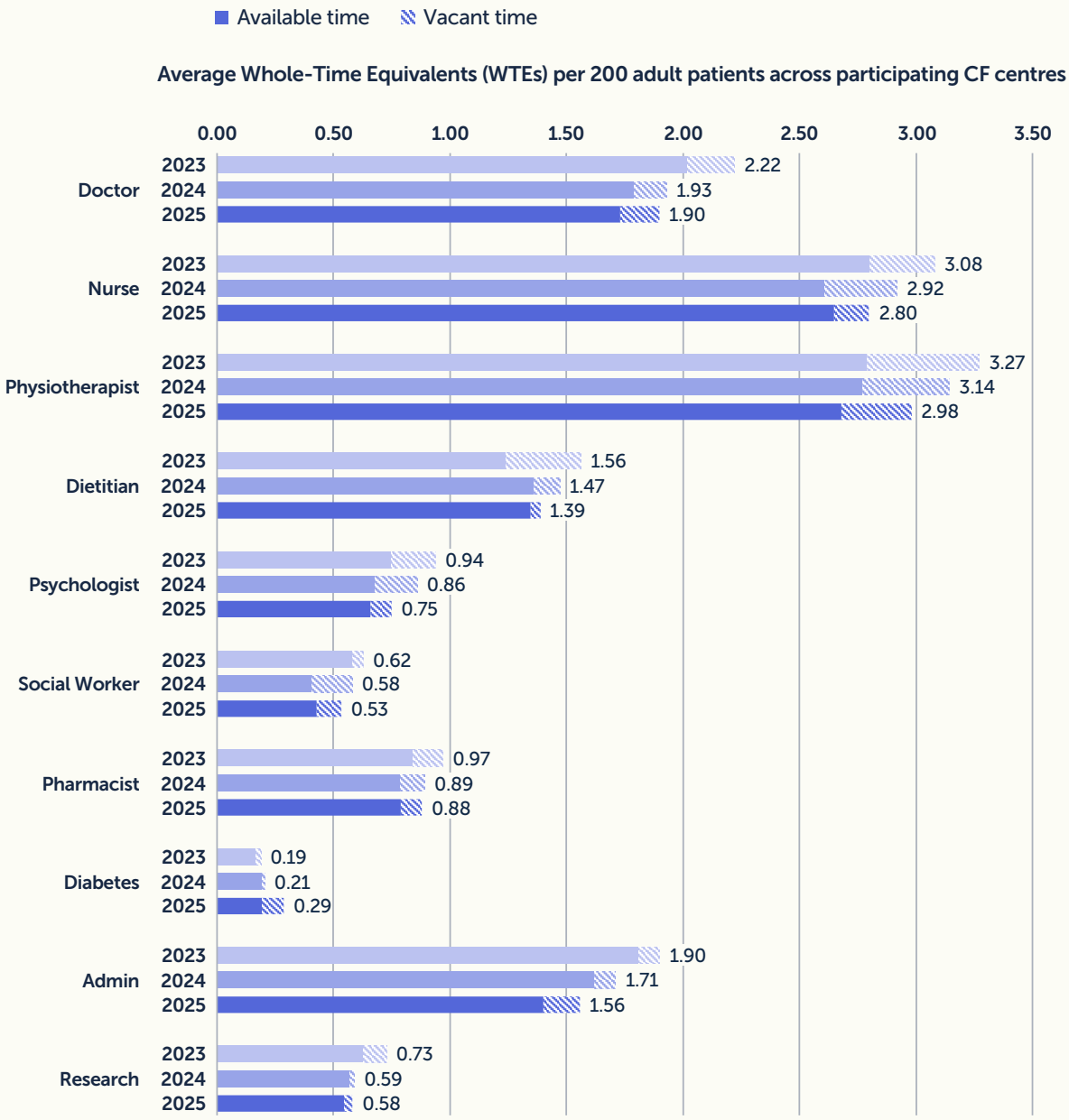


Figure 5: Average staff time for adult population, by profession

Average staff time was calculated based on all posts in a profession (incl. vacant/covered posts) and total population in the sample (with shared care patients attributed proportionately); as per Figure 3b .



In paediatric care, average time in our samples fluctuates within a range of approximately 0.01–0.1 WTEs per 100 children for most professions (Figure 4). In adult care, average time for most professions reduced between 2023 and 2025 within a range of 0.1–0.3 WTEs per 200 patients (Figure 5). Reductions in staff time available to the adult CF population in our samples were most pronounced for doctors, nurses, and physiotherapists, but also seen in other professions.

When looking at average staff time, it is important to consider context. New modulator treatments for CF have been approved and rolled out to increasing proportions of the population in recent years, improving both life expectancy and quality of life. This means there are now more people living with CF than ever before. When patient numbers rise, an overall reduction in average staff time would be expected over time, particularly in adult CF services, unless there was an uplift to match changes in patient numbers. Fluctuations can also be impacted by staff availability and or differences in our sample of services. The latter is likely a driver for the fluctuations seen in paediatric average staff time in Figure 4.

Cystic Fibrosis Trust will continue to monitor staffing levels and outcomes via the UK CF Registry and will work closely with the CF community to explore and advocate for the evolving needs of a growing and ageing CF population.

2.1 Staff seniority

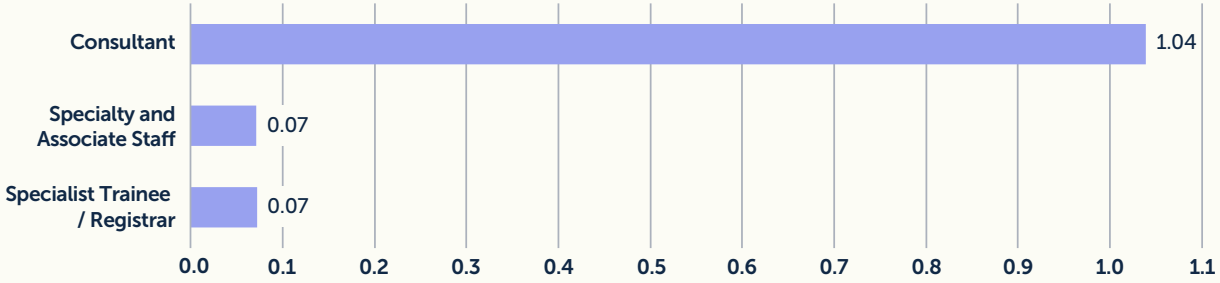
Staffing levels in CF teams also vary by seniority of roles available. Adult centres usually report more roles at Band 5 or below. In 2025, 17.7% (132 of 746) of roles in adult care were Band 5 or below, compared to 15.6% (79 of 508) in paediatric care.

Figures 6 to 15 show staff time available to populations under the care of participating services in October 2025 split by seniority level (NHS Agenda for Change banding / medical grading)[15]. Open vacancies are not included, but cover arrangements are. Where a vacant post was covered at a different level to the usual role, the WTE of the available cover was included.

To align with the Standards of Care, staff time is shown as WTE per 100 children for paediatric care, and WTE per 200 adults for adult care. Sample populations used in these calculations were based on the total number of people cared for by participating CF centres (see Table 1), with shared care patients attributed proportionally. As such, the sample populations include patients from centres that do not have access to some professions. This will result in low availability figures for such professions when looking at staff time across the full sample population. Therefore, staffing levels shown should not be interpreted as recommended levels but rather provide an indication of the composition of the CF workforce and how CF roles are graded for different professions.

Figure 6a: Medical staff time available per 100 children, by seniority

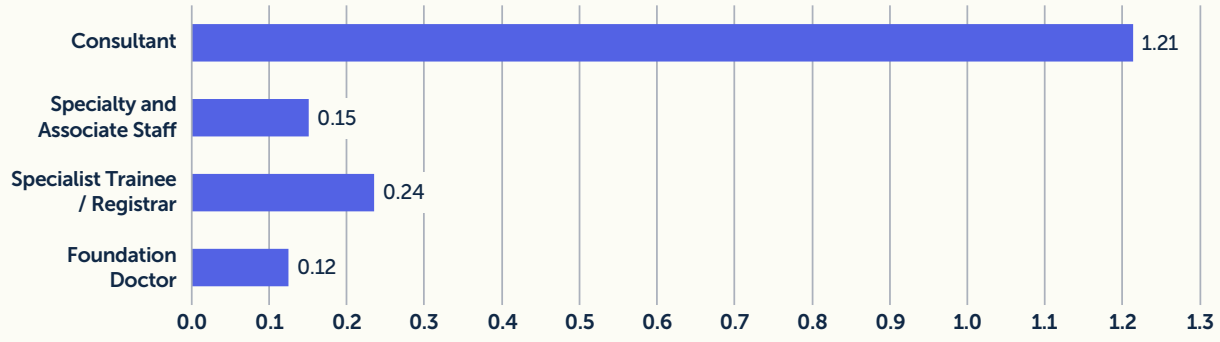
Based on average 1.18 WTE of medical staff time per 100 children declared by participating paediatric services.



Whole-Time Equivalents (WTE) available per 100 children across participating paediatric CF centres

Figure 6b: Medical staff time available per 200 adults, by seniority

Based on average 1.73 WTE of medical staff time per 200 adults declared by participating adult services.



Whole-Time Equivalents (WTE) available per 200 adults across participating adult CF centres

15 NHS England, Agenda for Change; 2022: Agenda for change - pay rates | Health Careers

Banding for doctors differs from other NHS banding, with most medical staff in CF centres working at consultant level (Figures 6a and b). Experienced consultants also act as centre directors or leads in many CF centres and clinics. The most junior medical roles (Foundation Doctors) were only working in adult care.

Figure 7a: Nursing staff time available per 100 children, by seniority

Based on average 2.09 WTE of nursing time per 100 children declared by participating paediatric centres.

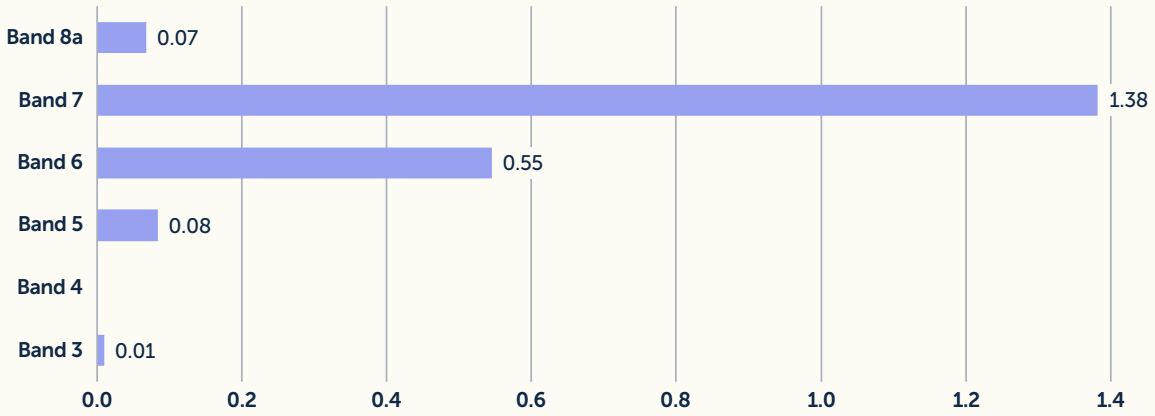
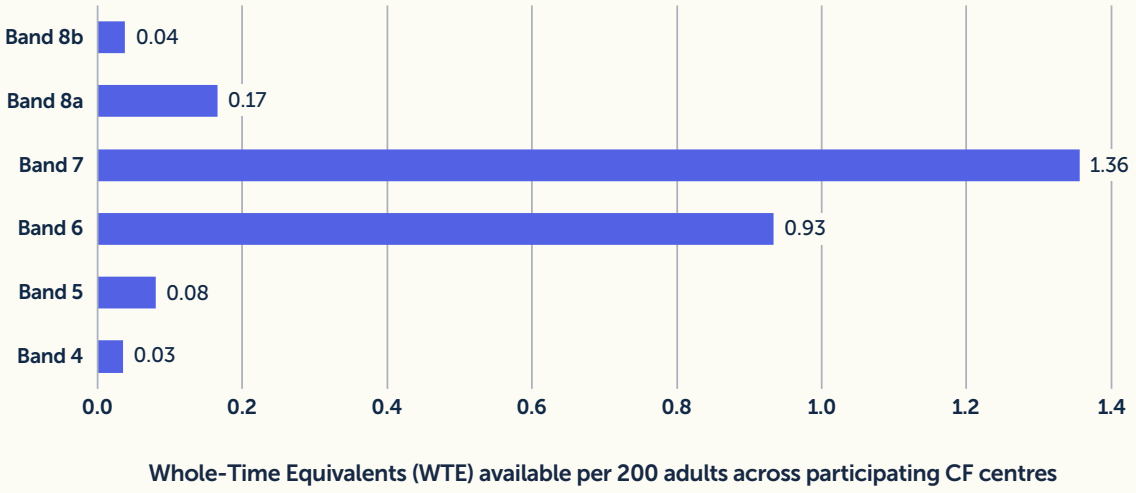


Figure 7b: Nursing staff time available per 200 adults, by seniority

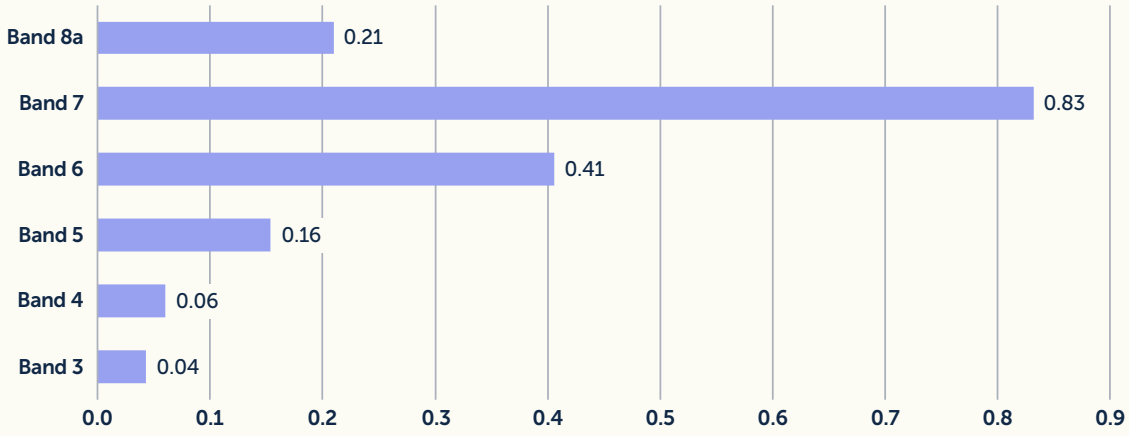
Based on average 2.62 WTE of nursing time per 200 adults declared by participating adult centres.



Nurses provide advocacy and support with diagnosis, treatment, and a wide range of other issues. Clinical nurse specialists in CF may also possess additional skills and expertise; for example, in prescribing or advanced practice. CF nurses are usually employed at Bands 6 and 7, with some higher banded posts that may include managerial responsibilities (Figures 7a and b).

Figure 8a: Physiotherapy staff time available per 100 children, by seniority

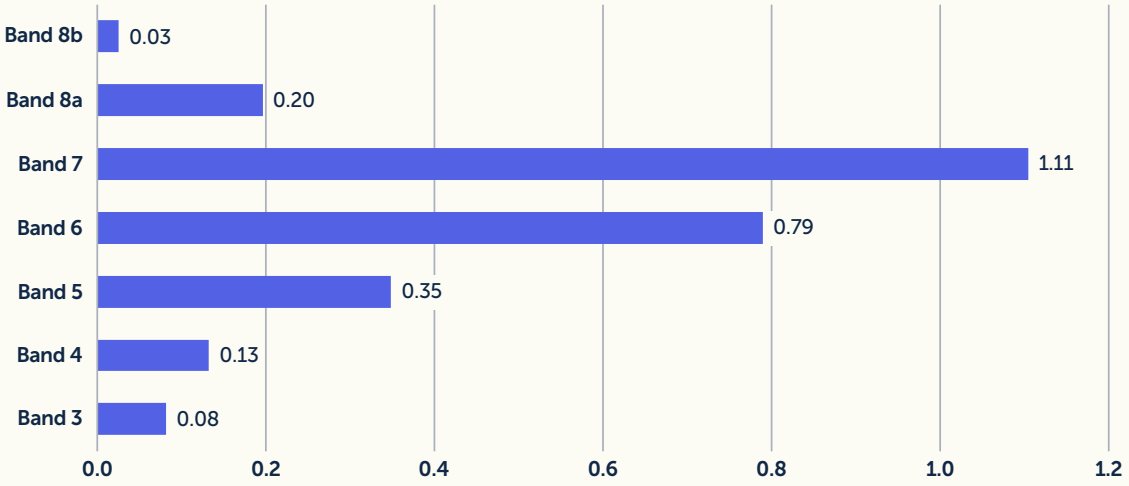
Based on average 1.71 WTE of physio time per 100 children declared by participating paediatric centres.



Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

Figure 8b: Physiotherapy staff time available per 200 adults, by seniority

Based on average 2.68 WTE of physio time per 200 adults declared by participating adult centres.

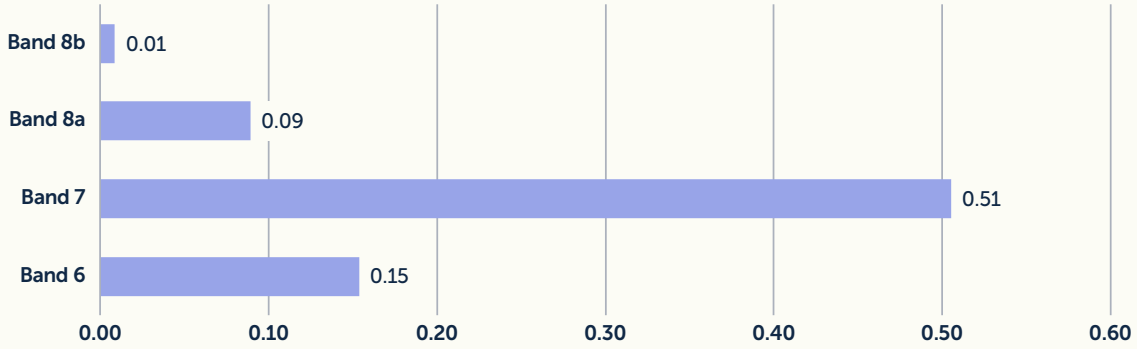


Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

Physiotherapists are an essential part of the CF team as they support many aspects of care from assessments to treatments in clinic, inpatient, and community settings. Most physiotherapists working in CF are respiratory physiotherapists. However, other backgrounds, such as musculoskeletal physiotherapy, may become increasingly important in future within CF care. Similar to nurses, CF physiotherapists were usually employed at Bands 6 and 7, though some centres also included more senior roles for physiotherapists (Figures 8a and 8b). There were also some lower-banded roles (Band 5 and below) available in physiotherapy, which are likely assistants or physiotherapists in training.

Figure 9a: Dietetics staff time available per 100 children, by seniority

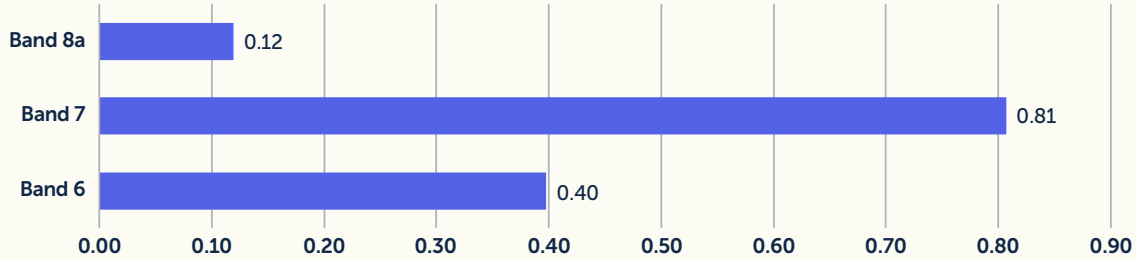
Based on average 0.78 WTE of dietetics time per 100 children declared by participating paediatric centres.



Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

Figure 9b: Dietetics staff time available per 200 adults, by seniority

Based on average 1.34 WTE of dietetics time per 200 adults declared by participating adult centres.

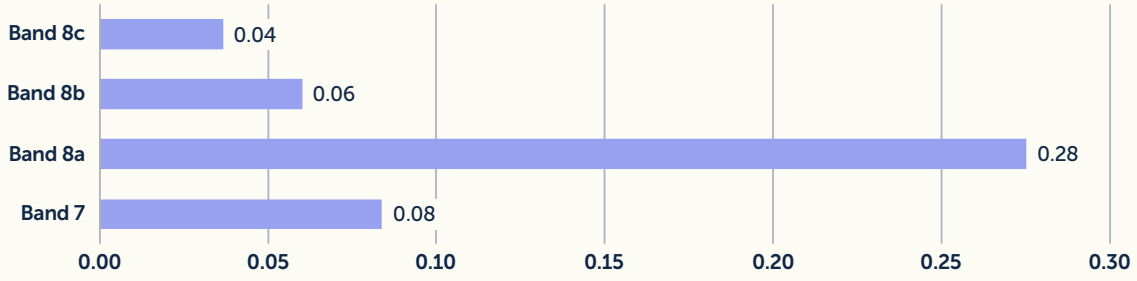


Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

Dietitians working in CF carry out assessments and provide evidence-based nutritional advice and support, which can include dietary management, supplementation, and pancreatic enzyme therapy. While average time available from dietitians was lower in paediatric and adult CF care than from nurses and physiotherapists, dietitians were also mainly working at Bands 6 and 7 (Figures 9a and 9b).

Figure 10a: Psychology staff time available per 100 children, by seniority

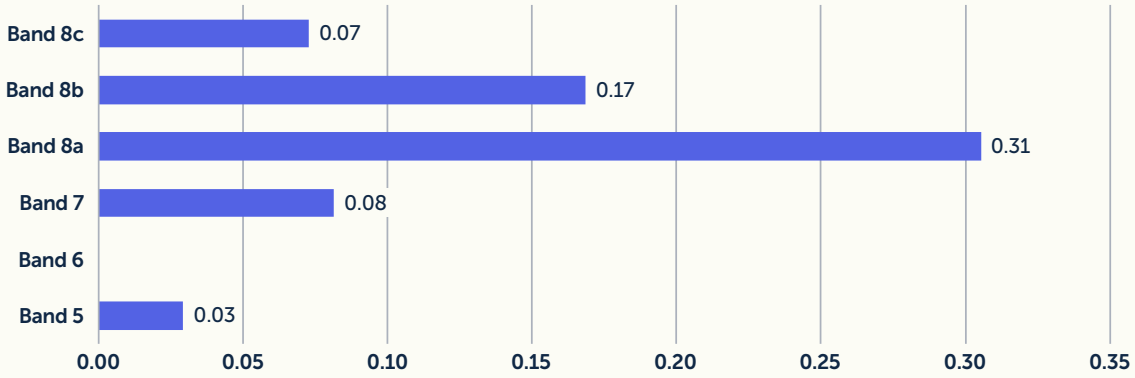
Based on average 0.50 WTE of psychology time per 100 children declared by participating paediatric centres (one Band 4 post not shown).



Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

Figure 10b: Psychology staff time available per 200 adults, by seniority

Based on average 0.66 WTE of psychology time per 200 adults declared by participating adult centres.

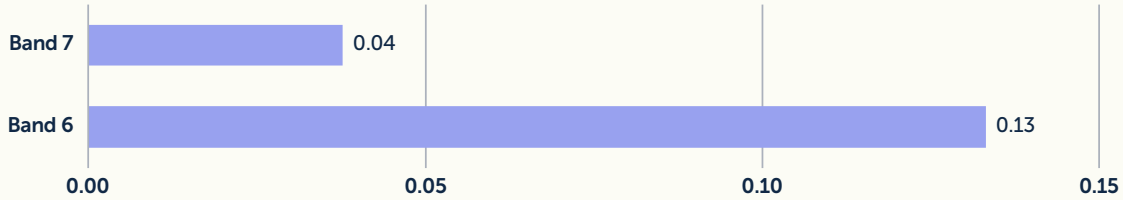


Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

Clinical psychologists are an essential part of the wider CF team, as they deliver psychological screening, prevention, and intervention activities to support the mental and emotional health of people with CF. In October 2025, for the first time since the staffing tool began collecting data in 2019, all participating centres reported that they had access to a psychologist within the CF team. Such roles were usually employed at Band 8a in paediatric care, whereas in adult care there was a wider spread of banding for psychology roles (Figures 10a and 10b).

Figure 11a: Social work staff time available per 100 children, by seniority

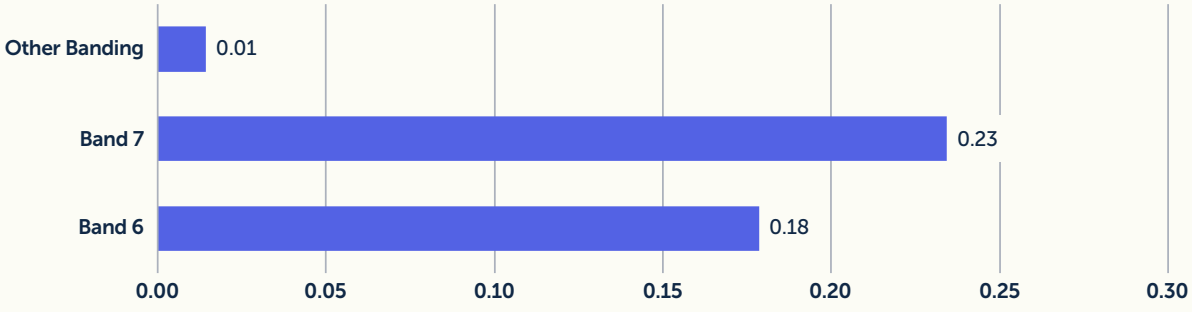
Based on average 0.17 WTE of social work time per 100 children declared by participating paediatric centres.



Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

Figure 11b: Social work staff time available per 200 adults, by seniority

Based on average 0.43 WTE of social work time per 200 adults declared by participating adult centres.

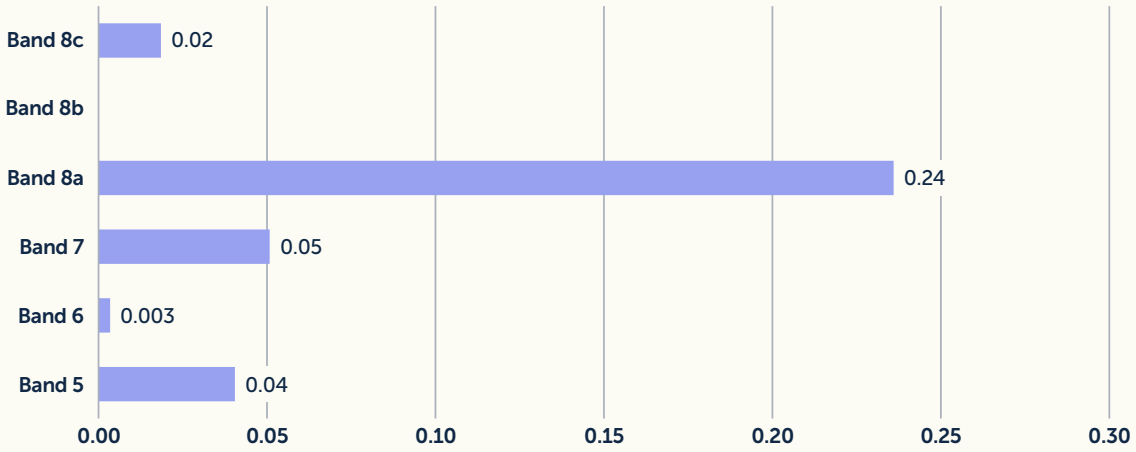


Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

Social workers, like psychologists, are vital for delivery of holistic CF care. They can offer support with many aspects of life, from finances, housing, and employment to social and family functioning, providing expert advice, advocacy, and intervention. Social workers in paediatric CF teams were most commonly employed at Band 6, with a wider banding spread in adult care (Figures 11a and 11b). It is important to note that this is based on time available across the whole population cared for by participating centres. As not all services had social workers in October 2025, average time available to the full sample population is lower compared to other professions. This is the case for pharmacy as well.

Figure 12a: Pharmacy staff time available per 100 children, by seniority

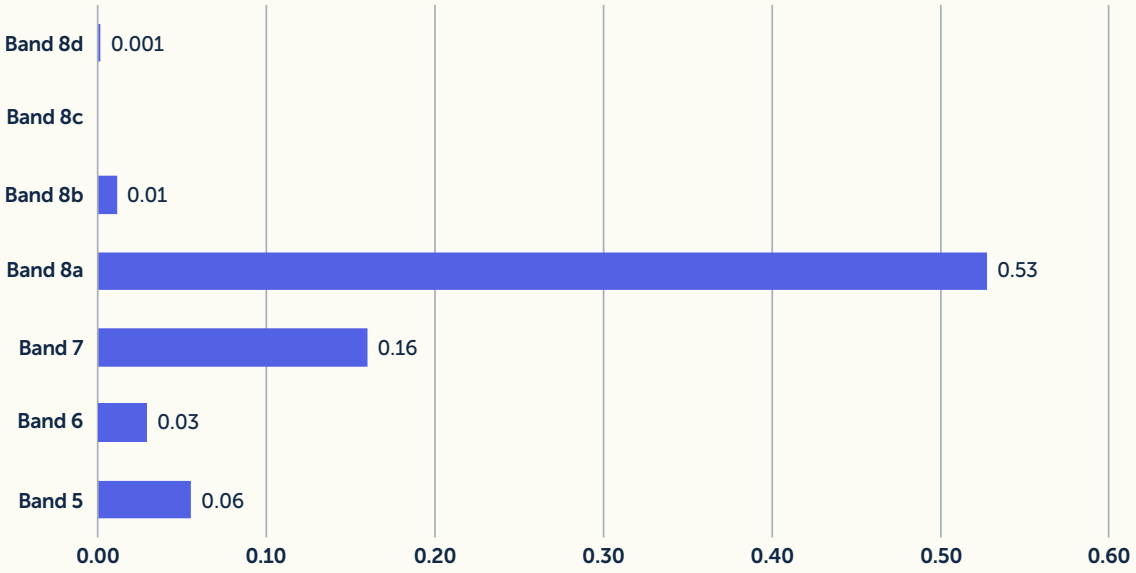
Based on average 0.35 WTE of pharmacy time per 100 children declared by participating paediatric centres.



Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

Figure 12b: Pharmacy staff time available per 200 adults, by seniority

Based on average 0.78 WTE of pharmacy time per 200 adults declared by participating adult centres.



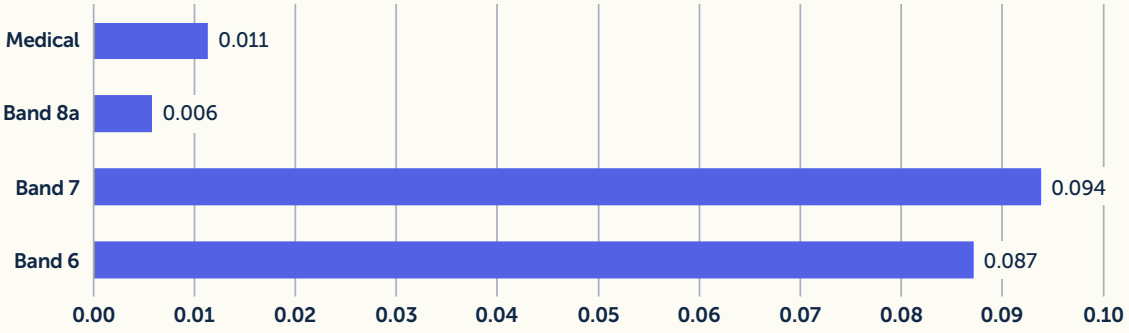
Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

Pharmacists in CF carry out prescription monitoring and medicine optimisation, liaising with community and other services as needed. They can also advise on adherence and provide education about treatments and medications. Most CF pharmacists are working at Band 8a in paediatric and adult services (Figures 12a and 12b).

In addition to psychosocial and pharmacy staff, the staffing tool also asked about CF diabetes staff within adult CF care. Figure 13 shows average diabetes staff time available per 200 adults across the adult population in our sample. It is important to keep in mind that only 48% of adult services (n=12) said they had CF budget-funded diabetes staff in their MDT. Other teams may have access to diabetes staff input funded through the specialist diabetes service or may refer to such services.

Figure 13: Diabetes staff time available per 200 adults, by seniority

Based on average 0.20 WTE of diabetes staff time per 200 adults declared by participating adult centres.



Administrative staff, such as secretaries and database coordinators, concentrated at Bands 3 and 4 in paediatric and adult CF care.

Figure 14a: Administrative staff time available per 100 children, by seniority

Based on average 0.89 WTE of admin time per 100 children declared by participating paediatric centres.

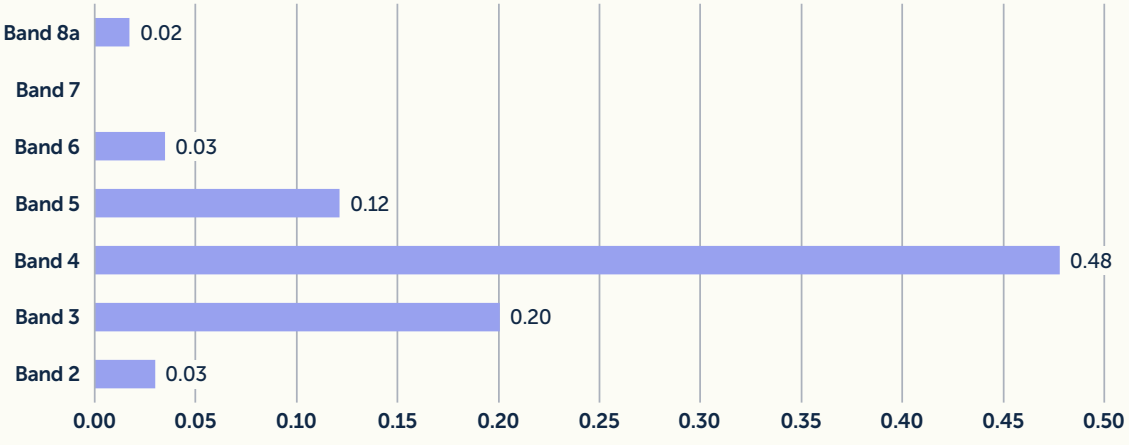
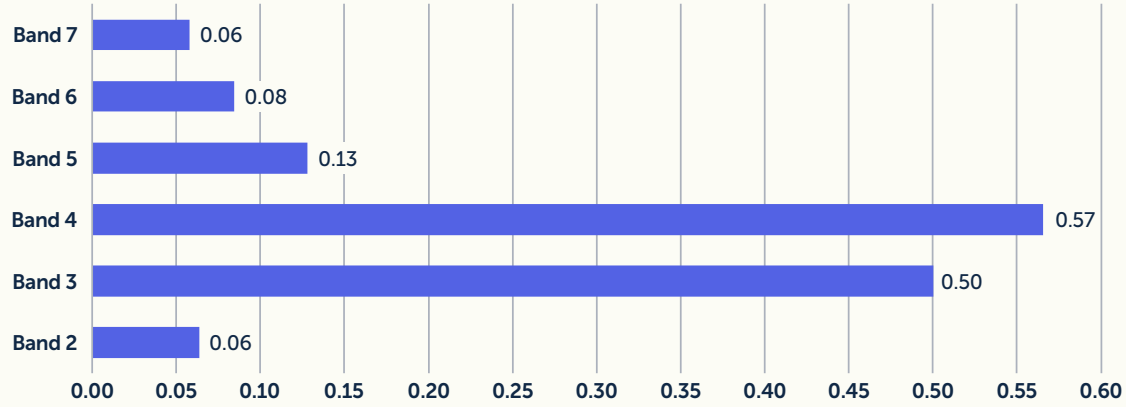


Figure 14b: Administrative staff time available per 200 adults, by seniority

Based on average 1.40 WTE of admin time per 200 adults declared by participating adult centres.

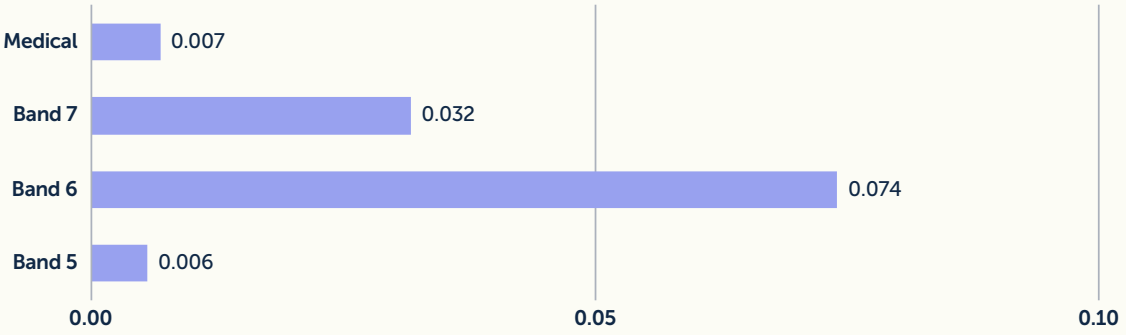


Whole-Time Equivalents (WTE) available per 200 adults across participating CF centres

In addition to professions delivering and coordinating clinical care, people with CF should be enabled to take part in research and clinical trials[16]. Dedicated research staff embedded within CF teams can support this by ensuring people with CF and families are informed about and invited to relevant research opportunities.

Figure 15a: Research staff time available per 100 children, by seniority

Based on average 0.12 WTE of research time per 100 children declared by participating paediatric centres.

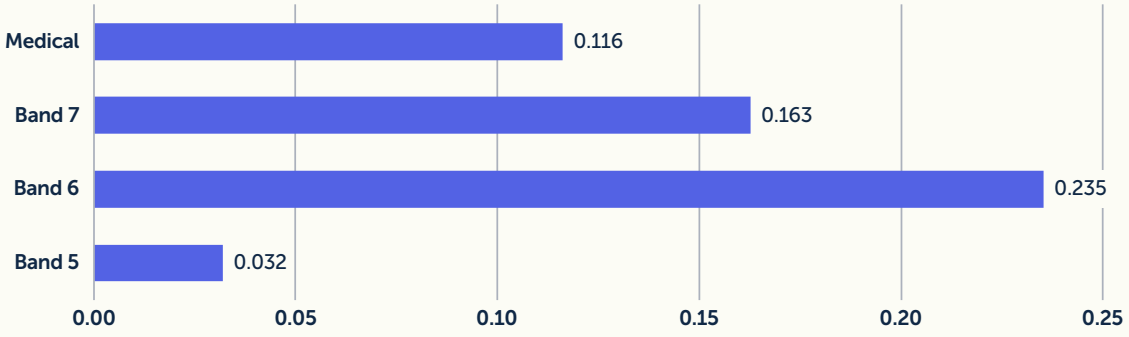


Whole-Time Equivalents (WTE) available per 100 children across participating CF centres

16 Cystic Fibrosis Trust, 2024: Clinical Trials Accelerator Platform (cysticfibrosis.org.uk)

Figure 15b: Research staff time available per 200 adults, by seniority

Based on average 0.55 WTE of research time per 200 adults declared by participating adult centres.



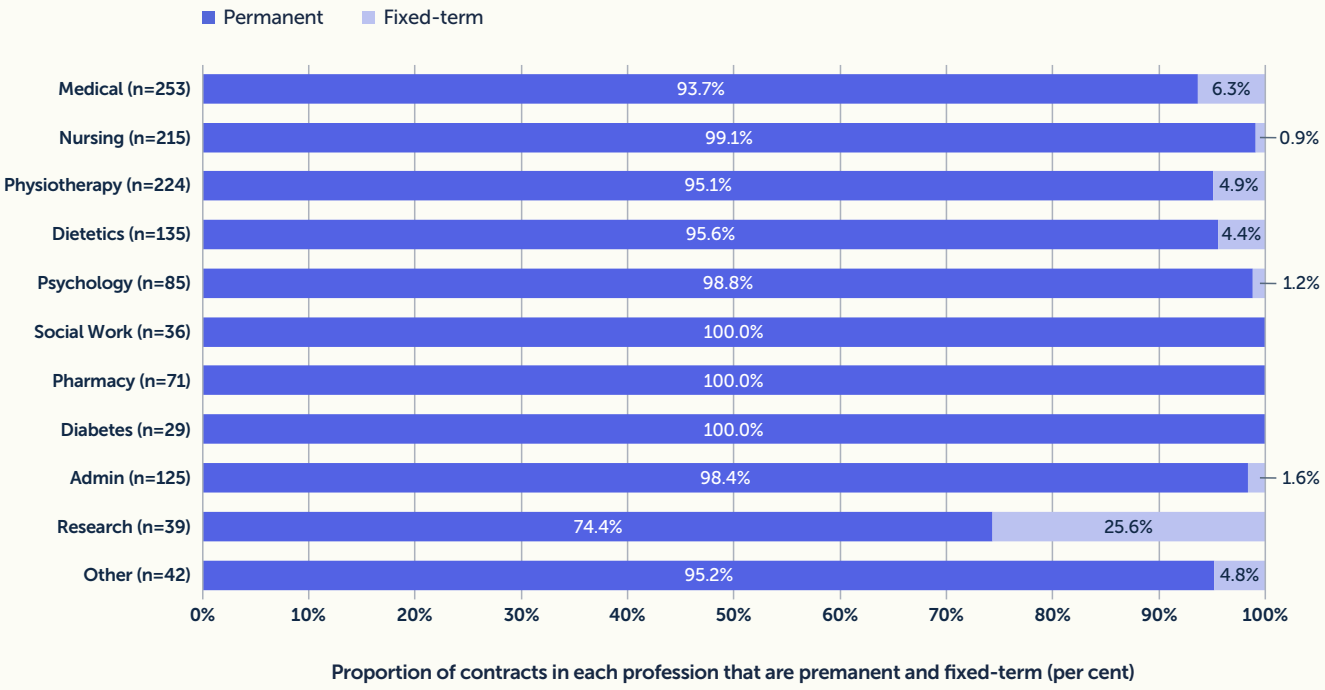
While dedicated roles for researchers in CF MDTs are relatively rare, those that exist are usually graded at Bands 6 or 7, with several posts for research staff from medical backgrounds available as well. There were some research roles in CF teams not funded from CF budgets, which are not shown in Figures 14a and 14b, but an overview is included in **section 1.1**. It is important to note that, even where services did not report access to dedicated CF research staff funded from CF budgets, they may be able to access other research staff within their NHS Trust, which would not be captured by the staffing tool. Overall, the adult population had more dedicated CF research staff time than was available to the paediatric population.

2.2 Contract types

While most roles in CF services are permanent, some staff are on fixed-term contracts (FTCs), which do not guarantee that a role will remain available when the term ends. The proportion of FTCs in October 2025 was 4%, while 96% of roles declared had permanent contracts. While this is lower than in previous years (5% in October 2024), it still means 1 in 25 roles in CF MDTs were only fixed term.

Figure 16: Contract types by profession in October 2025

Based on 1,254 roles in participating paediatric and adult centres, regardless of hours contracted.



For all professions except research, over 90% of contracts in place across participating CF services were permanent, with 0–6.3% of contracts being fixed term, depending on profession. For medical doctors, consultant roles tended to be permanent, whereas others, particularly specialist registrar and trainee roles, were fixed term. Research staff were the only group that had a substantial proportion of staff on FTCs (25.6%).

Section 3
Vacancies

Even when a centre has active staff in a profession, it may not be fully staffed. This is exemplified by nursing vacancies in the latest dataset, where 31 vacancies were reported across our sample despite all participating centres having active nursing staff. While some vacant time may be covered by temporary staff, it is important to consider the impact of vacancies, particularly roles that remain vacant long term, on CF care delivery.

In October 2025, there were 114 vacant roles across 48 participating CF centres, with 15 of 23 paediatric and 18 of 25 adult centres reporting at least one vacancy. Of these, three paediatric and twelve adult centres said they had three or more vacancies. Additionally, eight centres declared a total of 13 roles part-vacant in October 2025 due to secondments, training, or other work taking priority.

To better understand how vacancy rates in CF services compare with the NHS overall, the staffing tool collects information on currently active staff in each service, as well as vacant roles and cover arrangements. Table 6 shows the vacancy rates across participating services from the last three years of the staffing tool. Our approach to calculate the vacancy rate is aligned with NHS England's approach to calculating overall NHS vacancy rate[17] and therefore does not indicate how much of the reported substantive gap is covered by temporary staff. The bottom row in Table 6 includes additional information about covered time.

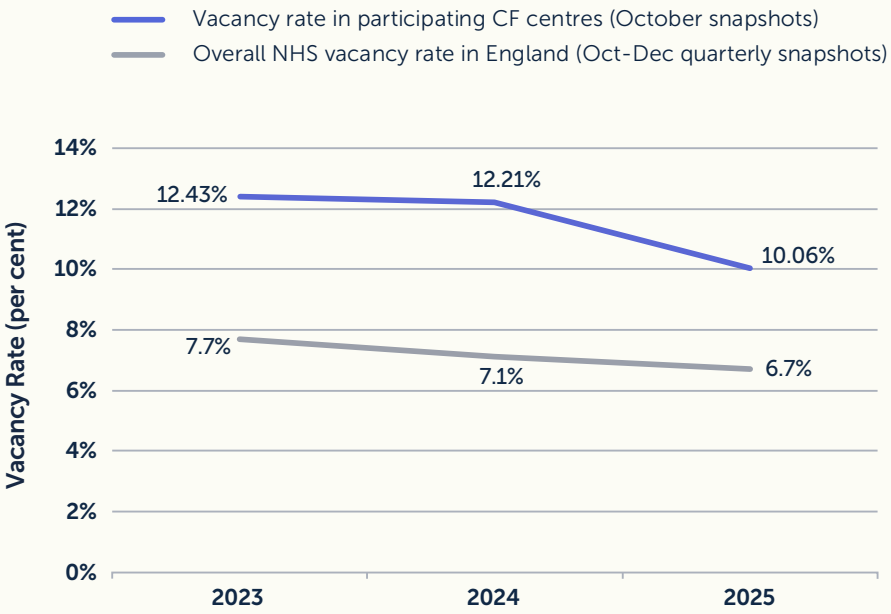
Table 6: WTE workforce and vacancy rates across participating CF centres

	2023	2024	2025
Planned CF Workforce (WTE)	695.82	739.66	736.81
Vacancies (WTE, incl. covered time)	86.47	90.33	74.12
Vacancy Rate* (%)	**12.43%**	**12.21%**	**10.06%**
Covered Arrangements (WTE)	14.25	20.44	15.06

* The vacancy rate is the proportion of WTEs that are not filled by a substantive post holder, out of the total planned / budgeted WTEs for the CF workforce across participating centres; covered vacant time is included as vacant time in this calculation; [Planned Workforce WTE = all active workforce WTE plus vacancies WTE; Vacancy Rate (%) = (Vacancies WTE ÷ Planned WTE) x 100].

17 NHS Digital, NHS Vacancy Statistics England [Experimental Statistics: April 2015 – December 2025 – Tables]; March 2026: NHS Vacancy Statistics (and previous NHS Vacancies Survey) - NHS Digital

Figure 17: Vacancy rate over time: 2023, 2024, 2025



In the last quarter of 2025 (October to December), NHS Vacancy Statistics[18] showed a vacancy rate of 6.7% across NHS providers in England, compared to a vacancy rate of 10% in participating CF centres in October 2025, though it should be noted that some CF centres were located in devolved nations.

Insight: Similar to the NHS overall, CF services are facing issues with vacancies and recruitment. In October 2025, the vacancy rate in participating CF centres was higher than the NHS vacancy rate overall at 10.1% versus 6.7%.

18 NHS Digital, NHS Vacancy Statistics England [Experimental Statistics: April 2015 – December 2024 – Tables]; March 2025: NHS Vacancy Statistics (and previous NHS Vacancies Survey) - NHS Digital

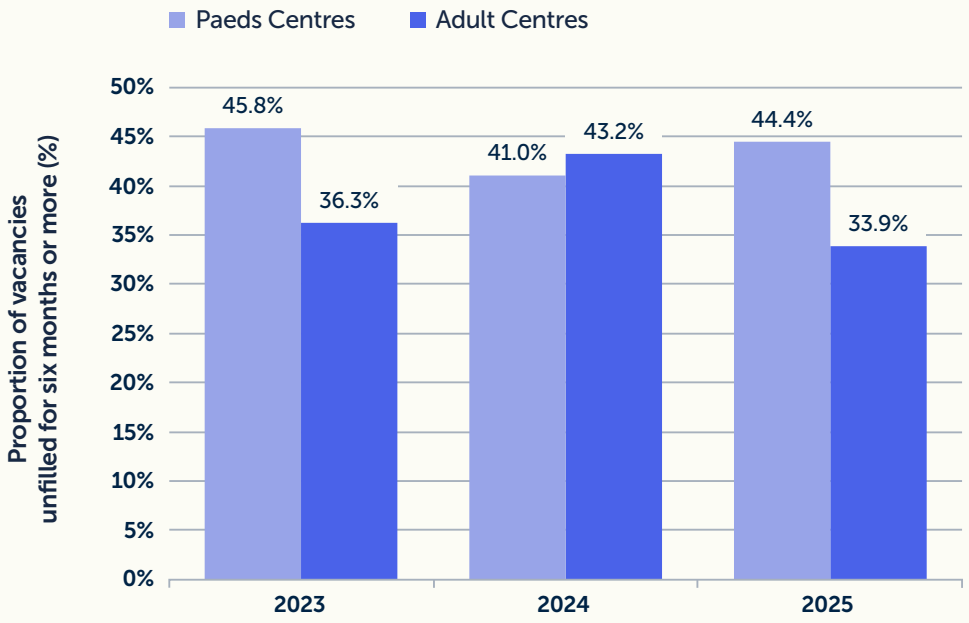
Table 7: Vacancies* unfilled for more than six months by profession

	Paediatric Services (n=23)			Adult Services (n=25)		
	Proportion vacant ≥ six months	Vacant ≥ six months	Total vacant posts	Proportion vacant ≥ six months	Vacant ≥ six months	Total vacant posts
Medical (Doctors)	50%	1	2	75%	6	8
Nursing	33.3%	1	3	14.3%	1	7
Physiotherapy	40%	2	5	30%	3	10
Dietetics	33.3%	2	6	0%	0	2
Psychology	66.7%	2	3	20%	1	5
Social Work	66.7%	2	3	40%	2	5
Pharmacy	33.3%	1	3	40%	2	5
Diabetes	--	0	0	16.7%	1	6
Administrative	100%	1	1	25%	2	8
Research	0%	0	1	100%	2	2
Other	--	0	0	25%	1	4
Total proportion of vacancies unfilled for more than 6 months	**44.4%**	**12**	**27**	**33.9%**	**21**	**62**

* Vacancies that are being covered are excluded from the total vacant count in Table 7; further information about cover arrangements is shown in Table 8

Compared to previous years, the overall vacancy rate and number of vacancies across services in our sample had reduced in October 2025. In line with this, the long-term vacancy rate in adult care had also reduced (from 43.2% in 2024 to 33.9% in 2025); however, in paediatric settings, long-term vacancies still made up more than 40% of vacancies and there was a slight increase in the proportion left open long term.

Figure 18: Proportion of vacancies unfilled for more than 6 months

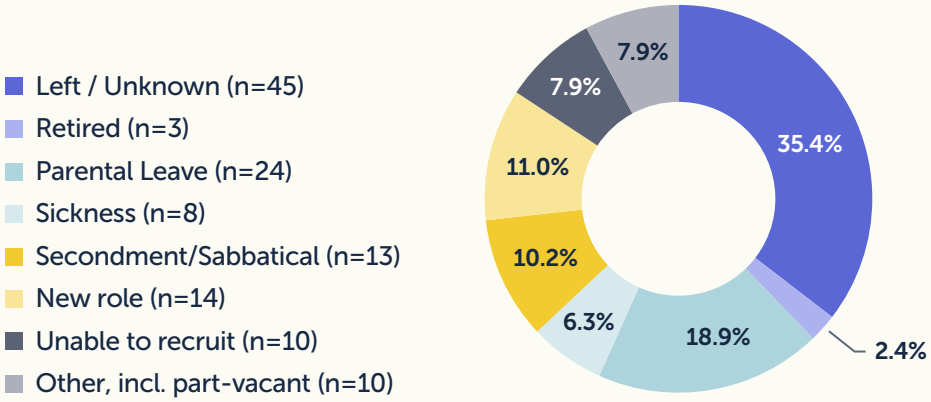


Insight: More than a third of uncovered vacancies in participating CF services remained unfilled for six months or longer.

3.1 Vacancy reasons

Posts may be vacant or part-vacant for a number of different reasons, such as staff moving on or retiring, or existing staff going on longer-term leave or study.

Figure 19: Vacancy reasons provided in 2025



In October 2025, just over a third of all vacancies were due to staff leaving (35.4%) or retiring (2.4%). Another third was due to a contracted member of staff on longer-term leave, such as parental or sick leave, secondment, or sabbatical. 1 in 10 roles (11%) was reported vacant due to being a newly created role, which is encouraging. However, 8% of vacancies were declared vacant due to an inability to recruit, which could be driven by a lack of applicants or hospital-wide recruitment freezes preventing roles from being advertised.

3.2 Cover arrangements

In some cases, vacancies can be temporarily covered by existing staff, although such staff may not be as qualified and/ or available to cover a role fully. To better understand if and how vacant roles are backfilled, the staffing tool collects information about cover arrangements for vacant posts. Of 114 fully vacant posts in October 2025, 25 were covered (21.9%), with a slightly higher proportion covered in paediatric care compared to adult care. However, cover staff can often be a lower banding or work fewer hours than the staff they are filling in for (Table 8).

Table 8: Vacancy cover arrangements

	Paediatric Services			Adult Services		
	Covered at ≥ banding & WTE level	Total covered posts	Proportion covered at same level	Covered at ≥ banding & WTE level	Total covered posts	Proportion covered at same level
2023	5	13	38.5%	9	16	56.3%
2024	7	13	53.8%	12	16	75.0%
2025	5	8	62.5%	8	17	47.1%

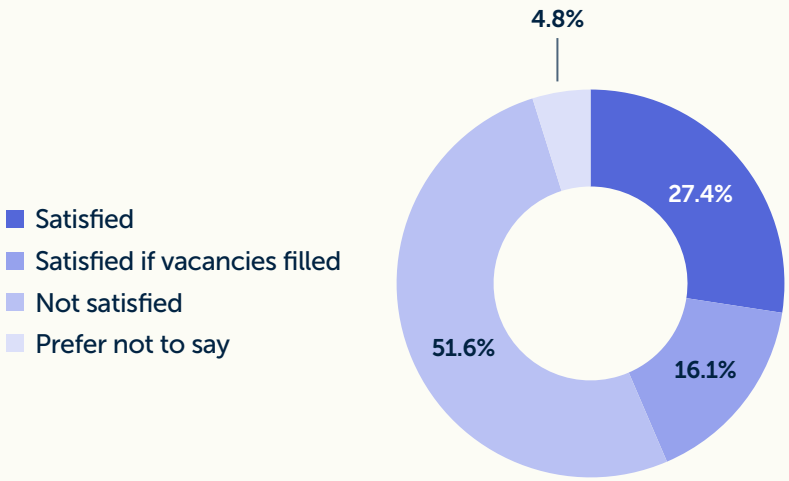
Cover availability varies year-on-year, with only a minority of vacant roles having any cover arrangement in place. Where cover is in place, this is often not at the same level in terms of time or seniority as the vacant role. In October 2025, only half (52%) of backfilled vacant roles were covered at the same level as the substantive post. It remains concerning that many vacancies in CF are only partially covered, and most not covered at all, putting additional pressure on remaining staff.

Section 4
Satisfaction with staffing levels

To understand how services perceive their levels of staffing, our staffing tool offers respondents an opportunity to share whether they felt satisfied with the levels of staffing in their service at the time of data collection.

Figure 20: Overall satisfaction with staffing levels in October 2025

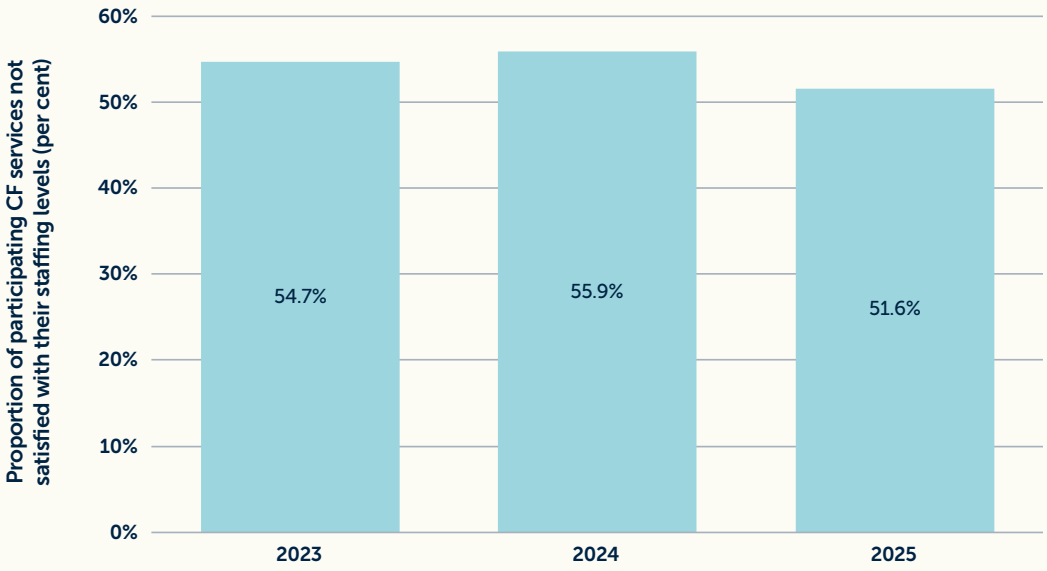
Responses from clinics were counted individually in this calculation; total responses included: 62; 48 CF centres and 14 associated network clinics.



In October 2025, 17 responding services (27%) confirmed they were satisfied with their staffing levels, while ten (16%) said they would be satisfied if their existing vacancies were filled. However, more than half of participating services (51.6%, n=32) were not satisfied with their staffing, which is in line with previous years (Figure 21).

Figure 21: Proportion not satisfied with staffing levels: 2023, 2024, 2025

Based on responses received from participating services, incl. individual clinics, by year.



Insight: More than half of participating CF services say they are not satisfied with their staffing levels year-on-year.

It is likely that CF services are impacted by ongoing challenges with staffing across the NHS. Since 2023, a response option in the staffing tool allows services to confirm that they would be satisfied with staffing if all their vacancies were filled. Interestingly, this did not significantly reduce the proportion who remained dissatisfied with their staffing, indicating that staffing challenges within CF teams go beyond issues with vacant roles and that a lack of provision or inadequate provision is impacting satisfaction with staffing in some services.

As paediatric and adult centres serve different populations, it is also important to consider this information individually (Figures 22 and 23). While more paediatric services in 2025 said they were satisfied compared to previous years, the proportion of adult services that were dissatisfied had grown.

Figure 22: Satisfaction with staffing levels in paediatric services over time

Responses from clinics were counted individually in this calculation, which is why service numbers differ from those in previous sections, where clinic responses had been included under their network centre.

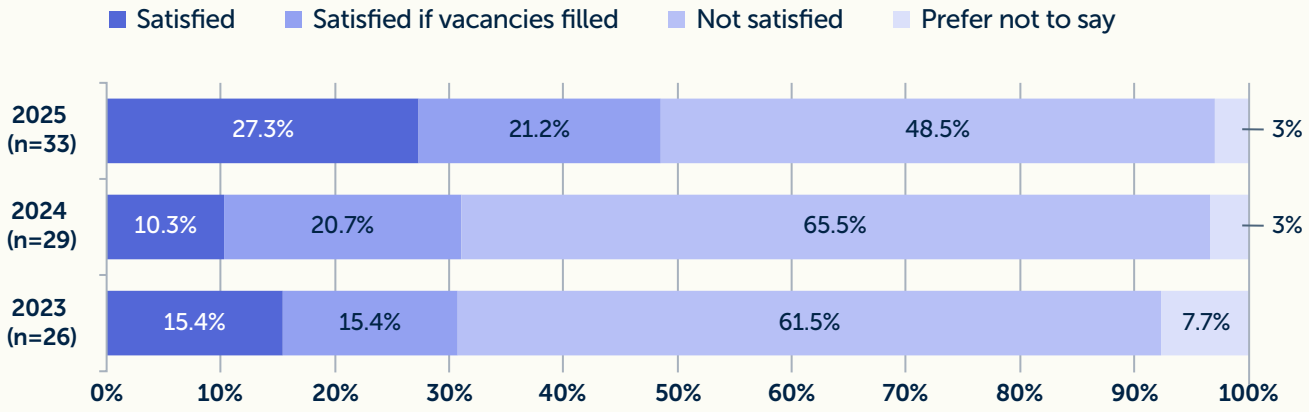
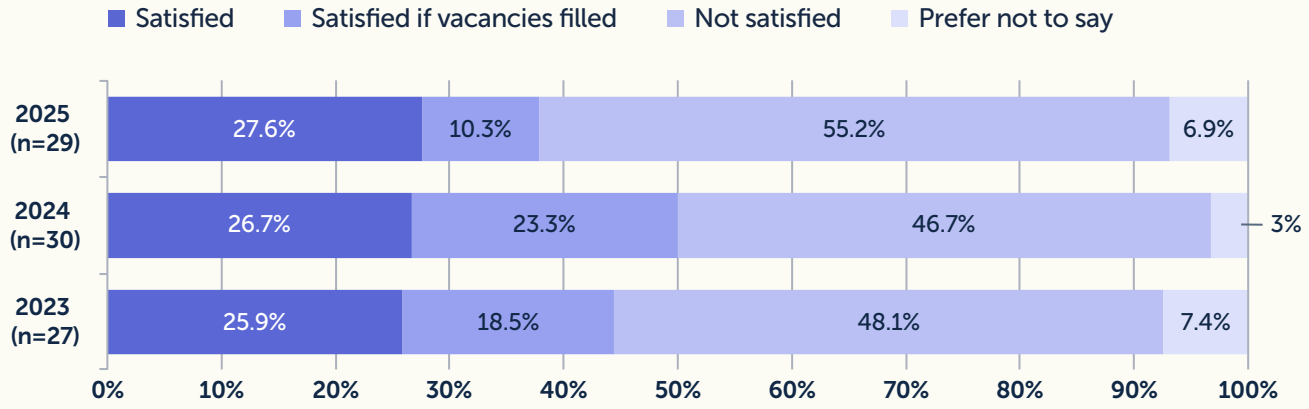


Figure 23: Satisfaction with staffing levels in adult services over time

Responses from clinics were counted individually in this calculation, which is why service numbers differ from those in previous sections, where clinic responses had been included under their network centre.

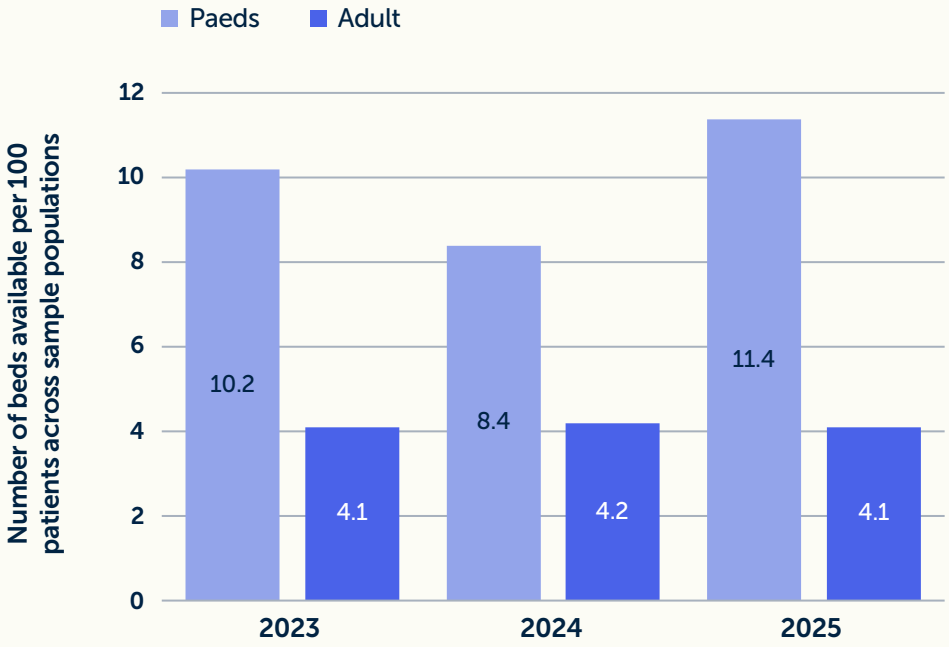


Section 5
Facilities

While modulator therapies have improved the health of many in the CF community, access to suitable inpatient facilities is still critical for high-quality CF care. To maintain infection control, the Standards of Care[19] recommend that people with CF should have their own room with en-suite facilities during inpatient stays. The staffing tool collects data on the number of beds accessible to CF patients, as well as the proportion of these that are en-suite rooms.

Figure 24: Bed availability across sample populations 2023, 2024, 2025

Bed availability is shown as beds available per 100 patients in our sample populations (paediatric and adult), with shared care patients included.

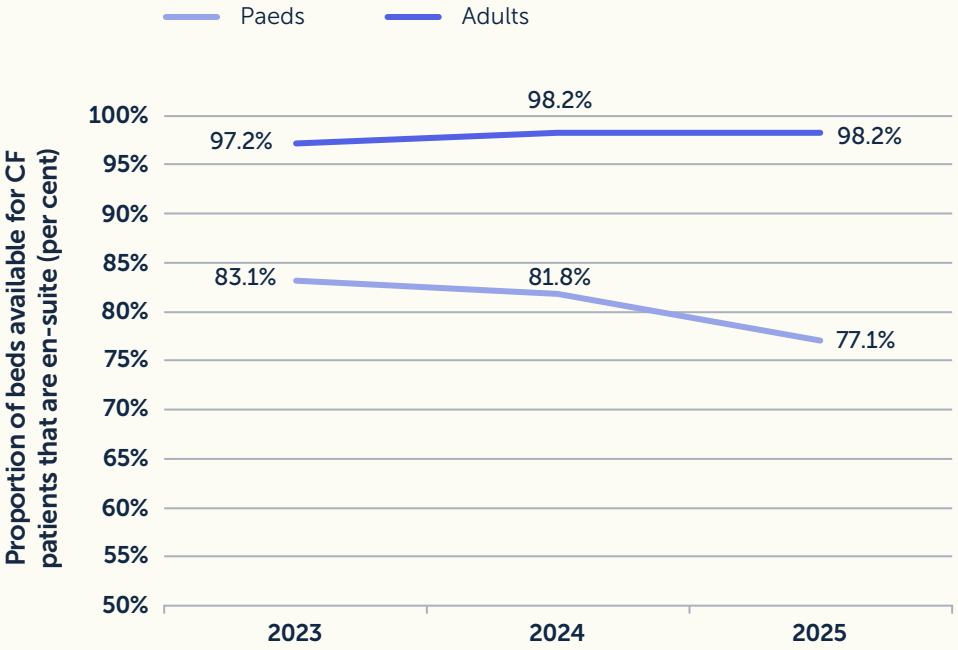


Year-on-year, the number of beds available per 100 paediatric patients was higher than for the adult population (Figure 24). However, beds in paediatric services were less likely to be en-suite (Figure 25).

19 Cystic Fibrosis Trust, Standards for the Clinical Care of Children and Adults with cystic fibrosis in the UK. 3rd edition, August 2024: www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals/consensus-documents

Figure 25: Proportion of beds available to people with CF that are en-suite

Proportion of en-suite beds out of the total number of beds available across participating CF centres.



Variations in bed availability may be impacted by changes in our sample of CF services or the populations they care for, by temporary closures of wards or refurbishment of facilities, and by other factors, such as bed occupancy rates across NHS Trusts, which can impact on beds available for CF.

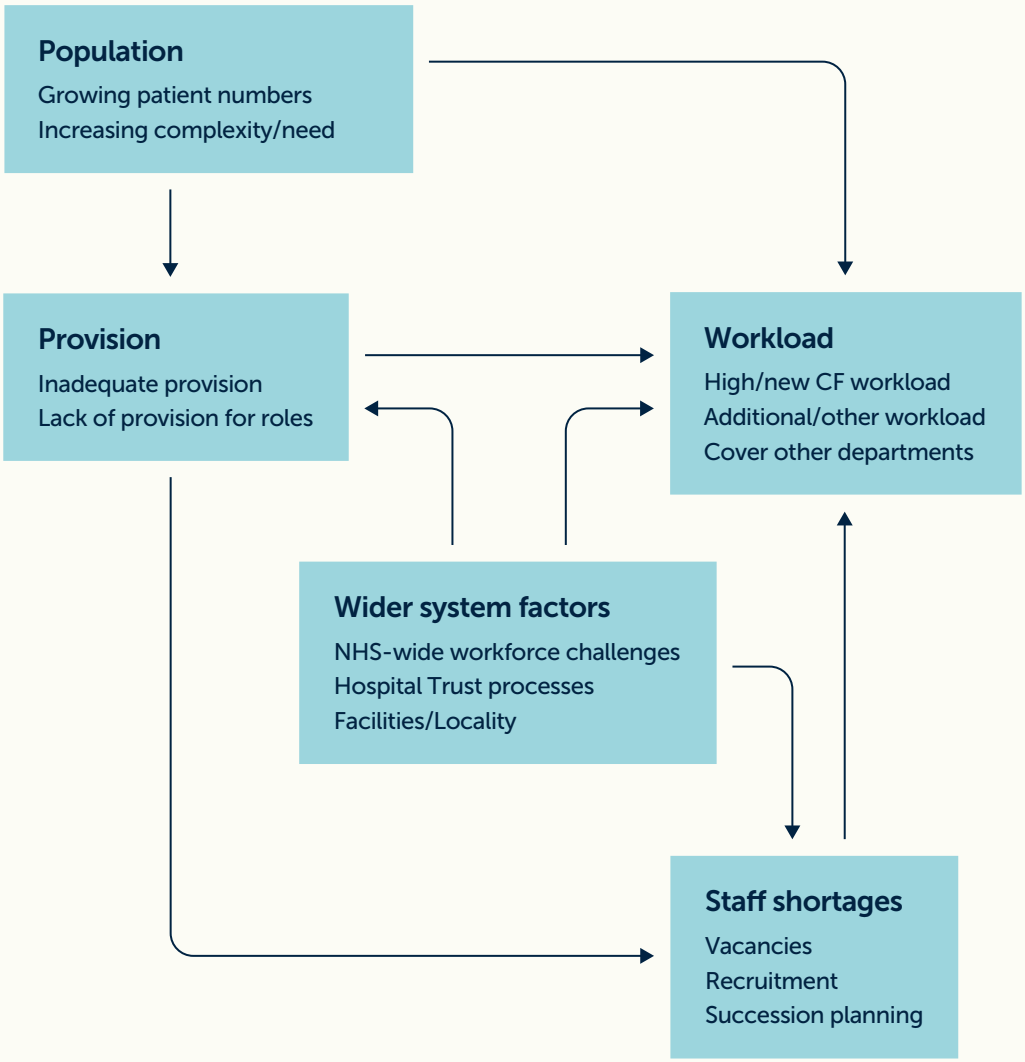
Section 6
Challenges and innovations

In addition to collecting information about the makeup of CF MDTs and bed availability, the staffing tool asks respondents to share reflections on challenges and innovations in their service.

6.1 Staffing challenges

Forty-four participating CF centres, and some of their network clinics, shared specific staffing challenges they were facing, shining a light on several factors affecting satisfaction with staffing levels, many of which lie outside the direct control of CF teams. Figure 26 shows an overview of themes from the analysis of challenges, followed by example quotes for each theme. Quotes are anonymous but disclose service type and, in brackets, the service's perception of its own staffing levels (ie whether or not it was satisfied).

Figure 26: Factors driving staffing challenges within CF teams



Despite the vacancy rate in our October 2025 sample being lower than in previous years, 30 of 44 centres/networks that shared about their challenges specifically highlighted staffing levels and provision. This included gaps in staffing due to leave or vacancies as well as inadequate provision and or a lack of provision for certain professions. Many services shared within their comments how staff shortages were impacting their service and or patient care.

> "We have gaps in our service with regards to Pharmacy, Psychology, Nursing, Dietetics, Physio, Social Work and Medical due to maternity leave, secondments, and staff leaving post. The impact of this is we cannot offer outreach at home in a way that we would like to. This also limits opportunities for research and development of our service as we are focusing just on delivering immediate care." — **Paediatric service (Dissatisfied)**
>
> "Severe shortage of consultants has meant we are currently unable to accept new patients into the service via transition or via transfer." — **Adult service (Dissatisfied)**
>
> "We don't meet Trust Standards of Care Guidelines for dietetic capacity so in areas we're providing sub-optimal care due to limited capacity." — **Adult service (Dissatisfied)**
>
> "No CF social worker over last 6 months. Substantial impact on patients re Personal Independence Payments, housing support etc. Funding is available but unable to arrange employment contract." — **Adult service (Dissatisfied)**
>
> "We don't have adequate physio support and currently they are unable to provide annual reviews for the CF patients. We don't have any dedicated pharmacy time." — **Paediatric service (Dissatisfied)**
>
> "Due to sickness and vacancies within the nursing team earlier in the year we were unable to offer a home IV service and all patients that required IVs had to be admitted to hospital." — **Adult service (Dissatisfied)**
>
> "Psychology services have reduced the WTE attributed to CF so our patient cohort are just reviewed at annual review by a psychology trainee who feeds back to the psychologist covering CF. [Our patients] need to be referred to our CF psychologist for a particular issue rather than having regular contact to try and prevent issues or even build a relationship with the CF psychologist." — **Paediatric service (Dissatisfied)**

Linked to staffing levels and provision were concerns around succession planning, particularly in adult settings, to help maintain current levels of staffing.

> "We are looking at potential problems with succession planning/sustainability in the future." — **Adult service (Dissatisfied)**
>
> "Succession is a challenge for all posts." — **Adult service (Satisfied)**

Several services also reported issues with recruitment to vacant or new posts; for example, a lack of applicants or delays in roles being advertised.

> "There are long operational delays in recruitment to maternity leave cover and vacant posts. There also appear to be significant challenges in staff recruitment in the region as a whole." — **Adult service (Dissatisfied)**
>
> "We have been a dietitian down for >6 months. No appropriate candidates nationally. Upbanded the post but lost a day's hours to do so. There has been less cover, no additional CPD or service development during this time. Delayed patient response time, and not the same level of support for patients as our dietitian has been stretched." — **Paediatric service (Satisfied if vacancies filled)**
>
> "Unfilled exercise therapist post, unfilled CF pharmacist post, no CF social worker. This impacts on staff workload and morale. We are attempting to avoid it impacting on patient experience." — **Adult service (Dissatisfied)**

High or increasing workload was another challenge highlighted by responding services. In part, this was driven by staffing shortages within CF teams; however, this could also be impacted by competing non-CF workload. Specifically, several services mentioned that CF physiotherapy staff were covering bronchiectasis and or general respiratory services alongside CF.

> "Many of the roles are not full time in CF. They cover with general paediatric roles in addition – often these roles take priority, as they cover inpatients first, then CF." — **Paediatric service (Satisfied if vacancies filled)**
>
> "Physiotherapists are being pulled to support other respiratory services due to decrease in inpatient CF bed occupancy at times and there is pressure on rotational roles to support further development in other respiratory services." — **Adult service (Dissatisfied)**
>
> "Physio team provides care to a large unfunded bronchiectasis service alongside CF activity. All medical staff have significant other (non-CF) clinical and non-clinical commitments." — **Adult service (Dissatisfied)**

Wider system challenges were also mentioned by some services. This included hospital-wide recruitment freezes, business case decisions, digitalisation, and facilities.

> "Due to the current financial difficulties within the Trust, any role that was vacant during month 8 has lost its funding and therefore the post is no longer available." — **Adult service (Dissatisfied)**
>
> "We have put together a business case for an exercise specialist and increased psychology and social worker hours, but unfortunately these have not yet been supported by our Trust." — **Adult service (Dissatisfied)**
>
> "A new Electronic Patient Record system shifted more patient documentation to clinicians and away from admin staff. In the months leading up to and after 'go live' this impacted hugely on clinical workload." — **Paediatric service (Satisfied if vacancies filled)**
>
> "Lack of office space within the CF paediatric team has impacted the admin staff." — **Paediatric service (Dissatisfied)**

Additionally, population factors were raised as a challenge, particularly in adult care, due to growing numbers and complexity necessitating new ways of working.

> "Our challenge is adjusting our model of care to the changing needs of our patient population." — **Adult service (Satisfied)**

Insight: CF teams face several staffing challenges, with many citing inadequate provision as a key issue, alongside recruitment challenges and high workloads.

6.2 Service innovations

Many CF centres and teams adapt and innovate to mitigate or overcome staffing and other challenges to deliver the best possible care for people with CF. Our analysis of free text comments in the staffing tool identified several different approaches to addressing staff shortages and other arising challenges. Mitigating actions taken range from developing existing staff and expanding collaboration to changes in care delivery and initiatives aimed at specific groups of patients.

Figure 27: Staffing innovations and mitigations used by CF teams

Staff and wider team

- Non-medical prescribers
- Upskilling
- Expanded and advanced practice roles
- New and emerging roles
- Collaborating beyond CF team:
  - Primary care
  - Cardiology
  - Maternal health
  - Health in Mind (NHS Talking Therapies)

Care delivery[1]

- Adapting clinics
- Harnessing technology:
  - Virtual clinics
  - Text messaging
- Home and community care:
  - Postal sputum
  - Home spirometry
- On-call CF MDT
- Cardiopulmonary Exercise Testing (CPET)
- Electronic psychology questionnaires
- Bone / musculoskeltal MDT
- Outpatient bowel screening

Specific initiatives[2]

- Diabetes clinics
- B. cepacia clinics
- Underserved MDT meetings
- Transition service
- Commit to fit for teenagers
- 'Bone Building Base Camp'
- Coffee mornings
- Cooking class

Other activities

- Service development
- Quality improvement
- Research
- Clinical trials

[1]**Care delivery =** programmes impacting care delivery for all patients

[2]**Specific initiatives =** programmes aimed at a specific subgroup of people (such as teenagers, those with CFD) or initiatives that are not directly related to care (such as coffee mornings and online classes)

Insight: CF services across the UK continue to adapt and innovate to mitigate staffing challenges and meet the needs of their patients. Key innovations include developing existing staff and enhanced collaboration. Despite these innovations, staffing often remains a challenge.

Staff and wider team

Development and upskilling of existing members of the CF MDT plays an important part in addressing staffing challenges. In October 2025, similar to previous years, many responding CF services specifically mentioned having non-medical prescribers or staff training to become non-medical prescribers.

> "Established MDT independent prescribing, with nursing, physiotherapist and pharmacist prescribing." — **Adult service (Dissatisfied)**
>
> "We have a Paediatric Pharmacist Prescriber, which has improved management of home delivery of high-cost drugs including nebulised therapies and CFTR modulators." — **Paediatric service (Dissatisfied)**

Distributed prescribing responsibilities offer an effective way to reduce reliance on doctors and can make prescribing more efficient. Due to the specialised nature of CF care, use of non-medical prescribers appears to be more common in CF than in other fields.

Upskilling and development of existing staff were also used to mitigate staff shortages. Several services had staff with advanced practice skills, or staff who were developing these via Masters or e-portfolio routes. A few adult services had embedded new roles in their CF MDTs, such as practitioner and consultant roles.

> "We now have a Nurse Consultant in post, to work with the consultants, helping to triage patients, general reviews and provide timely clinical support." — **Adult service (Dissatisfied)**
>
> "The exercise practitioner has had a positive impact on our patients with them engaging well and benefiting massively from this support. [The exercise practitioner] now has their own caseload and supports patients both in the community and while an inpatient." — Adult service (Dissatisfied)
>
> "We have a diabetes consultant who does sessions in CFD and musculoskeletal physiotherapists who do sessions in CF." — **Adult service (Satisfied)**

In addition to building expertise within the CF team, several services also specifically mentioned expanding their collaboration and ways of working with non-CF services, ranging from other specialist teams in hospital settings to primary and community services. This was especially the case in adult care.

> "Development of pathways to manage cardiometabolic risk, integrating with cardiology services and primary care. Continued links with diabetology, obstetric, gastroenterology and hepatology services." — **Adult service (Dissatisfied)**
>
> "We are building better communication between GP-led services and CF care." — **Adult service (Dissatisfied)**
>
> "We have links with cardiologist for cardio-pulmonary advice on a monthly basis if required – shared care agreements with local District General Hospital and Women's Hospital for gastro, hepatology and pregnancy/fertility input." — **Adult service (Prefer not to say)**
>
> "Dedicated psychology CF staff are also able to refer patients into the general Health in Mind [Talking Therapies] services (all children across the network) which includes groups, workshops, and specialist therapies, including, this year, a family therapy pilot which some CF families have been referred into." — **Paediatric service (Satisfied)**

Innovations in care delivery were used by several services to streamline clinics, ease communication, and improve experiences of patients and staff. Such innovations included services making use of new technologies and changing how clinics were run. Other services shared that they were planning changes to care delivery in the near future.

> "We have improved the speed of communicating results to young people and their parents by use of text messages." — **Paediatric service (Satisfied if vacancies filled)**

> "SOP developed for the use of home spirometry to clarify – patient selection, use, quality control, maintenance, and infection control." — **Paediatric service (Dissatisfied)**
>
> "We have developed a screening tool to determine which patients it is appropriate and safe to offer a virtual clinic appt for the annual review consultation." — **Paediatric service (Dissatisfied)**
>
> "Parallel clinics – that is, identifying some patients to be reviewed by senior nurse specialists at outpatient appointments – has allowed us to accommodate more patients within clinics when consultant and resident doctor availability is limited." — **Paediatric service (Satisfied)**
>
> "About to start a test with homecare of electronic prescribing for modulator therapy. Also, hoping to formalise the process to record and allow tracking of medication reviews which are done as part of clinic, inpatient admissions or ongoing patient management." — **Adult service (Satisfied)**
>
> "Proposed changes to clinic include changing how liver clinics will run, investigating our pathway for gastro patients, and new format for diabetes clinic following a change in consultant endocrinologist." — **Adult service (Dissatisfied)**

In addition to general changes to care delivery, several services had also implemented initiatives for specific groups, such as teenagers with CF or people with CF diabetes, or offers not directly related to clinical care, such as coffee mornings and parent evenings.

> "We have developed the transition service. We now hold four clinics within the adult setting for patients from the age of 16 up. This allows us to invite patients to this clinic to begin to engage with the adult team in a safe and supported environment." — **Paediatric service (Dissatisfied)**
>
> "We have strong links with our diabetes teams and monthly diabetes/CF MDT and diabetes/CF clinic, and also quarterly diabetes/CF pump clinics run from our unit. These measures help offering the best and most appropriate diabetes/metabolic care including access to GLP-1 analogues when appropriate." — **Adult service (Satisfied)**

Finally, several services shared about local service development, improvement, and research activities.

> "We are undertaking a service development review of our clinic system, from how appointments are booked to patients' attendance and follow-up, as we received feedback from patients and felt staff dissatisfaction about our long clinic appointments." — **Adult service (Dissatisfied)**
>
> "We have a strong commitment to Quality Improvement and currently have 9 active QI groups that are fully multidisciplinary." — **Paediatric service (Dissatisfied)**
>
> "We are looking to develop a 'brand' for the service/team. We hope to involve our patients with this." — **Paediatric service (Dissatisfied)**
>
> "Currently undertaking full workforce planning review, with an aim to ensure all stakeholder needs are still met and plan for the future, taking on board the changed needs of the stakeholders accessing the service currently and in the future. A new model of working is envisaged to deliver patient-focused care and adapt to changed needs of an ageing CF patient population." — **Adult service (Satisfied if vacancies filled)**

Recommendations and next steps

Conclusions

Engagement with the staffing tool has remained high despite increasing staffing pressures across the NHS, with 48 of 58 CF centres/networks contributing in 2025. Findings from our Patient-Reported Experience Measures[20] show that CF teams are still delivering high-quality care, but our staffing tool continues to show that they are stretched.

With vacancy rates above NHS-wide levels, there are staffing gaps in several CF services, and we have repeatedly found that not every CF team includes the core roles recommended in the Standards of Care. There is also little resilience to cover staff absences, particularly for psychosocial and pharmacy staff.

Our recent CF workforce survey[21] found that workload for most professionals working in CF MDTs is evolving, not reducing. There has been positive progress for many but not all with CF due to the availability of modulator therapies, but this has led to a diversification of needs, higher salience of health inequalities, and greater complexity. These new challenges emphasise the need for equitable access to holistic, multidisciplinary CF care, including specialist pharmacists, psychologists, and social workers. They also highlight the increasing importance of collaboration with specialists beyond the CF team, and the need for new pathways to ensure people with CF can access the right care and expertise.

Paediatric and adult services have different staffing configurations and face diverse staffing challenges. Consideration of service type, size, and population is important when trying to address staffing challenges at local and regional levels. Furthermore, each centre's staffing data should ideally be considered in the context of the care model in use, relevant best practice guidelines, and complementary intelligence, such as data on patient experiences and outcomes.

UK-wide recommendations

From insights provided by the staffing tool in 2025 and previous years, we can make some general recommendations that apply across the UK. Using these insights, Cystic Fibrosis Trust will continue to support efforts to ensure all people with CF have access to high quality care.

- Sufficient resourcing of CF services is critical to ensure staffing levels are adequate to meet the evolving and diversifying needs of the CF community. We will continue to advocate and campaign for this, working with the community to ensure their views and feedback are heard.
- Exploring issues around staff recruitment and retention at national level is important to address vacancy challenges and gaps in provision. We will work to understand these issues further, liaising with relevant CF professional interest groups. While the reasons are likely multifactorial, a better understanding will inform projects to tackle some of the key challenges with staffing.
- Continuous monitoring of staffing levels in CF centres and across the CF population as a whole is warranted to understand how these change over time and to identify early trends that could impact CF care delivery. We will keep monitoring this annually with our staffing tool.
- Many services innovate to address staffing challenges and should continue to be encouraged to share learning from the changes they made with others. We will continue to facilitate peer to peer learning through our events and materials for CF professionals.[22]

20 Cystic Fibrosis Trust, Patient-Reported Experience Measures; 2024 www.cysticfibrosis.org.uk/QI

21 Cystic Fibrosis Trust, CF workforce survey insights 2025; 2025 www.cysticfibrosis.org.uk/QI

22 Cystic Fibrosis Trust, Resources for CF professionals; 2026 www.cysticfibrosis.org.uk/about-us/resources-for-cf-professionals

Service-level recommendations

All CF centres that contributed to the staffing tool are issued with a bespoke data summary showing staffing and vacancy levels in their centre or network, compared to average levels from across the full sample. CF MDT staff can review the full report alongside their bespoke centre-level summary.

When exploring staffing challenges, consideration should also be given to the needs of a centre's population, which may also change over time, particularly with increasing availability of modulator therapies. This could be facilitated by regularly capturing and reviewing patient outcomes and experiences, such as, through ongoing contributions to the Trust's UK CF Registry and participation in the staffing tool, as well as future cycles of patient-experience surveys.

If a service identifies any specific issues with their staffing levels, it is important to consider the underlying cause of any shortages in order to address them. For example, a lack of funding for posts needs to be tackled differently to issues with recruitment to existing but vacant posts. A service might also be fully staffed for some professions but lack others entirely.

Depending on local needs and challenges identified, CF centres could consider steps they could take to address these. For example:

- if a centre has longstanding vacancies in a profession and is struggling to recruit to these posts, it could review the recruitment process, including job descriptions and how roles are advertised, seeking advice from professional bodies such as the UK CF Medical or Nursing Association, or UK Psychosocial Professions in CF, to attract candidates
- if a centre has recognised that it needs additional funding for posts, it could use evidence from its staffing summary and the full sample findings, in addition to other intelligence, to develop a business case
- if a centre has identified specific pressures, it could explore innovative solutions to relieve some of these pressures, such as:
  - use of virtual or joint clinics
  - use of digital platforms for efficient communication of test results
  - upskilling existing staff to become non-medical prescribers to reduce pressure on existing prescribers
  - increase provision of services such as remote monitoring and home IVs in the community to relieve pressures on inpatient facilities
  - use alternative roles to deliver some aspects of care, to free up specialist CF staff time for more specialised aspects of care.

Support from Cystic Fibrosis Trust's Quality Improvement team is available: **QI@cysticfibrosis.org.uk**

Our next steps

Cystic Fibrosis Trust is uniting for a life unlimited for everyone affected by cystic fibrosis. Timely access to CF specialist staff is crucial to help ensure people with CF are supported to manage the physical challenges and mental pressures of CF so they can live a fulfilled life.

Cystic Fibrosis Trust will continue to work with CF centres to explore and address staffing challenges at a local level. For example, we support data deep-dives, facilitate planning of targeted quality improvement activities, or advise on business cases based on data insights. Depending on the specific challenges a service is experiencing, existing resources and support offered by Cystic Fibrosis Trust will also be relevant and helpful[23].

Cystic Fibrosis Trust has a range of support services for people living with CF and their families that CF centres can signpost to.

- **Helpline** – practical support and information via our Helpline at **cysticfibrosis.org.uk/helpline**. Email **helpline@cysticfibrosis.org.uk**, call 0300 373 1000, or WhatsApp on 07361 582053.
- **Grants** – a range of welfare grants to help people with CF in times of financial need, including for emergencies, transplant assessments, health and wellbeing, education, prescription prepayment certificates (PPC), and funerals **>cysticfibrosis.org.uk/grants**
- **Benefits support and income maximisation service** – financial entitlement checks and support with applying for benefits, such as DLA, PIP or Universal Credit **>cysticfibrosis.org.uk/benefits**
- **Youth programme** – a dedicated programme of events and activities for children and young people with CF and their siblings **>cysticfibrosis.org.uk/CFyouth**
- **CF Forum** – an online space to connect with others living with or affected by CF **>forum.cysticfibrosis.org.uk**
- **CF Connect** - peer support service for parents of children with CF **>cysticfibrosis.org.uk/cfconnect**
- **Work Forwards** – one-to-one support from employment experts, support with employment rights, and group sessions to learn key employability skills **>cysticfibrosis.org.uk/workforwards**
- **Helen Barrett Bright Ideas Awards** to help people with cystic fibrosis turn their hobbies into new businesses **>cysticfibrosis.org.uk/hbbi**

We will continue to monitor staffing levels in CF centres through our staffing tool. This will be particularly important as models of care change and commissioning responsibilities for CF care in England transfer to regional bodies. We will also continue to improve and update the staffing tool and welcome feedback **QI@cysticfibrosis.org.uk**

23 Cystic Fibrosis Trust, 2024: **www.cysticfibrosis.org.uk/the-work-we-do/support-available**

Glossary

Word/phrase	Meaning
Centre	Hospital providing expert care and specialised disease management to people living with cystic fibrosis
CF	Cystic Fibrosis
CFD	CF Diabetes
CFTR modulators	CFTR modulators and modulator therapies, also known as 'precision medicines', work to tackle the underlying cause of cystic fibrosis (ie the underlying genetic mutations) by helping to make the CFTR protein work effectively
Clinic	Regional hospital or site where treatment is provided locally for people with CF; clinics are linked to a centre hospital / CF team via a Network
CNS	Clinical Nurse Specialist
Community support	Care that is delivered locally, ie in the community or at your home
CF Service Specification	Standards of care issued by NHS England that adult and paediatric CF centres in England are working to
FTC	Fixed-term contract, a time-limited type of employment
Home IVs	Intravenous antibiotic therapy given in the patient's home
Median	The middle value (number) when all values in a series are arranged from smallest to largest
MDT	Multidisciplinary team; your CF team made up of each discipline ie nurse, physio, social worker, dietitian, *etc*
Network	A CF centre and its linked clinics form a Network
PREMs	Patient-Reported Experience Measures
QI	Quality Improvement – a framework to systematically improve the ways care is delivered to patients
QI WG	Quality Improvement working group – a group of health professionals and people with CF/family members helping the Trust's QI team to work to improve the way CF care is delivered
Range	Smallest to largest value in a series
SOP	Standard Operating Procedure, a protocol that describes a process to standardise it
Staff time	In this report, 'staff time' is time contracted for CF and funded from the CF budget, this includes patient-facing as well as administrative and other CF-related activity
Standards of Care	3rd edition of Cystic Fibrosis Trust's recommended best practice guidelines for CF services (published August 2024)
WTEs	Whole Time Equivalents (also sometimes called 'Full Time Equivalents'; FTEs)

Cystic Fibrosis Trust

Cystic Fibrosis Trust is the charity uniting people to stop cystic fibrosis. Our community will improve care, speak out, support each other and fund vital research as we race towards effective treatments for all.

We won't stop until everyone can live without the limits of cystic fibrosis.

cysticfibrosis.org.uk

Uniting for a life unlimited