NHS England

GIRFT
GETTING IT RIGHT FIRST TIME

Optimising care for patients with inflammatory bowel disease (IBD)

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BRITISH SOCIETY OF GASTROENTEROLOGY

CROHN'S & COLITIS UK

The Association of Coloproctology of Great Britain & Ireland

The Dukes' Club

Contents

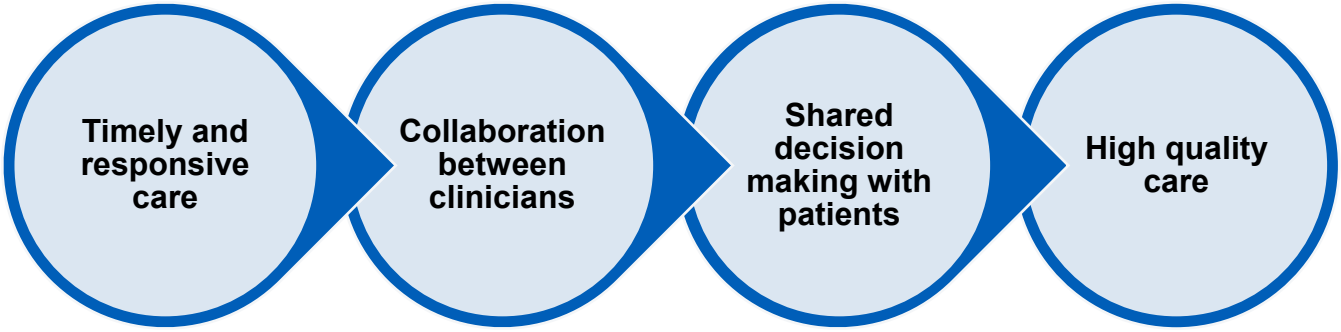
Introduction

Inflammatory bowel disease (IBD) is estimated to affect around 500,000 people in the UK[1]. IBD is a long term condition which has periods of relapse and remission meaning it can significantly affect people's quality of life. Early and co-ordinated care enables timely initiation of treatment and appropriate consideration of surgery, helping to reduce emergency admissions and readmissions.

Effective management of IBD relies on a holistic, integrated approach, with clinicians working collaboratively - both with each other and with patients - to deliver personalised, evidence-based care. Effective shared decision-making with patients must be embedded throughout the patient pathway as it key to ensuring the delivery of high quality care.

Unwarranted variation in the different aspects of IBD care has been identified around the country hence the need to improve services.

Figure 1: Core elements of high quality IBD care



A range of clinical guidelines and standards can be used support the improvement of IBD services. Some key examples include:

- The Association of Coloproctology of Great Britain and Ireland (ACPGBI) Consensus Guidelines in Surgery for Inflammatory Bowel Disease
- British Society of Gastroenterology (BSG) guidelines on IBD in adults: 2025
- BSG guidelines on colorectal surveillance in IBD
- European Crohn's and Colitis Organisation (ECCO) Guidelines
- IBD UK's Consensus standards of healthcare for adults and children with IBD
- NCEPOD's Making the Cut?

This handbook aims to align with and complement these publications.

[1] *IBD UK, 2021. Crohn's and Colitis Care in the UK: The Hidden Cost and a Vision for Change*

About this handbook

This handbook offers practical advice to help services to optimise care for patients with IBD. It is not new clinical guidance or a comprehensive guide to clinical care but is informed by evidence-based publications and multidisciplinary expertise.

Across the country, there are many examples of effective and innovative IBD services. However, during GIRFT visits we have noted that clinical guidance is not consistently implemented in practice. This handbook aims to address that gap by sharing learning, highlighting proven solutions, and describing key actions that can be applied locally. In doing so, it supports the national ambition set out in Fit for the Future: The 10 Year Health Plan for England to take the best of the NHS to the rest of the NHS.

The content of the handbook prioritises key messages from published IBD guidance and describes how to translate them into operational improvements across the patient pathway. It also signposts to relevant resources, including metrics and reports, to support local implementation.

Commissioners, managers and clinicians working in IBD services are encouraged to review the key messages and implement the recommended actions where they are not already in place. This will support improving patient experience, increasing productivity and overall optimisation of IBD care.

1. Organisation

Context

Delivery of holistic, high-quality care for patients with IBD requires strong leadership and a collaborative approach. An effective IBD service should be led by a team that takes responsibility for overseeing service management, monitoring performance and driving continuous improvement.

Multiple specialties and services are involved in the delivery of IBD care, and it is essential that they take a joint approach to all aspects of care including emergency care. Some services have established a Digestive Health Directorate to achieve this aim. These directorates/teams focus on how providers organise and deliver services, typically bringing together Gastroenterology, Colorectal Surgery, Upper Gastrointestinal (GI) Surgery, and GI Endoscopy under a single, managed service model.

Key messages

- Effective communication and co-ordination between the different specialists involved in IBD care is essential for providing optimal patient care.
- Breaking down professional silos improves the efficiency and quality of patient care.
- Services should have succession planning in place to ensure continuity and resilience.

Action checklist - Organisation	
☑	The IBD service has a dedicated leadership team which includes a senior gastroenterologist, colorectal surgeon, IBD nurse specialists (medical and surgical) and manager.
☑	An annual plan has been developed for the service which includes named leads for key activities and timeframes for completion.
☑	The IBD leadership team work in partnership with specialist dietitians and pharmacists, who have expertise in IBD, to support nutrition and robust medicines governance.
☑	Ideally, the IBD leadership team work in partnership with psychologists to support the mental wellbeing of people living with IBD.
☑	Joint or parallel medical and surgical outpatient clinics for IBD are in place to facilitate effective cross disciplinary working, with access to the multidisciplinary team (MDT) available as required.
☑	Cross disciplinary working between medical and surgical teams is the standard approach to managing inpatient care. See the section on Surgery and the appendices for more details.

Resources

Guidance:

- **BSG Guidelines on IBD in adults: 2025**
- **IBD UK Consensus standards of healthcare for adults and children with IBD, Section 1: The IBD Service**
- **NHS England Digestive Health Directorates: A clinical and operational guide**

Case studies:

- **Case study: IBD Specialist Pharmacy Service, Brighton & Sussex University Hospitals Trust**
- **Case study: The role of a specialist IBD pharmacist in a virtual biologic clinic, Lancashire Teaching Hospitals**

2. Research and training

Context

In addition to the operational and clinical priorities already outlined, the delivery of high-quality, holistic care for patients with IBD depends on the training and development of the healthcare workforce. Active involvement of resident doctors in gastroenterology, colorectal surgery, radiology and pathology, as well as trainees in nursing, dietetics, psychology and pharmacy, is essential to build the knowledge, skills and collaborative working needed for effective IBD care.

Alongside workforce development, research is vital to advancing the care of people with IBD. Current therapies are not curative, and many important questions remain unanswered in relation to disease mechanisms, prevention strategies, personalisation of care and long-term outcomes.

Key messages

- Exposure to IBD pathways enables resident doctors and trainees to gain experience in working as part of an MDT, co-ordinating complex care, communicating across disciplines and advocating for the holistic needs of patients.
- Supporting structured learning opportunities in IBD contributes to workforce sustainability and succession planning.
- IBD research is key to delivering improvements in diagnosis, treatment and quality of life for patients.

Action checklist – Research and training	
☑	Resident doctors and trainees from all of the relevant disciplines observe and actively participate in joint/parallel clinics, as well as other collaborative working arrangements between medical and surgical teams.
☑	Resident doctors and trainees from all of the relevant disciplines included in the MDT are given the opportunity to participate in MDT meetings, for example, by preparing and presenting cases.
☑	Early exposure to training in IBD surgery, particularly advanced and minimally invasive techniques, and simulated learning is actively encouraged. Attendance at accredited educational activities is recommended to support skill development - see the resources section for further information.
☑	Early exposure to training in IBD endoscopy, particularly disease assessment and cancer surveillance, is actively supported, with simulated learning incorporated wherever possible.

Action checklist – Research and training	
☑	Resident doctors and trainees are encouraged to participate and contribute to locally, nationally and/or internationally led collaborative research. Where feasible, ongoing research is highlighted at the IBD service's governance or MDT meetings.

Resources

- **The Association of Coloproctology of Great Britain and Ireland (ACPGBI) – Courses, events and webinars (ACPGBI membership required)**
- **The Dukes' Club – Training and exams (The Dukes' Club membership is via ACPGBI affiliated membership)**
- **BSG – Endorsed IBD Fellowships**
- **BSG – Trainee Research Networks**
- **Bowel Research UK & ACPGBI Colorectal trials research app (registration is required)**

3. The multidisciplinary team (MDT)

Context

IBD is a complex and variable condition that affects individuals differently in terms of its physical and psychological impact. People with IBD therefore need care from an MDT that is patient-centred, responsive and effectively co-ordinated.

The core MDT must have the appropriate skills and knowledge to manage IBD, and they must work with general practitioners (GPs) and other supporting services to ensure joined up care. Effective communication within the MDT, between services and with primary care, should be supported by good record keeping and timely information sharing. The views of the patient should be central to MDT discussions and the options for treatment or care should be discussed with patients as part of a shared decision-making approach.

Services must be designed to enable the MDT to support patients with IBD in a timely and responsive way. When this is not in place, it can significantly impact on patient experience and outcomes and can also lead to increased costs for services.

Key messages

- All local areas should have access to a dedicated IBD team.
- The MDT should support and collaborate with people with IBD in relation to all aspects of their care, including urgent or emergency care that may include surgery, throughout the patient pathway.
- Core MDT roles should have dedicated time for IBD outpatient and inpatient activity, with job plans reflecting their contribution to clinical care, service development and audit.

Action checklist – MDT	
☑	A defined MDT is in place and is led by a named adult or paediatric consultant/experienced senior clinician who has job planned time for this role.
☑	The IBD MDT has the following core membership: IBD physician, surgeon, clinical nurse specialists (medical and surgical), radiologist and histopathologist. Ideally, wider membership should include a dietitian, pharmacist and psychologist. All of these roles have expertise in IBD.
☑	The IBD MDT has weekly (or frequently enough to ensure decision-making is not delayed) meetings that are run by a named co-ordinator. During these meetings they discuss patients with complex needs, diagnostic uncertainty or dysplasia, inpatients, those who potentially need surgery and post-operative patients.

Action checklist – MDT	
☑	Job plans for core members of the MDT include dedicated time for IBD care and leadership.
☑	Access to psychological support for patients with IBD is available within the service or via referral pathways.
☑	Decisions made about patient care during MDT meetings are recorded and documented in patient records and then communicated with the patient and their GP[2].
☑	A formal process is in place for auditing outcomes of patients discussed or treated by the MDT.

Resources

- **BSG Guidelines on IBD in adults: 2025**
- **IBD UK Consensus standards of healthcare for adults and children with IBD Section 1: The IBD Service**
- **NCEPOD Making the Cut?**
- **NICE Shared decision making guideline**
- **BMJ A three-talk model for shared decision making: multistage consultation process**

[2] *NCEPOD Making the Cut? Chapter 4: Elective Surgery.*

4. Access to specialist input

Context

Patients with IBD benefit from timely access to specialist advice throughout the course of their disease from diagnosis, when experiencing flares, during admission and soon after hospital discharge. Consistent access to expert input improves disease control, reduces the need for emergency care and supports patients' confidence in managing their condition.

Specialist IBD advice should be readily available for both planned and emergency care and should be responsive to patient need. Ambulatory or Same Day Emergency Care (SDEC) should be used to avoid admission for patients who present acutely but are clinically stable. Establishing ambulatory/SDEC pathways enables timely specialist input, reduces admissions and improves patient experience.

Key messages

- Patients referred with suspected IBD should have access to specialist review or attend a 'straight to test' procedure within 4 weeks in line with the NICE quality standard for IBD. Services should undertake regular audit to monitor achievement of this target.
- Services should have an urgent pathway in place for suspected IBD which includes the faecal calprotectin result.
- Patients with IBD should have timely access to specialist advice and investigations.
- Mechanisms should be in place to support remote specialist advice.

Action checklist - Access to specialist input	
☑	Advice and guidance services are available for GPs and other referring clinicians to access advice from IBD specialists.
☑	Policies and pathways for referral of suspected IBD have been agreed locally by primary and secondary care.
☑	Members of the IBD team facilitate direct access to specialist advice or referral to other specialities e.g. dermatology or rheumatology, for IBD related problems.
☑	An IBD nurse-led telephone/email advice line is in place. The service collects data on the number of contacts and time taken to resolve queries to inform job planning.
☑	Patients have access to rapid review pathways, supported by digital solutions where possible, when experiencing flares or complications.
☑	IBD specific ambulatory/SDEC pathways, with defined referral criteria, are in place to facilitate timely access to imaging, endoscopy and specialist opinion for acute presentations.

Action checklist - Access to specialist input	
☑	Mechanisms are in place to notify the IBD team within 24 hours of any IBD patient that has presented as an emergency, regardless of whether they are admitted. Ideally this should be via an automated, digital flag. See the resources section for an example of a tool used to share daily alerts between the Emergency Department (ED) and the IBD service.

Resources

Guidance:

- **NICE Inflammatory bowel disease quality standard**
- **IBD UK Consensus standards of healthcare for adults and children with IBD**

Tools and pathways:

- **GIRFT Gastroenterology Advice & Guidance Toolkit**
- **Stockport NHS Foundation Trust – ED alert system tool for IBD patients**
- **GIRFT IBD Pathway**
- **NHS Birmingham and Solihull IBD pathways**

Case study:

- **Hull University Teaching Hospital @ IBD Hull (Start of the) journey to digitalizing IBD care – presentation and video recording**

5. Diagnostics

Context

Diagnosis and management of IBD involves several investigations. It is important that these are undertaken and reported in a timely way to ensure that patients with IBD receive appropriate treatment and support as early as possible. To achieve this, primary care, secondary care, and specialties within secondary care including emergency medicine, must collaborate and have clearly documented protocols in place.

Delayed diagnosis of IBD is associated with disease progression and a higher likelihood of requiring bowel surgery, compared with patients diagnosed more promptly.[3] There is a clear need for more timely diagnosis of IBD to ensure better long-term outcomes for patients and efficient use of resources.

Key messages

- Clear pathways and standardised protocols, including the use of faecal biomarkers (calprotectin and/or faecal immunochemical testing (FIT) in adults), help to accelerate diagnosis and improve patient outcomes.
- Timely access to investigations and tests for patients presenting acutely is essential.
- IBD services should undertake regular audit and review of diagnostics to ensure efficient use of resources and delivery of effective care.

Action checklist – Diagnostics	
☑	Pathways for the investigation of suspected IBD include the availability of faecal biomarker testing (i.e. calprotectin and/or FIT).
☑	Emergency admissions for patients with suspected IBD who have waited longer than 6 weeks for endoscopic investigations are subject to a clinical incident review. Cases should be investigated appropriately, and any learning disseminated to the wider service to support continuous improvement.
☑	Radiological investigations and endoscopic assessments are accessible within 24 hours for inpatients when considered clinically necessary.
☑	The service has a named GI pathologist who provides specialist pathology input into the IBD MDT.
☑	Histopathology turnaround time is audited regularly.
☑	Pathology results for patients with suspected IBD are reported by a pathologist with a specialist interest in GI disease.

[3] *Jayasooriya, N., Baillie, S., Blackwell, J. et al, 2023. Systematic review with meta-analysis: Time to diagnosis and the impact of delayed diagnosis on clinical outcomes in inflammatory bowel disease.*

Action checklist – Diagnostics	
☑	The service has a named GI radiologist who provides specialist radiology input into the IBD MDT.
☑	IBD service providers have undertaken a demand and capacity exercise for MR Enterography (MRE) to help to understand and address gaps in provision.
☑	A scoring system is used by endoscopists to record inflammatory disease activity to help ensure consistent interpretation of disease severity. Examples of established scoring systems include the Modified Mayo Endoscopic Score (MES), Ulcerative Colitis Endoscopic Index of Severity (UCEIS) or Simple Endoscopic Score for Crohn's Disease (SES-CD).
☑	Patients who are diagnosed with IBD in the endoscopy unit are provided with contact details for the IBD helpline before they leave the unit.
☑	A mechanism (ideally digital) is in place to flag patients who are newly diagnosed with IBD to the IBD team within 1 working day.
☑	There is an agreed pathway in place for patients who have been diagnosed with IBD via the urgent suspected cancer pathway to be referred to the gastroenterology service. All relevant information - including the patient's symptoms, test results and clinical history - is shared with the gastroenterology team at the point of referral.

Resources

Pathways:

- **What's up with my gut? National Primary Care Diagnostic Pathway for lower GI symptoms**
- **GIRFT IBD Pathway**

Guidance:

- **NICE Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel diagnostics guidance**
- **IBD UK Consensus standards of healthcare for adults and children with IBD**
- **ECCO-ESGAR Guideline for Diagnostic Assessment in IBD Part 1: Initial diagnosis, monitoring of known IBD, detection of complications**
- **ECCO-ESGAR Guideline for Diagnostic Assessment in IBD Part 2: IBD scores and general principles and technical aspects**

Data collection:

- **NHS England DM01 Diagnostics Waiting Times and Activity**

Case studies and scenarios:

- **IBD UK Case study: Endoscopy algorithm, Kingston Hospital NHS Foundation Trust including a downloadable algorithm**
- **NHS RightCare scenarios - Optimal pathway for IBD – Hannah's story**
- **Case study: Faecal calprotectin referral pathway, Stockport NHS Foundation Trust**

6. Medical management

Context

Medical management of IBD aims to induce and maintain remission, minimise complications and avoid admissions. Rapid access to effective therapy, education, proactive disease monitoring and personalised care plans are central to achieving these goals. It follows that patients are more able to manage their symptoms and have better long-term outcomes.

Advances in therapeutic options have increased the complexity of decision-making and highlighted the need for shared decision-making and robust monitoring frameworks. Patient reported outcome measures (PROMs) can be used to support patient-centred care and monitor the quality of care provided by the service. A digital system should be used to enable efficient and accurate collection and monitoring of electronic PROMS.

Key messages

- Prompt diagnosis and initiation of treatment improves outcomes. Therapies should be initiated in line with national guidelines and monitored for efficacy and safety.
- Personalised management plans and flare plans are important tools to support patients to manage their symptoms and should be developed with the patient using shared decision making principles.
- Non-adherence and deteriorating PROMS scores should trigger a structured review.

Action checklist – Medical management	
☑	A standard operating procedure (SOP) is in place to guide endoscopists in starting treatment or referring patients to the IBD team, both for newly diagnosed patients and for those presenting with a flare in the endoscopy unit.
☑	Services provide easily accessible information, signposting and referral to education resources to enable patients to manage their condition effectively.
☑	Patients have a flare plan and management plan that they have developed in collaboration with their care team and that is communicated to the patient and GP.
☑	The frequency of reviews is agreed with the patient and includes access to supported self-management and Patient Initiated Follow Up (PIFU).
☑	Patients receiving IBD therapies are reviewed at appropriate clinical intervals to assess response and adjust treatment where necessary. When appropriate reviews can be undertaken via remote/digital platforms.
☑	Patients with IBD who are admitted to hospital for medical treatment receive venous thromboembolism (VTE) prophylaxis unless contraindicated.

Action checklist – Medical management	
☑	A multidisciplinary approach involving gastroenterology, hepatology, rheumatology, dermatology and ophthalmology is adopted for the management of extra-intestinal manifestations whenever possible.
☑	Relevant disease information is recorded in a shared care record that is accessible by all members of the care team including primary care.
☑	Any changes to treatment plans - whether initiated in primary or secondary care - are clearly documented and communicated to all relevant parties within 2 days to ensure continuity and safety of care.
☑	Clinical, biochemical, radiological and endoscopic remission is confirmed before de-escalating therapy. This will help to minimise the risk of future flares or relapse.
☑	A system is in place to ensure that IBD patients receive recommended vaccinations, and the service actively promotes uptake of age-appropriate national cancer screening, recognising the increased cancer risk in this population.
☑	All patients with IBD are advised to stop smoking, and national guidance on smoking cessation is followed.
☑	A system is in place to identify patients with IBD who require colonoscopy surveillance and appropriate recall intervals are agreed. See Appendix 3 for further information.

Resources

Guidance:

- **BSG Guidelines on IBD in adults: 2025**
- **BSG Guidelines on colorectal surveillance in inflammatory bowel disease**
- **IBD UK Consensus standards of healthcare for adults and children with IBD**
- **ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment**
- **ECCO Guidelines on Therapeutics in Ulcerative Colitis: Medical Treatment**
- **NICE Shared decision making guideline**

Model & case study:

- **BMJ A three-talk model for shared decision making: multistage consultation process**
- **Case study: New diagnosis clinic, St Mark's Hospital**

7. Surgery

Context

Timely surgical intervention, delivered by appropriately specialised surgeons, is associated with improved outcomes for patients with IBD for both emergency and elective surgery. Optimal care requires a shared approach between medical and surgical teams when considering and performing surgery. Patients having IBD surgery should be supported by the wider MDT throughout the surgical pathway.

Emergency complications of IBD are serious and require rapid decision-making and regular assessment. The complexities of complications such as acute severe ulcerative colitis, bowel perforation and perianal Crohn's disease mean that a multidisciplinary approach is essential.

See the appendices for actions required for specific emergency complications of IBD.

Key messages

- Patients requiring emergency IBD care should be admitted to a centre that has the skills and expertise to support them.
- Early joint decision making for emergency and elective surgery for patients with IBD is key to ensuring good outcomes for patients.
- Once the decision to operate has been made, it is important to ensure surgery is scheduled at the optimal time. Unnecessary delays can lead to deterioration in patients awaiting elective surgery. This can result in patients requiring emergency surgery and consequently experiencing poorer outcomes.
- Co-ordinated working between the medical and surgical teams to develop a clear plan regarding optimisation before and after surgery is essential.

Action checklist - Surgery	
☑	The IBD MDT refers patients for surgical consideration when they are not responding to, or relapsing after, medical treatment or when the patient expresses a preference for surgery over initiation or continuation of drug therapy.
☑	The service has named surgeons with a specialist interest in IBD who provide surgical input to the MDT and undertake elective resections for IBD. They are supported by specialist nurses with experience in IBD surgery and stoma care to bridge the gap between medicine and surgery.
☑	Joint medical and surgical care for inpatients is delivered via joint discussions, assessments and ward rounds, and collaborative decision-making. This

Action checklist - Surgery	
	approach may also be supported by the use of designated GI wards for patients with IBD.
☑	Protocols are in place to ensure multimodal optimisation of medical therapy, nutritional status, corticosteroid wean, drainage of sepsis and treatment of anaemia before surgery.
☑	Postoperative VTE prophylaxis is extended to 28 days for patients undergoing surgery for IBD unless contraindicated.
☑	Surgery is undertaken within 4 weeks of the patient being considered as optimised. Services undertake regular audits of time from patient optimisation to surgery being undertaken.
☑	Postoperatively, the IBD team proactively review the plan for ongoing medical therapy with the patient. This discussion may include the pharmacist and/or IBD nurse and should take place before discharge where possible.
☑	A written postoperative plan is in place and is shared with the MDT, primary care and the patient before discharge.
☑	Post-discharge follow-up is routinely scheduled with both the gastroenterology and surgical teams.

Resources

- **BSG Guidelines on IBD in adults: 2025**
- **NCEPOD Making the Cut? – recommendations 5 – 9.**
- **IBD UK Consensus standards of healthcare for adults and children with IBD – section 5.**
- **Brown, S.R. and Pinkney, T.D Editorial May 2025 emergency laparotomy for Crohn's disease – Should it be a 'never event'? (login required)**
- **ECCO Guidelines on Therapeutics in Crohn's Disease: Surgical Treatment**
- **ECCO Guidelines on Therapeutics in Ulcerative Colitis: Surgical Treatment**
- **ACPGBI Consensus Guidelines in Surgery for Inflammatory Bowel Disease**

8. Data and metrics

Context

Regular data collection and review of performance is essential to improving outcomes for people with IBD. Good quality data and metrics allow services to understand performance, identify unwarranted variation in care and drive improvement. Consistent review of data and metrics helps services to monitor patient experience and outcomes, support workforce planning and ensure resources are being used efficiently.

The move from analogue to digital systems is key to maximising the impact of data and metrics. Digital solutions enable automated data collection and asynchronous working, reduce duplication, and support the development of real-time dashboards that clinicians and managers can use to monitor performance.

Key messages

- Accurate clinical coding is central to understanding activity and outcomes in IBD services, particularly as the majority of care is delivered in an outpatient setting. Embedding digital systems and pathways supports this by ensuring that the clinical record is complete, structured, and available to coders in a timely manner.
- AI-enabled tools have the potential to further support coding by pre-populating structured fields, flagging inconsistencies, and prompting clinicians to provide the necessary detail for accurate coding.
- Digital processes and pathways allow continuous data capture, and the resulting data can then be fed back into pathway design. For example, if dashboards show high steroid dependency or delays in biologic initiation, services can redesign digital processes to address those gaps.
- Patient-Reported Experience Measures (PREMS) are an essential tool for supporting services to understand patient perceptions of the service and identify areas to focus on for service improvement.

Action checklist – Data and metrics	
☑	Metrics relevant to IBD services, such as those available via Model Health System (MHS) and the National Consultant Information Programme (NCIP) are regularly viewed, discussed and understood during governance meetings/IBD service meetings.
☑	Clinicians in the IBD service work with data analysts and coders to ensure a common understanding of the data that is available and required. There should be a particular focus on improving coding of outpatient care.

Action checklist – Data and metrics	
☑	Local or regional dashboards are developed, using locally collected and routine Hospital Episode Statistics (HES) data, to monitor the four key performance indicators proposed by the BSG (see below for further information).
☑	A structured dataset may include information incorporating IBD disease classification[4], IBD KPIs and other variables such as outcomes including hospitalisation, surgery and impact on quality of life.

Key national metrics – medical management

Model Health System:

- Emergency admission rate for patients with ulcerative colitis
- Emergency length of stay for patients with ulcerative colitis
- Emergency readmission rate within 30 days following an admission for ulcerative colitis
- Emergency admission rate for patients with Crohn's Disease
- Emergency length of stay for patients with Crohn's Disease
- Emergency readmission rate within 30 days following an admission for Crohn's Disease

Key national metrics – surgical management

National Consultant Information Portal (NCIP):

- Colectomy for Crohn's disease (age 17+, elective)
- Colectomy for ulcerative colitis (age 17+, elective)
- Anorectal fistula operations (age 17+, elective)

BSG proposed key performance indicators for IBD

The BSG[5] has suggested the following as KPIs for IBD:

- Time from primary care referral to diagnosis in secondary care.
- Time to treatment recommendation following a diagnosis.
- Appropriate use of steroids and advanced therapies pre-screening and assessment.

[4] *Satsangi J., Silverberg M.S, Vermeire S., Colombel J., 2006. The Montreal classification of inflammatory bowel disease: controversies, consensus, and implications. Gut. 55 (6): pp.749-53.*

[5] *Quraishi MN., Dobson E., Ainley R., et al, 2023. Establishing key performance indicators for inflammatory bowel disease in the UK. Frontline Gastroenterology 14: pp.407-414.*

Appendix 1: Management of acute severe colitis

Acute severe colitis is a potentially life-threatening condition. Patients need fast and close monitoring and review by appropriate specialists.

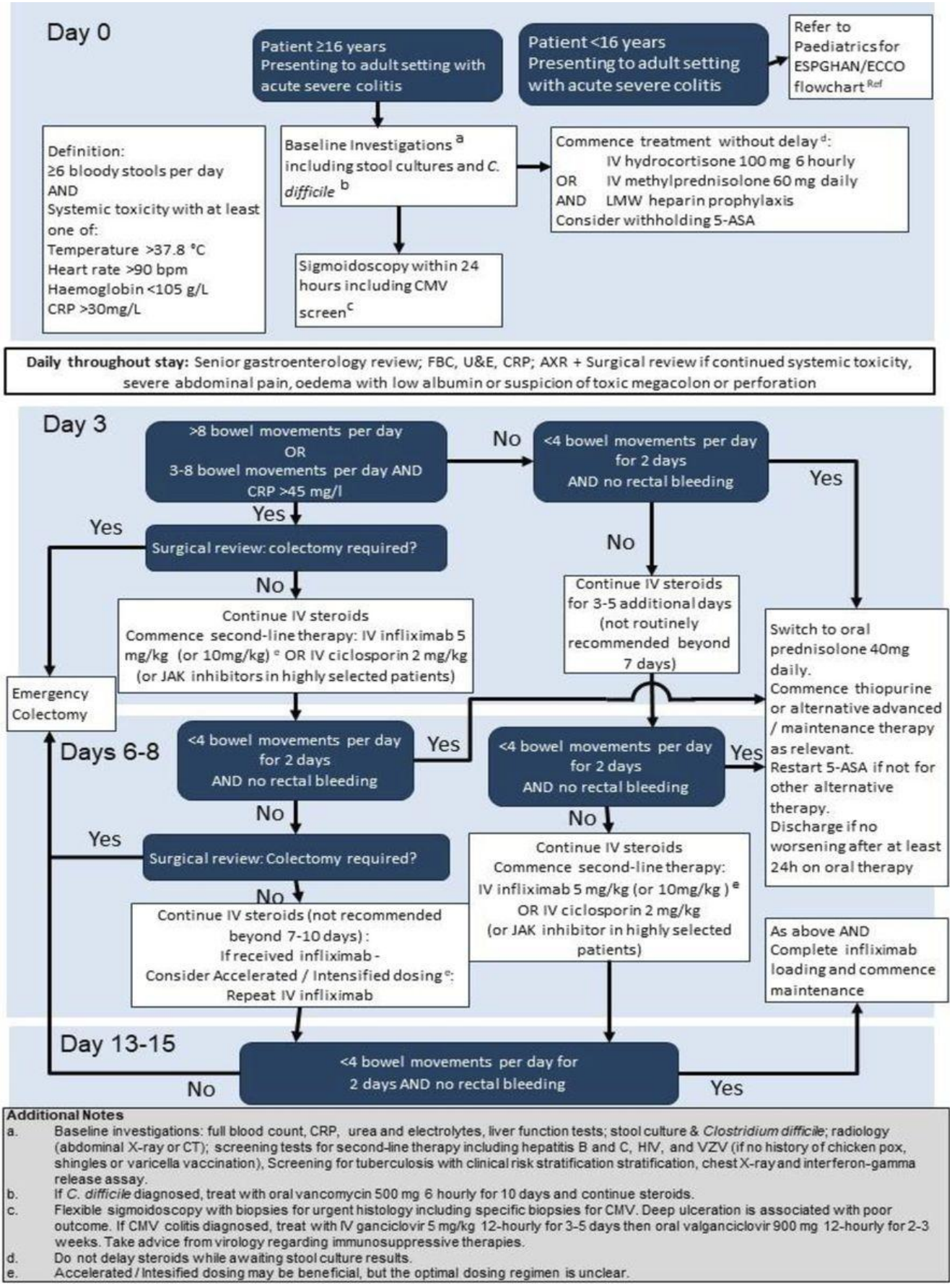
The following are key actions for this group of patients:

- Admit patients presenting with acute severe colitis to a centre with medical and surgical expertise in managing IBD that is available at all times[6].
- Undertake daily review, by appropriate specialists, for patients who are admitted with acute severe colitis[7].
- Assess and document the likelihood of requiring surgical intervention at the point of admission. This assessment should be revisited and recorded daily as part of routine review[8].

See the BSG guidelines on IBD in adults: 2025 figure 4: Management of acute severe colitis on the next page and the ECCO e-guide algorithm on acute severe colitis for more information.

[6] *IBD UK Consensus standards of healthcare for adults and children with IBD, Pre-Diagnosis section, statement 2.3.*
[7] *IBD UK Consensus standards of healthcare for adults and children with IBD, Inpatient Care section, statement 6.4.*
[8] *NICE Guideline on Ulcerative colitis: management, recommendation 1.2.26.*

British Society of Gastroenterology: Management of acute severe colitis[9]



[9] Reproduced from the British Society of Gastroenterology guidelines on inflammatory bowel disease in adults: 2025, Moran, G.W, Gordon M, Sinopoulou, V., et al, Gut 2025;74: s1-s101 with permission from BMJ Publishing Group Ltd.

Appendix 2: Management of acute Crohn's disease

Acute Crohn's disease presents a significant challenge for multidisciplinary teams, requiring an individualised approach to achieve the best results for patients.

Assessment and initial management

Rapid multidisciplinary evaluation:

- Patients with suspected acute Crohn's disease should be nursed on a specialist gastroenterology or colorectal surgery ward under the care of a named consultant in gastroenterology or colorectal surgery.
- Early assessment by core members of the IBD MDT (IBD physician, surgeon, clinical nurse specialist, radiologist and histopathologist) by means of in-reach into assessment areas (Surgical Assessment Unit (SAU) and Medical Assessment Unit (MAU)).
- Use cross-sectional imaging (usually CT scanning in an emergency situation) and endoscopy (where safe) to determine disease extent, localisation, and the presence of strictures or penetrating complications.
- Urgent CT scans should be reported within 4 hours of request.[10] [11]

Optimising patients for surgery

Optimisation should be prioritised from the moment of acute presentation.

Medical optimisation

- **Sepsis management**: Early recognition and aggressive management of sepsis are critical. Drain intra-abdominal collections radiologically when feasible to defer surgery and allow optimisation. If interventional radiology is not available on site, there should be a formal service level agreement (SLA) with a nearby organisation to provide this service.
- **Nutritional support:** Malnutrition is common in acute Crohn's disease and correlates with adverse post-operative outcomes. Assess nutritional status on admission and commence nutritional support promptly.
- **Medication review:** Review and appropriately modify immunosuppressants (steroids, thiopurines, biologics) in a multidisciplinary setting, balancing the need to control

[10] *NHS England, 2023. Diagnostic imaging reporting turnaround times*
[11] *NHS England, 2017. Seven Day Services Clinical Standards: Diagnostics*

inflammation with perioperative risks. Taper corticosteroids prior to surgery, when possible, to reduce infection and wound-healing complications.

- **Optimising comorbidities:** Proactively manage comorbid conditions - such as diabetes, anaemia, and cardiovascular disease - to reduce surgical risk.
- **Prehabilitation:** Where feasible, encourage physical activity and functional optimisation pre-operatively. Support from smoking cessation services is particularly important in this patient group.

Defining and timing “urgent elective” surgery

- **Identification of patients for surgery:** Involve colorectal surgeons at an early stage for patients with refractory disease, intra-abdominal sepsis, or obstruction.
- **Deferral of Surgery:** In suitable patients, defer surgery to allow nutritional and medical optimisation.
- **Shared Decision-Making:** Engage patients in the decision process, discussing the rationale for optimisation and the aims of urgent elective versus emergency surgery.

Service delivery and pathway co-ordination

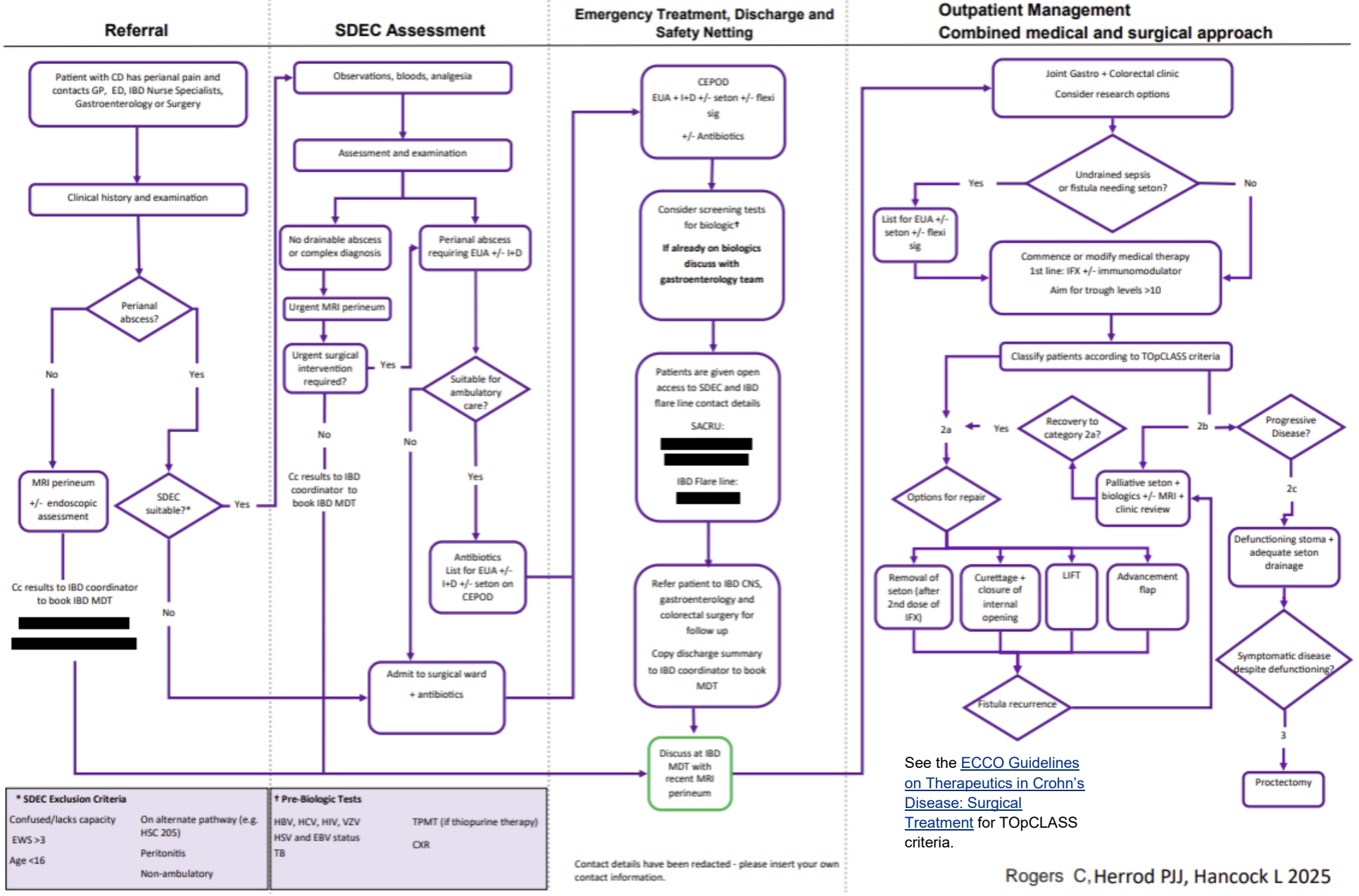
Streamlined and standardised pathways:

- Develop clear protocols to ensure rapid identification, referral, assessment, and escalation of patients with acute Crohn’s disease. See the next page for an example of an established perianal Crohn’s disease pathway.
- Early engagement of surgical teams, dietetics, and specialist nurses should be embedded within local pathways.
- Regularly audit outcomes of acute Crohn’s disease admissions, focusing on rates of emergency versus urgent elective operations, length of stay, complications, and 30-day readmissions. Utilise results to drive continuous service improvement.

Emergency surgery for a patient with Crohn’s disease who is awaiting elective surgery should be considered as a systems failure and be subject to a clinical incident review. Cases should be investigated appropriately, and any learning disseminated to the wider service to support continuous improvement.

Manchester Perianal Crohn's Disease Pathway

NHS Manchester University NHS Foundation Trust



See the ECCO Guidelines on Therapeutics in Crohn's Disease: Surgical Treatment for TOpCLASS criteria.

Rogers C, Herrod PJJ, Hancock L 2025

Appendix 3: Colorectal surveillance in IBD

Despite advances in therapy, surveillance and risk reduction, patients with IBD continue to have a higher risk of colorectal cancer and related mortality than the general population.

At service level, the key priorities for IBD colorectal surveillance are to ensure patients receive colonoscopy at the correct interval for their risk, and that any dysplasia detected is managed appropriately. Timely colonoscopy is essential, as dysplasia and early cancer can only be detected at a curable stage if patients are scoped on schedule. It should be noted that patients who have a pouch or have had most of the large bowel removed but still have the lower part of the bowel (the rectum), may also need regular surveillance.

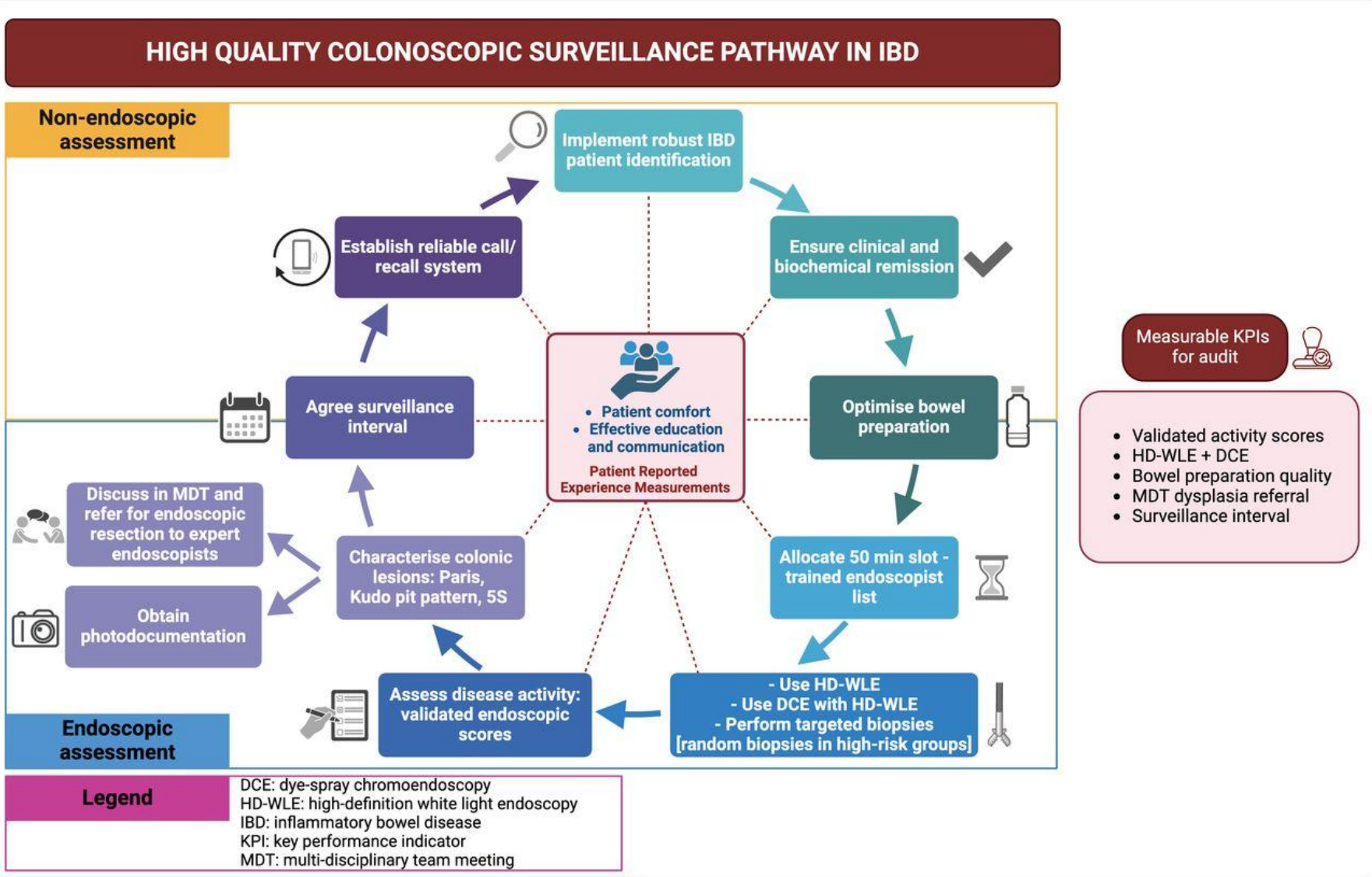
Using a tool to calculate estimated cancer risk is beneficial for informing discussions about required surveillance intervals. See the IBD Advanced Colorectal Neoplasia (aCRN) Risk Assessment Tool: Online Calculator for an example of an evidence-based model.

Achieving concordance rates above 70% for initial risk assessment at 8 years (for all patients with colonic IBD beyond proctitis) and subsequent surveillance intervals is achievable, but requires well-organised services supported by systematic, automated and personalised reminders.[12]

The BSG guidelines on colorectal surveillance in IBD have produced a High Quality Colonoscopic Surveillance Pathway in IBD and Risk Stratification for IBD Surveillance Flowchart. See figures 1 and 2 for reproduced versions of these infographics.

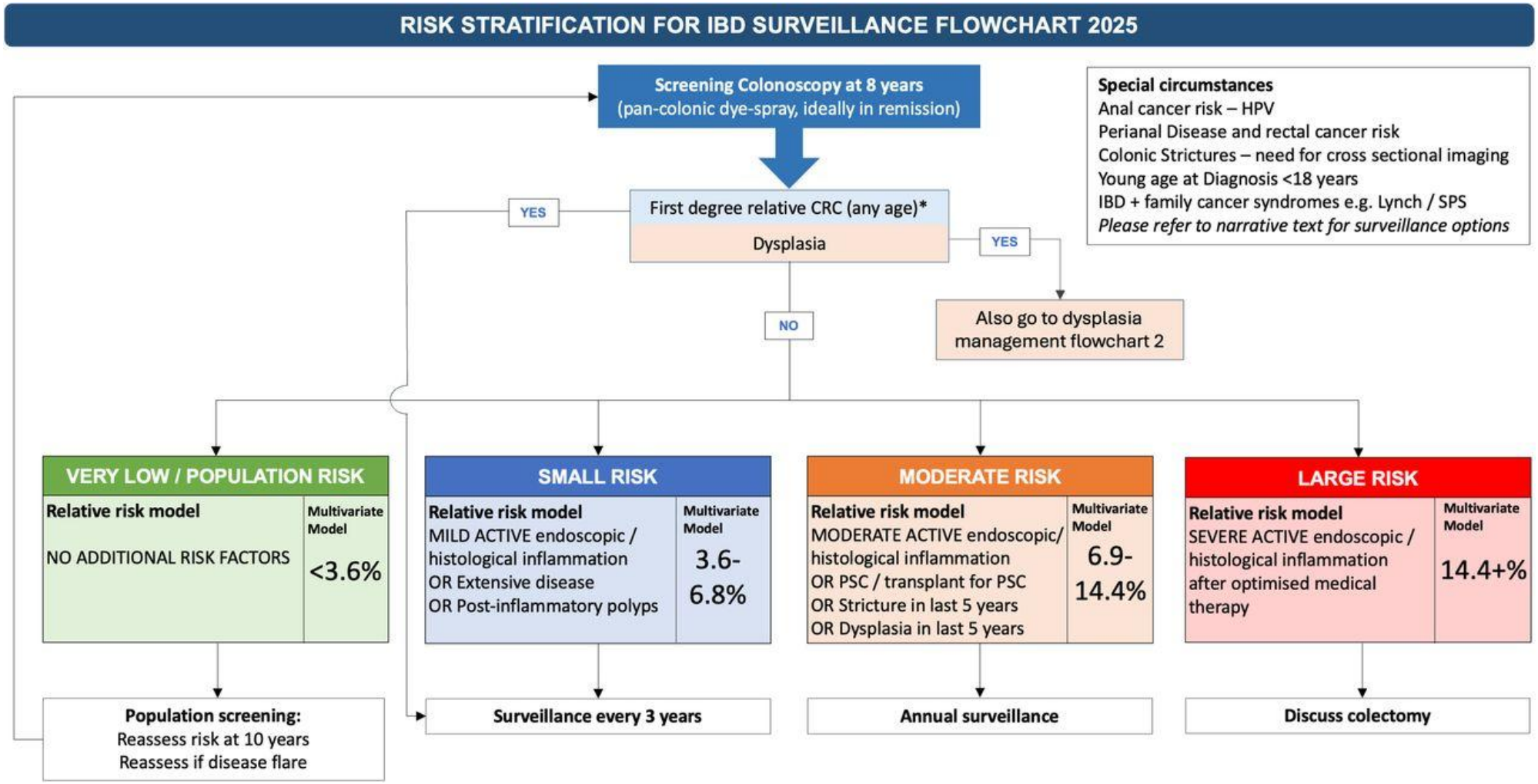
[12] *East J.E., Gordon M., Nigam G.B., et al., 2025. British Society of Gastroenterology guidelines on colorectal surveillance in inflammatory bowel disease. Gut.*

Figure 1: British Society of Gastroenterology - High Quality Colonoscopic Surveillance Pathway in IBD[13]



[13] *Reproduced from British Society of Gastroenterology guidelines on colorectal surveillance in inflammatory bowel disease, East JE, Gordon M, Nigam GB, et al, Gut Online 2025 with permission from BMJ Publishing Group Ltd.*

Figure 2: British Society of Gastroenterology - Risk Stratification for IBD Surveillance Flowchart[14]



[14] Reproduced from British Society of Gastroenterology guidelines on colorectal surveillance in inflammatory bowel disease, East JE, Gordon M, Nigam GB, et al, Gut Online 2025 with permission from BMJ Publishing Group Ltd.

Appendix 4: Transition from child to adult services

Transitioning between paediatric and adult care can be challenging for young people and their parents/carers and therefore should be carefully managed. It is essential for healthcare providers to have a clear process in place.

Transition usually happens between the age of 16 to 18 years but may be earlier or later depending on the needs and preferences of the individual. Transition is an individual experience and should be supported with shared decision-making and flexibility.

The following are key actions for this group of patients:

- Services have a structured transition programme in place to support teenagers and young adults with IBD, led by a paediatric and/or adult gastroenterologist. This should include overlap between paediatric and adult care as a core element.
- Young people and their parents/carers are involved in transition planning and transfer to adult services throughout the process.
- Effective transition should include:
    - Flexible timing of transition.
    - A named transition co-ordinator to oversee the process.
    - Individualisation of the transition model based on local expertise, staffing, resources and geography.
    - Assessment of readiness for transfer.
    - Disease-specific education.[15]

Key resources:

- IBD UK Consensus standards of healthcare for adults and children with IBD
- BSG UK guideline on transition of adolescent and young persons with chronic digestive diseases from paediatric to adult care.
- ECCO Topical Review on Transitional Care in Inflammatory Bowel Disease
- NCEPOD The Inbetweeners

[15] *Brooks, A.J., Smith, P.J., Cohen, R. BSG, 2017. UK guideline on transition of adolescent and young persons with chronic digestive diseases from paediatric to adult care. Gut online 66: pp. 988 – 1,000.*

Appendix 5: Pregnancy for people with IBD

It is important for patients and their partners to understand how having IBD can affect fertility and pregnancy. IBD services should consider how care should be managed during the pre-conception period, during pregnancy, delivery and post-partum.

The following are key actions for this group of patients:

- Patient education includes the importance of keeping well and the potential adverse foetal outcomes of uncontrolled IBD.
- Individualised IBD management plans are developed for disease monitoring and management during pregnancy.
- The IBD service's approach to IBD maintenance, IBD relapses and indications for surgery in pregnant women is the same for non-pregnant patients.
- All IBD patients who are pregnant should be assessed at least once in a consultant-led obstetric clinic. Joint IBD antenatal clinics may offer optimal care.
- The mode of delivery is determined by obstetric considerations and patient preference, except in people with active peri-anal disease, ileoanal pouch or ileorectal anastomosis, where caesarean section is often advised.

Key resources:

- Mahadevan U, Seow CH, Barnes EL, et al. Global consensus statement on the management of pregnancy in inflammatory bowel disease
- BSG Guidelines on IBD in adults: 2025
- ECCO Guidelines on Sexuality, Fertility, Pregnancy, and Lactation
- The PAPooSE Study Group (2022) Pregnancy outcomes after stoma surgery for inflammatory bowel disease: The results of a retrospective multicentre audit

Appendix 6: Accreditation of pouch units

Accreditation of pouch surgery units is essential to ensure consistent, high-quality care for patients undergoing such surgery. Given the technical demands of ileoanal pouch surgery and the potential for significant long-term complications, accreditation provides a framework for evaluating surgical expertise, multidisciplinary care, patient outcomes and service standards. It also fosters continuous improvement, accountability, and reassurance for patients and clinicians alike that care is being delivered in line with best practices and nationally agreed benchmarks.

The Association of Coloproctology of Great Britain and Ireland (ACPGBI) follows a rigorous process for evaluating units applying for accreditation, based on pre-specified criteria. These criteria encompass the overall structure and function of not only the surgical team, but also the wider MDT. Key requirements include:

- **Volume-related metrics:** procedures performed annually and over the preceding five years, including ileoanal pouch formation, revision, and excision.
- **MDT participation**: the active involvement of all key members of the MDT.
- **Specialised care provision:** availability of dedicated pouch nurse practitioners.
- **Patient-reported outcome measures (PROMs):** routine collection and review.
- **Patient information:** provision of relevant educational materials, locally designed where appropriate.
- **Data submission:** commitment to submit outcomes and other relevant data for ongoing monitoring.

Each accredited unit is now officially recognised by the ACPGBI for its commitment to excellence in pouch surgery and patient care. See the ACPGBI pouch unit accreditation page and a paper on guidelines for units seeking accreditation for further information.

Appendix 7: Information to support patients

People living with IBD need access to support and information throughout their pathway of care. It is important that services signpost patients to high quality information and resources to enable them to understand and self-manage their condition and access support when they need it.

Key resources from Crohn's & Colitis UK (CCUK):

- Understanding Crohn's and Colitis
- Newly diagnosed with Crohn's or Colitis
- Crohn's and Colitis in children, young adults and students
- Transition: moving to adult care
- Living with Crohn's Disease, Ulcerative Colitis or Microscopic Colitis
- Pregnancy and Birth with Crohn's and Colitis
- Postnatal care and breastfeeding
- Mental health and wellbeing with Crohn's or Colitis

Key sources of information which services can signpost to patients:

CICRA: better lives for children with Crohn's and colitis shares stories and resources for children and young people living with IBD and their parents/carers.

The Kangaroo Club is a UK registered charity, set up to support anyone with an Ileo-Anal pouch or a Koch pouch, anyone considering Ileo-Anal pouch surgery or Koch pouch surgery and supporters.

The Ileostomy and Internal Pouch Association, known as IA, is a registered charity supporting people living with an ileostomy or internal pouch, their families, friends and carers.

The Patient Information Forum promotes access to trusted, evidence-based health information for patients, carers, the public and healthcare professionals.

Further information

Recommended document	Author	Overview
Making the Cut?	NCEPOD	A review of the care received by patients undergoing surgery for Crohn's disease.
Guidelines on IBD in adults: 2025	British Society of Gastroenterology	Disease management guidance for healthcare professionals managing IBD, focused on ensuring that investigation, treatment and monitoring decisions are based on the best available evidence, and to promote and improve best accepted practice.
BSG guidelines on colorectal surveillance in IBD	British Society of Gastroenterology	Evidence-based recommendations for colorectal cancer surveillance in people with IBD, including risk stratification, surveillance intervals, techniques and service delivery.
Consensus standards of healthcare for adults and children with inflammatory bowel disease in the UK	IBD UK	Consensus statements across seven clinical areas that make up the journey of patients with IBD.
The State of IBD Care in the UK	IBD UK	Based on data from the 2023 IBD UK Benchmarking surveys, the IBD UK Report provides an outlook on the state of IBD care across the UK.
ECCO Guidelines on Therapeutics in Crohn's Disease: Surgical Treatment	European Crohn's and Colitis Organisation	The guideline focuses on surgery for Crohn's Disease, including pre- and perioperative aspects, and provides technical advice for a variety of common clinical presentations.
ECCO Guidelines on Therapeutics in Ulcerative Colitis: Surgical Treatment	European Crohn's and Colitis Organisation	The guideline addresses medical treatment of acute severe ulcerative colitis and surgical management of medically refractory ulcerative colitis patients, including preoperative optimisation, surgical strategies, and technical issues.
Shared decision making guideline	NICE	This guideline covers how to make shared decision making part of everyday care in all healthcare settings.

Inflammatory bowel disease quality standard	NICE	The standard describes high-quality care in priority areas for improvement for IBD in adults, young people and children.
Consensus Guidelines in Surgery for Inflammatory Bowel Disease	The Association of Coloproctology of Great Britain and Ireland	Consensus recommendations on the surgical management of IBD outlining best practice for patient selection, perioperative care, surgical techniques, and postoperative management to improve outcomes and standardise care.
Digestive Health Directorates: A Clinical and Operational Guide	NHS England	A clinical and operational guide to support NHS providers and commissioners of digestive health services to achieve the best care possible for their patients with the available resources.

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