THE 2026 IBD STANDARDS

What’s changed?

IBD UK ALLIANCE

AIM OF THE RESOURCE

This toolkit provides a deep dive into the 2026 IBD Standards.

It includes:

- key data from the 2023 IBD UK Alliance Benchmarking

- details on the development process for the 2026 Standards

- a close look at the changes made within each of the Standards domains

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We know that every IBD service will have different areas of strength and weakness when it comes to the Standards. This toolkit is designed to help you navigate to the section(s) of the Standards most relevant to your needs.

MAIN CONTENTS

DEEP DIVE INTO A SPECIFIC SECTION OF THE STANDARDS

WHAT ARE THE 2026 IBD STANDARDS?

- **The IBD Standards provide a clear, practical framework for healthcare professionals, showing the high-quality IBD care that patients across the UK should expect to receive.**

- **They're designed to support services to reflect on current practice and to focus on Quality Improvement activity, where it can have the greatest impact, both nationally and locally.**

- **The Standards are based on the experiences of 26,000 patients and have been developed by the IBD UK Alliance.[1] They are deliberately aspirational, setting out what a great service should look like, rather than simply describing today's reality.**

- **This is the second set of IBD Standards to be published since the formation of the IBD UK Alliance.**

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[1]2023 IBD Patient Survey - The IBD Patient Survey 2023 | IBD UK

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THE HISTORY OF IBD STANDARDS IN THE UK

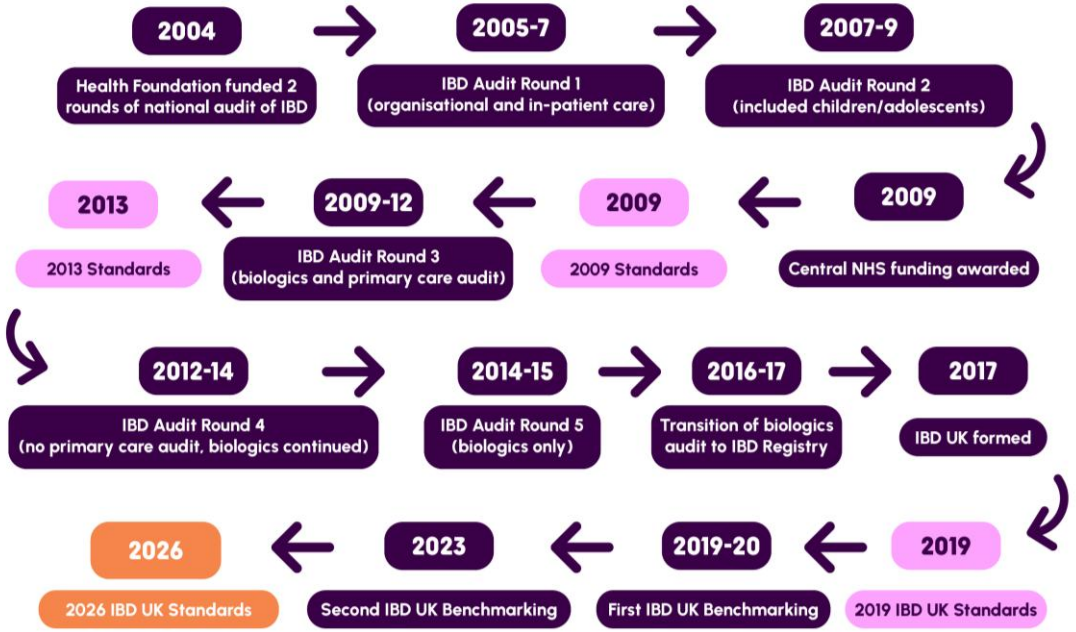
The first IBD Standards were created in 2009. They came as a response to findings from the first audit of IBD services in 2006.

The IBD Standards were updated in 2013, underpinning the 2015 NICE quality standard on IBD and were an integral component of the IBD Quality Improvement Programme in the UK.

This work led to improvements in care provision, but the final round of the UK National Audit in 2014 demonstrated continued inequalities and variation in care.

The IBD UK Alliance formed in 2017 with a key priority to update and build on the IBD Standards and ensure implementation throughout the UK. This led to the creation of the 2019 UK IBD Standards.

Following the 2023 benchmarking surveys, a decision was taken to review the IBD service Standards to ensure that the Standards remain reflective of current and future standards of care for IBD.

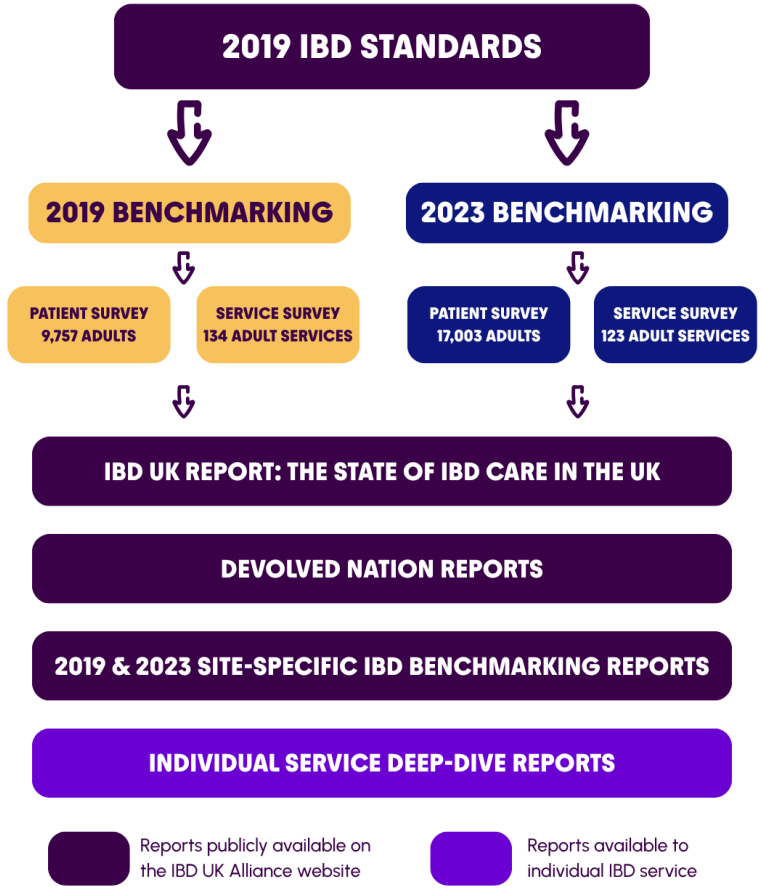


Lamb CA, Picton C, Arnott I, et al. BMJ Open Gastroenterology. 2026;13:e002227

EVIDENCE BASE FOR THE 2026 IBD STANDARDS

2019 and 2023 IBD UK Alliance Benchmarking

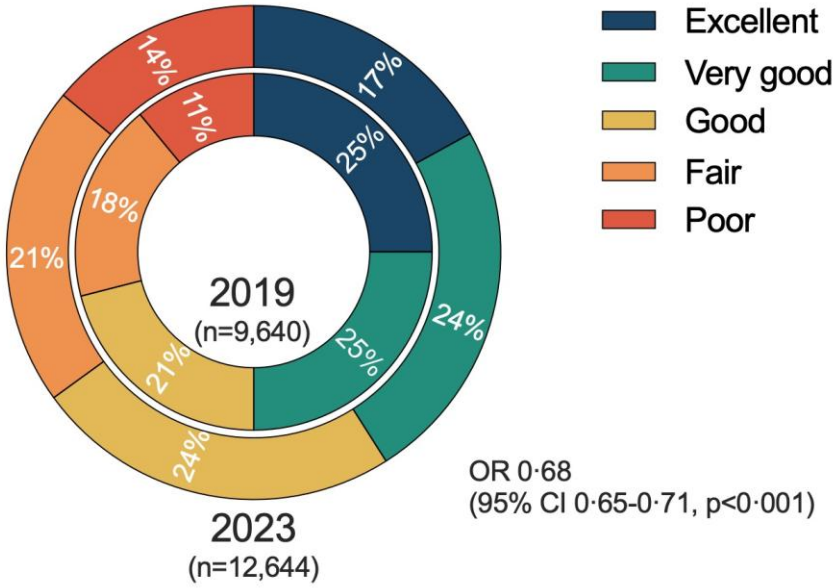
- Two rounds of Benchmarking were completed in 2019 and 2023 respectively. Both rounds consisted of a patient survey, capturing Patient-Reported Experience Measures (PREMs), and a survey for IBD services to self-evaluate.
- Combined across the 2019 and 2023 Benchmarking surveys, we heard from over 26,000 patients.
- 154 IBD services responded to the Service Survey in one or both years.
- Importantly, this means we have Benchmarking data from both before and after the Covid-19 pandemic.



Lamb CA, Picton C, Arnott I, et al. BMJ Open Gastroenterology. 2026;13:e002227

KEY DATA: PATIENT PERCEIVED CARE QUALITY

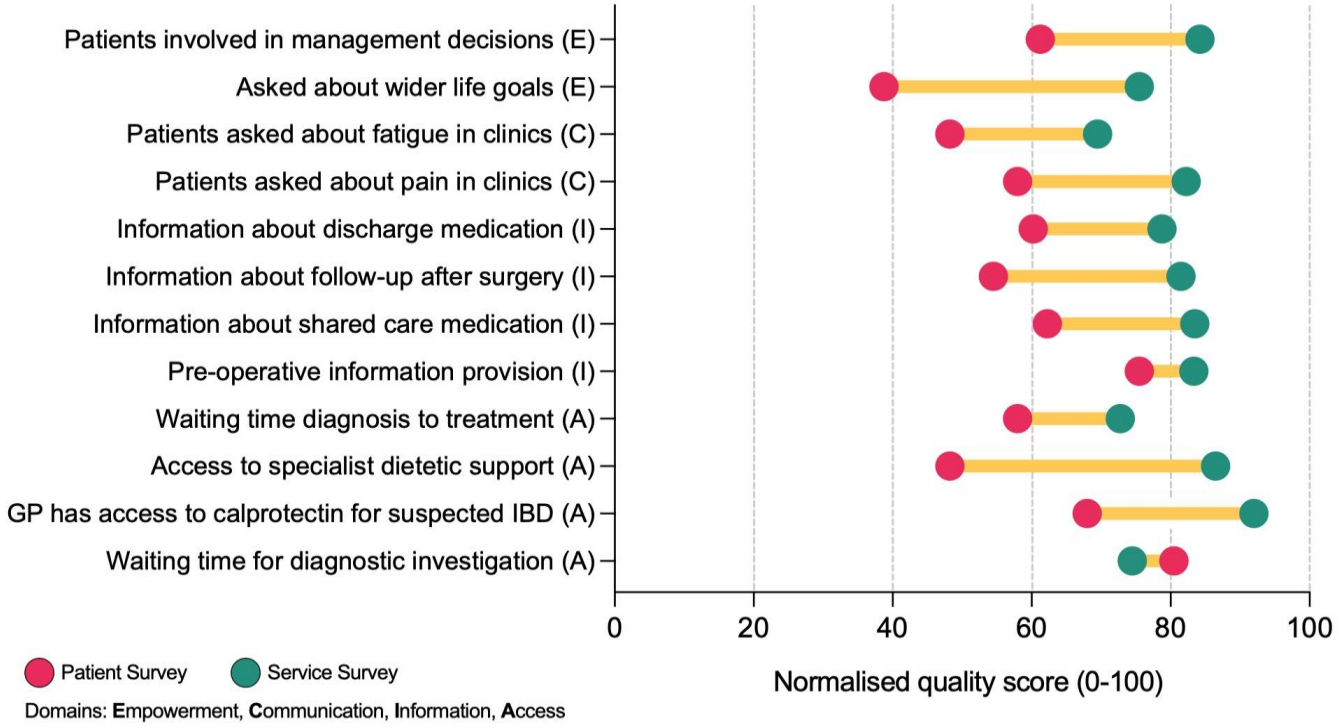
- Patient Perceived Care Quality (PPCQ) fell overall between 2019 and 2023 (p<0.001).
- More patients reported IBD symptoms having an impact on daily living in 2023, relative to 2019 (p<0.001).
- Associations with higher PPCQ:
  - Male and older age.
- Associations with lower PPCQ:
  - Greater disease severity.
- Service factors associated with higher PPCQ:
  - Shorter diagnostic timelines.
  - Starting treatment rapidly.
  - Being supported by an IBD team inclusive of a named gastroenterologist and knowledgeable IBD nurses.



Hawthorne AB, Christiansen P, Arnott I, et al. Journal of Crohn's and Colitis, Volume 20, Issue 3, March 2026, jjag005

KEY DATA: PATIENT PERCEIVED CARE QUALITY

Patients perceive poorer care quality than services believe they deliver



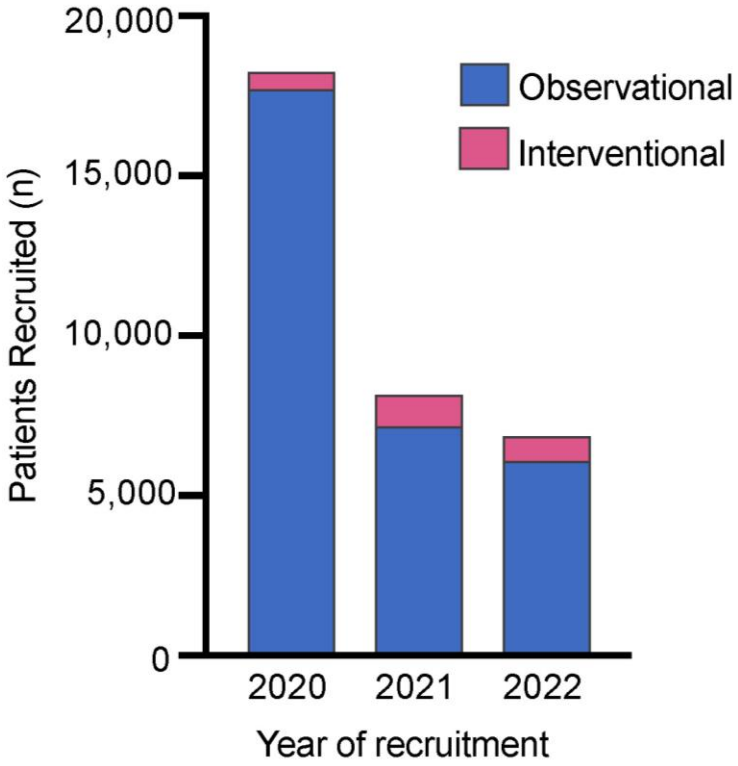
2023 Benchmarking

Implication: Patient experience metrics are important to identify areas for QI and evaluate impact of intervention

Hawthorne AB, Christiansen P, Arnott I, et al. Journal of Crohn's and Colitis, Volume 20, Issue 3, March 2026, jjag005

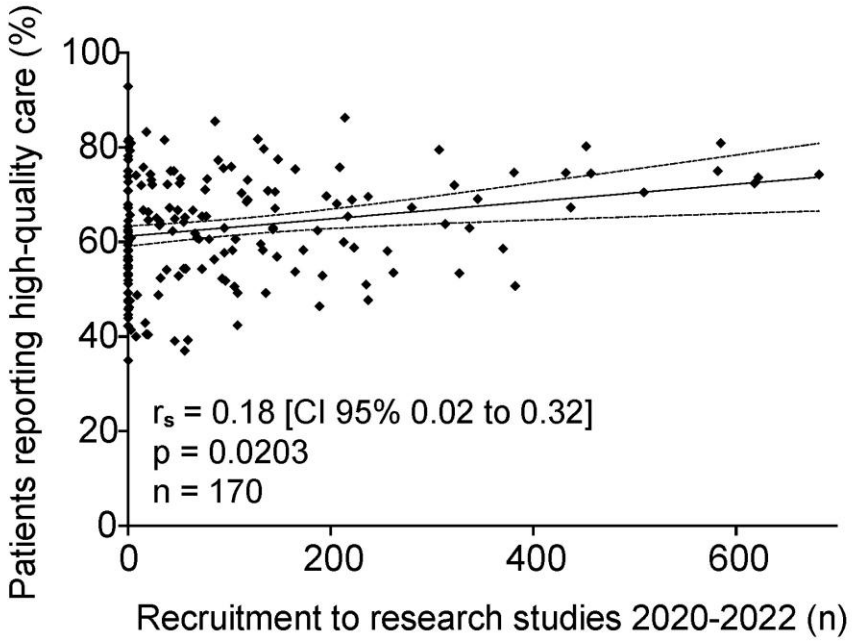
KEY DATA: PATIENT PERCEIVED CARE QUALITY

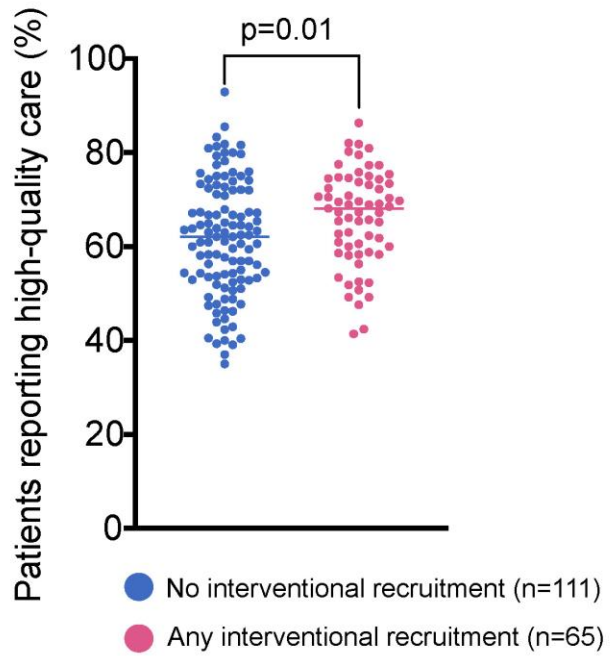
Patient reported care quality was high in research active units



Annual recruitment to NIHR-CPMS studies

Association between CPMS recruitment and proportion of patients in that service reporting high quality care in 2023 IBD UK benchmarking





Mulligan RJ, Ryan P, Beck LC, et al. BMJ Open Gastroenterology. 2026;13:e002122

KEY DATA: PATIENT PRIORITIES

Both quantitative and qualitative feedback from the Patient Survey highlighted priority areas that matter to patients

ACCESS (93%)*

Efficient and effective ACCESS at all stages of a patient's journey, with joined up information and support

COMMUNICATION (94%)*

Proactive two-way COMMUNICATION with patients and intra-service, which bolsters meaningful shared decision making.

WELLBEING SUPPORT (89%)*

Personalised care planning that SUPPORTS WELLBEING through tailored, holistic, and proactive care that caters to the changing needs and priorities of the patient.

EMPOWERMENT (89%)*

Patient experiences that optimise health and life outcomes, providing dignity, respect, transparency and EMPOWERMENT, with a focus on partnership with patients.

*Proportion of adult patients reporting as important

HOW WE DEVELOPED THE 2026 IBD STANDARDS

- Who was involved?
- Scope and principles
- What was the process?
- Overview of changes

DEEP DIVE INTO A SPECIFIC SECTION OF THE STANDARDS

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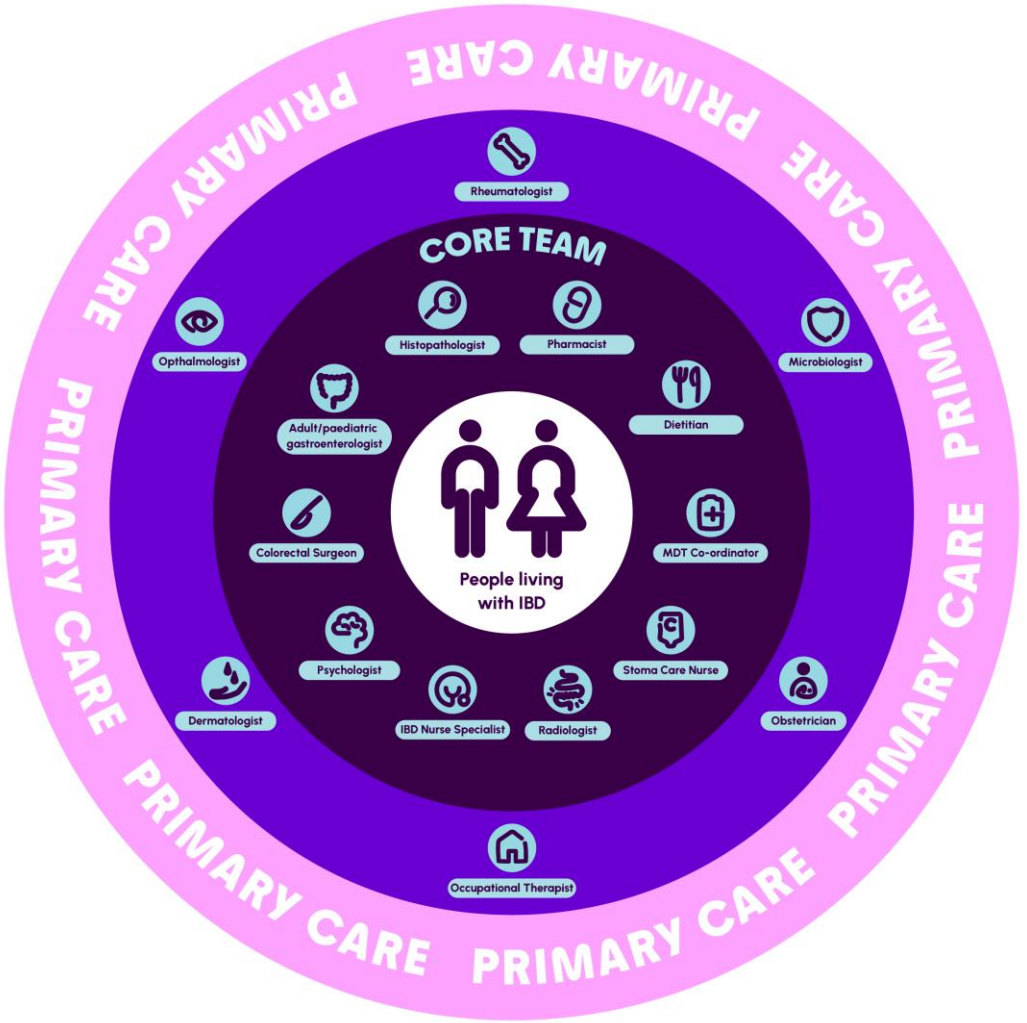
WHO WAS INVOLVED?

- The 2026 IBD Standards was co-produced by a core working group comprising people with lived experience and professionals from across the IBD multidisciplinary team.
- We took a structured, iterative and consensus-based process to reviewing and drafting the Standards, with an external consultation period prior to confirmation of the final document.
- The working group had representation from:
  - People with lived experience
  - IBD Nurse Specialists
  - Adult and paediatric Gastroenterology
  - IBD surgery
  - Radiology
  - Pharmacy
  - Dietetics
  - Psychology
- Additional discussions also took place with allied specialties: Dermatology and Rheumatology.



Lamb CA, Picton C, Arnott I, et al. BMJ Open Gastroenterology. 2026;13:e002227

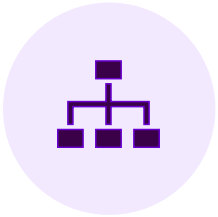
SCOPE AND PRINCIPLES

The Standards would remain aspirational. Despite considerable demand on services, it is in mutual interest to not dilute the aims for high-quality care.

2019 and 2023 Benchmarking rounds were based on the 2019 Standards. To maintain comparability between past and future Benchmarking rounds, we would only modify statements where necessary.

The Standards should consist of service delivery standards, rather than clinical guidelines. Some statements were therefore deleted or modified to account for duplication of existing clinical guidelines.

The Standards would be future-proofed, considering UK-wide health strategic objectives, while establishing a foundation to facilitate evolving tools and guidance in IBD service delivery.



We decided against creating a hierarchy within the Standards. Service needs are locally variable and dynamic over time—a standard may represent a critical risk in one service yet be fully met by another. The relative importance of different statements may also vary between patients and through the course of a patient's journey.

We would review the Standards through the lens of the previously mentioned areas of patient priority: Access, Communication, Wellbeing Support, and Empowerment.

WHAT WAS THE PROCESS?

- All statements from the 2019 IBD Standards were reviewed by each member of the working group. Every member of the working group graded each statement as either: 1) no change necessary, 2) minor amendments required, 3) major amendments required, or 4) deletion required. The working group provided written justifications for any proposed changes, and they were also able to propose new statements to add to the 2026 edition.
- The working group met to discuss the graded statements and co-produced a draft of updated Standards, ready for consultation.
- The draft went out for consultation from IBD healthcare professionals from May to July 2025, receiving 47 responses from across the IBD multidisciplinary team professions.*
- A lived experience workshop was held in July 2025 to hear patient views on the updated Standards draft.
- Consultation and workshop responses were collated and reviewed by the working group. Changes were made, with the 2026 IBD Standards finalised in September 2025.
- The 2026 IBD Standards was published in April 2026, alongside a paper in BMJ Open Gastroenterology, and a patient-facing version of the Standards.

***Professional backgrounds of responders**

11 Gastroenterologists
10 IBD Nurse Specialists
8 Dietitians
4 Colorectal Surgeons
3 Clinical Psychologists
2 Pharmacists
2 Radiologists
1 Paediatric Gastro
1 Paediatrician
1 Rheumatologist
4 Did not specify

OVERVIEW OF CHANGES

- There are 60 statements in the 2026 IBD Standards, compared to 59 in 2019.
- 7 statements were deleted from the 2019 version, as these statements were either already covered elsewhere in the Standards or by existing clinical guidelines.
- 48 statements received either major or minor amendments.
- 6 statements received no changes between 2019 and 2026.
- 6 new statements were added to the 2026 IBD Standards.

Domain	No change	Amended	Deleted	New
Section 1: The IBD Service	1	16*	1	1
Section 2: Pre-diagnosis	2	2		
Section 3: Newly diagnosed	1	5*	1	
Section 4: Flare management		5		
Section 5: Surgery		8		2
Section 6: Inpatient care	2	5	4	1
Section 7: Ongoing care & monitoring		7	1	2

*In both Section 1 and Section 3, a single 2019 statement was split to form two separate statements

2026 IBD STANDARDS DEEP DIVE

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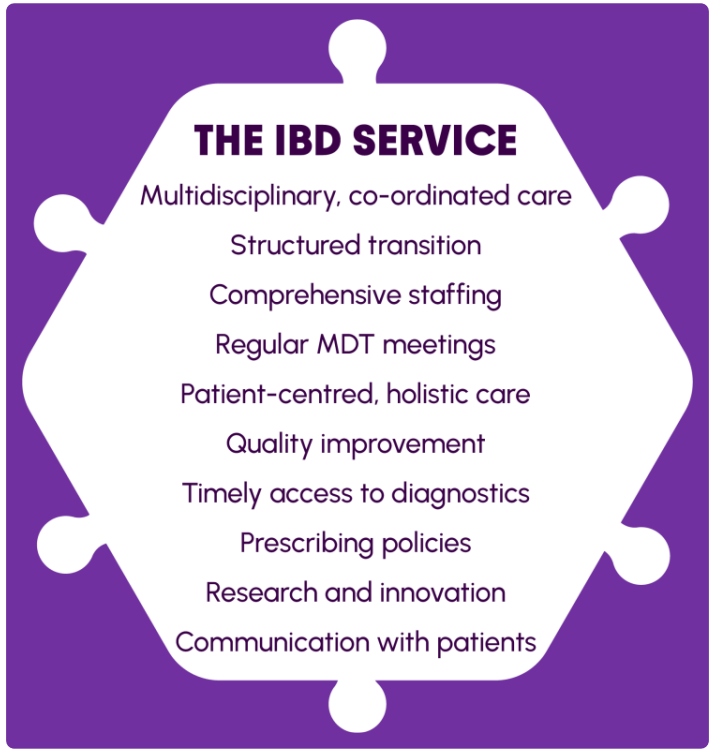
SECTION 1: THE IBD SERVICE

What the Benchmarking told us

- 82% of adult patients did not have the opportunity to give feedback about their care in last 12 months
- 26% of adult patients did not feel supported by a team of IBD specialists
- Only 12% of paediatric patients transitioning to adult care in the past 2 years had an individual transition plan
- Only 10% of patients reported receiving info about research, 9% offered opportunities
- Only 41% of services had a process to ensure all relevant information is discussed and recorded
- Only 31% of adult patients reported being asked questions beyond their gut—despite up to half of patients living with extra intestinal manifestations
- Only 20% of patients reported being asked about their mental health, despite the evidenced vulnerability for mental ill health as a non-gut feature of IBD and ill mental health's negative impact on disease impact
- Only 41% of patients reported having regular reviews, despite the highlighted importance of communication on not only patient experiences, but also on patient outcomes

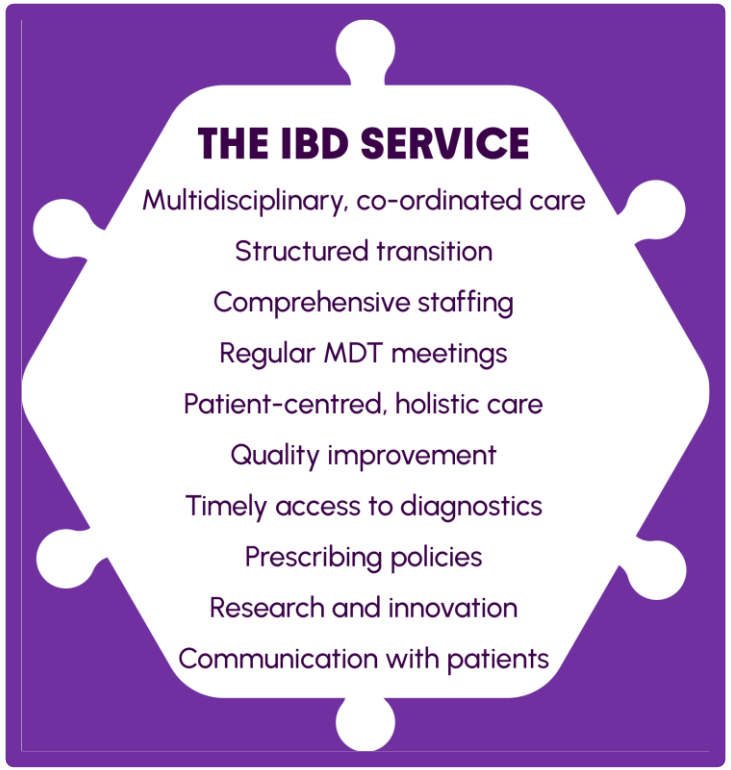


The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 1: THE IBD SERVICE

Summary of changes in 2026 Standards

- **1 new statement added in 2026**
- **1 statement deleted from 2019, as already covered in Statement 1.14 in 2026**
- **16 statements amended for wording, detail, and/or to bring in line with contemporary best practice**
- **1 statement kept the same**



IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 1: THE IBD SERVICE

2019 v 2026 deep dive

2019 statement	2026 statement
Patients should be cared for by a defined IBD multidisciplinary team led by a named consultant adult or paediatric gastroenterologist.	Statement 1.1 - Patients should be cared for by a defined multidisciplinary team. **For children and young people this must include a paediatric gastroenterologist.**
NEW STATEMENT IN 2026	Statement 1.2: **All patients should have a named specialist(s) responsible for their care.**
Multidisciplinary team meetings should take place regularly to discuss appropriate patients.	Statement 1.3 - Multidisciplinary team meetings should take place regularly to discuss appropriate patients **and be organised by a named coordinator. Patients should receive appropriate feedback from MDT meetings.**
Protocols should be in place which clearly define the local transition service and the personnel responsible.	Statement 1.4 - **A structured transition programme should be in place** to support teenagers and young people with IBD, **led by a paediatric and/or adult gastroenterologist**.

SECTION 1: THE IBD SERVICE

2019 v 2026 deep dive

2019 statement	2026 statement
The IBD service should have a leadership team which includes a senior clinician, IBD nurse specialist and manager, who have responsibility for managing, monitoring and developing the service.	Statement 1.5 - The IBD service should have a leadership team which includes, **as a minimum, a gastroenterologist and/or a paediatric gastroenterologist, colorectal surgeon**, IBD nurse specialist and manager, who have responsibility for managing, monitoring and developing the service.
The IBD leadership team should work with an expert pharmacist in IBD to ensure good medicines governance, including medicines optimisation and cost-effectiveness.	Statement 1.6 - The IBD leadership team should work with **or include** an expert pharmacist in IBD to ensure good medicines governance, including medicines optimisation and cost-effectiveness; **an expert dietitian to ensure appropriate oversight of dietetic assessment and intervention; and a psychologist with an interest in IBD to coordinate psychology provision within the service.**
IBD teams should promote continuous quality improvement and participate in local and national audit.	Statement 1.7 - IBD teams should **engage with** continuous quality improvement and participate in local and national audit. **This should include feedback from patients on outcomes and experiences**.

SECTION 1: THE IBD SERVICE

2019 v 2026 deep dive

2019 statement	2026 statement
STATEMENT KEPT THE SAME IN 2026	Statement 1.8: Patients and parents/carers should have a voice and direct involvement in the development of the service.
All patients with confirmed IBD should be recorded in an electronic clinical management system and data provided to the national IBD Registry.	Statement 1.9 - All patients with an IBD diagnosis should be recorded in an electronic clinical management system.
Clear information about IBD, the local IBD service and patient organisations should be accessible in outpatient clinics, wards, endoscopy and day care areas.	Statement 1.10 - In their clinical encounters, patients should receive **personalised signposting to easily accessible information about IBD, the local IBD service and patient organisations in a variety of formats that meet all needs.**

SECTION 1: THE IBD SERVICE

2019 v 2026 deep dive

2019 statement	2026 statement
Endoscopic assessment and ultrasound/MRI/CT/contrast studies should be accessible within four weeks, and within 24 hours where patients are acutely unwell or require admission to hospital.	Statement 1.11 - **Where clinically appropriate, radiological investigations should aim to prioritise the use of MRI and ultrasound** as they do not use ionising radiation. These should be accessible **within 6 weeks of referral for routine care, within 2 weeks for urgent IBD referrals** and within 24 hours for patients requiring admission.
	Statement 1.12 - Endoscopic assessment should be **available within 6 weeks of referral for routine care, within 2 weeks for urgent IBD referrals** and within 24 hours for patients requiring admission.
Histological processing and reporting should take place routinely within five working days or within two working days for reporting of urgent biopsy samples.	Statement 1.13 - Histological processing and reporting should take place routinely **within one week** or within two working days for reporting of urgent biopsy samples.
Agreed protocols should be in place for pre-treatment tests, vaccinations, prescribing, administration and monitoring of immunomodulator and biological therapies.	Statement 1.14 - **A locally agreed policy** should be in place for **immunomodulators, targeted small molecules and biologics**, including pre-treatment tests, vaccinations, prescribing, administration and monitoring.

SECTION 1: THE IBD SERVICE

2019 v 2026 deep dive

2019 statement	2026 statement
Patients should be fully informed about the benefits and risks of, and the alternatives to, immunomodulator and biological therapies, including surgery.	Statement 1.15 - Patients should be fully informed about the benefits and risks of **all treatments including medical therapy, diet and surgery**.
Patients receiving immunomodulator and biological therapies should be offered vaccinations in accordance with clinical guidelines	DELETED – ALREADY COVERED IN **STATEMENT 1.14**
All forms of nutritional therapy should be available to IBD patients, where appropriate, including exclusive enteral nutrition for Crohn's Disease and referral to services specialising in parenteral nutrition.	Statement 1.16 - **Appropriate** nutritional therapy should be available to IBD patients, including exclusive enteral nutrition for Crohn's disease and **parenteral nutrition where required**.

SECTION 1: THE IBD SERVICE

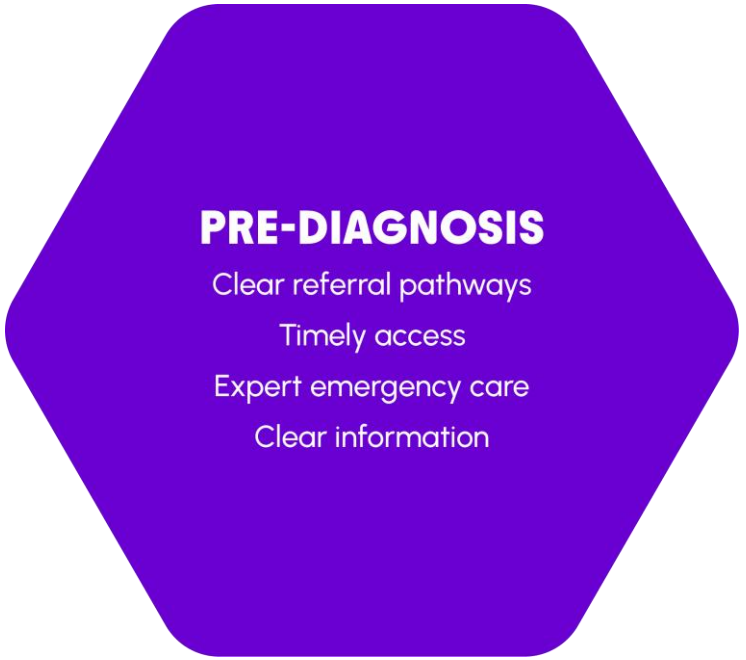
2019 v 2026 deep dive

2019 statement	2026 statement
All members of the IBD team should develop competencies and be educated to a level appropriate for their role, with access to professional support and supervision.	Statement 1.17 - All members of the IBD team should **be trained and supported to** develop competencies and be educated to a level appropriate to their role with access to professional support, supervision **and funded study leave**.
IBD services should encourage and facilitate involvement in multidisciplinary research through national or international IBD research projects and registries.	Statement 1.18 - IBD services **should participate in research**. **Patients should have the opportunity to participate in observational or interventional studies.**

SECTION 2: PRE-DIAGNOSIS

What the Benchmarking told us

- 1 in 7 adults waited >1yr to be referred to hospital after discussion with an HCP
- 14% of patients were diagnosed upon emergency admission
- A third of patients reported no faecal calprotectin test prior to hospital referral
- Once referred, 75% of patients reported waiting >4 weeks to see a specialist
- 67% of adults reported it took >4 weeks from hospital referral to diagnosis (1 in 8 more than a 1 year)



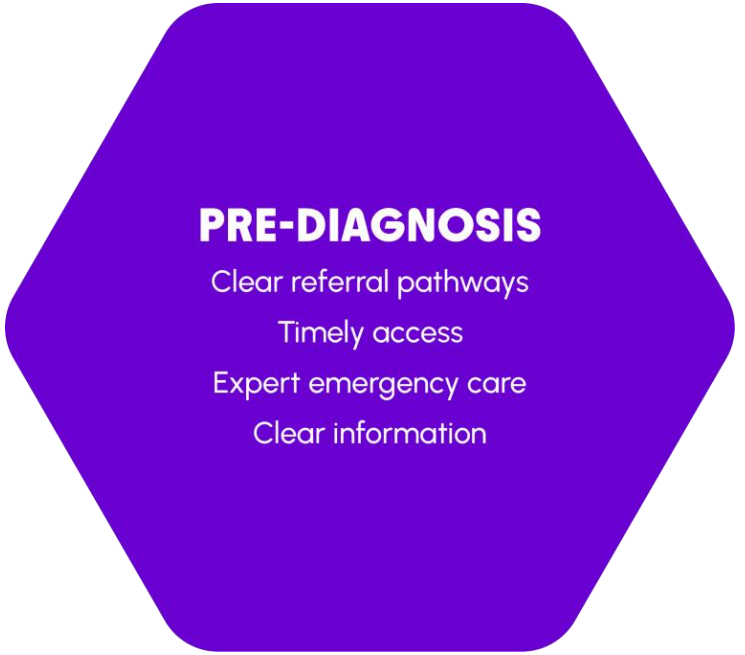
The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 2: PRE-DIAGNOSIS

Summary of changes in 2026 Standards

- **2 statements kept the same**

- **2 statements amended for wording, detail, and/or to bring in line with contemporary best practice**



IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 2: PRE-DIAGNOSIS

2019 v 2026 deep dive

2019 statement	2026 statement
Clear pathways and protocols for investigating children and adults with persistent lower gastrointestinal symptoms should be agreed between primary and secondary care and should include guidance on the use of faecal biomarker tests in primary care to aid rapid diagnosis.	Statement 2.1 - There should be locally agreed adult and paediatric policies and pathways for referral of suspected IBD between primary and secondary care that include the availability of faecal biomarker testing - calprotectin and/or faecal immunochemical test (FIT).
Patients who are referred with suspected IBD should be seen within four weeks, or more rapidly if clinically necessary.	Statement 2.2 - Patients who are referred with suspected IBD should be **seen in clinic or attend a 'straight to test' procedure** within four weeks of referral, or more rapidly if clinically necessary.
STATEMENT KEPT THE SAME IN 2026	Statement 2.3: Patients presenting with acute severe colitis should be admitted to a centre with medical and surgical expertise in managing IBD that is available at all times.
STATEMENT KEPT THE SAME IN 2026	Statement 2.4: All patients should be provided with a point of contact and clear information about pathways and timescales while awaiting the outcome of tests and investigations.

SECTION 3: NEWLY DIAGNOSED

What the Benchmarking told us

- Almost all services agreed patients were supported to be actively involved in information and decisions about their treatment, but only 55% of patients agreed
- 69% of services reported asking about fatigue, but only 37% of patients agreed
- 67% of patients did not agree that they had specialist advice/support with diet and nutrition
- Only 20% of adults reported being asked about their mental health
- Only 31% of adults reported being asked about conditions beyond their gut
- 33% of patients reported initiating treatment 3 weeks or more from diagnosis

The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 3: NEWLY DIAGNOSED

Summary of changes in 2026 Standards

- **1 statement deleted from 2019, as already covered in Statement 1.10 and 7.2 in 2026**
- **5 statements amended for wording, detail, and/or to bring in line with contemporary best practice.**
- **1 statement kept the same**

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 3: NEWLY DIAGNOSED

2019 v 2026 deep dive

2019 statement	2026 statement
All newly diagnosed IBD patients should be seen by an IBD specialist and enabled to see an adult or paediatric gastroenterologist, IBD nurse specialist, specialist gastroenterology dietitian, surgeon, psychologist and expert pharmacist in IBD as necessary.	Statement 3.1 - All newly diagnosed IBD patients should be seen by **appropriate specialists from the IBD multidisciplinary team**.
After diagnosis, all patients should have full assessment of their disease, nutritional status, bone health and mental health, with baseline infection screen, in order to develop a personalised care plan.	Statement 3.2 - Following diagnosis, all patients should have a full assessment of their disease activity, nutritional status, mental health, **fatigue and extra intestinal manifestations**. **This should include growth status for children and teenagers and an infection screen for patients likely to require immunomodulators, targeted small molecules or biologics.**
STATEMENT KEPT THE SAME IN 2026	Statement 3.3: Patients should be supported to make informed, shared decisions about their treatment and care to ensure these take their preferences and goals fully into account.

SECTION 3: NEWLY DIAGNOSED

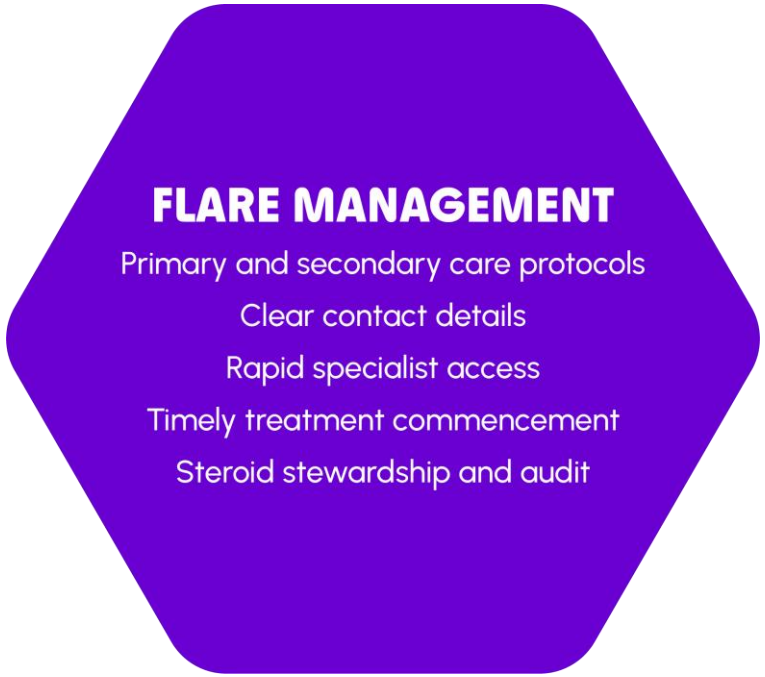
2019 v 2026 deep dive

2019 statement	2026 statement
After diagnosis, all outpatients with IBD should be able to start a treatment plan within 48 hours for moderate to severe symptoms and within two weeks for mild symptoms.	Statement 3.4 - After diagnosis, all outpatients with IBD should have a treatment plan.
	Statement 3.5 - After a confirmed diagnosis, treatment should be started immediately where clinically appropriate, for example oral mesalazine, oral corticosteroids, or topical therapies. If treatment with an immunomodulator, targeted small molecule or biologic is required, this should be started within two weeks of completion of the necessary pre-treatment screening tests.
GPs should be informed of new diagnoses and the care plan that has been agreed within 48 hours.	Statement 3.6 - Once a diagnosis has been confirmed, patients and GPs should be informed within two days
Patients should be signposted to information and support from patient organisations	DELETED – ALREADY COVERED IN **STATEMENT 1.10** AND **STATEMENT 7.2**

SECTION 4: FLARE MANAGEMENT

What the Benchmarking told us

- 56% of patients reported having 1 or more flares in the last 12 months, while 45% reported 3 or more flares
- A quarter of services had no provision to ensure accessible advice in suspected flare, while 1 in 3 adults reported waiting 2 or more days to receive response. 1 in 9 reported waiting over a week.
- 21% of patients reported that treatment initiation during flare took 2-7 days; 6% reported that it took 8-14 days; 11% reported waiting more than 2 weeks+; 6% reported that no-one responded.
- Only 53% of services reported having a locally agreed policy for steroid use.



The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

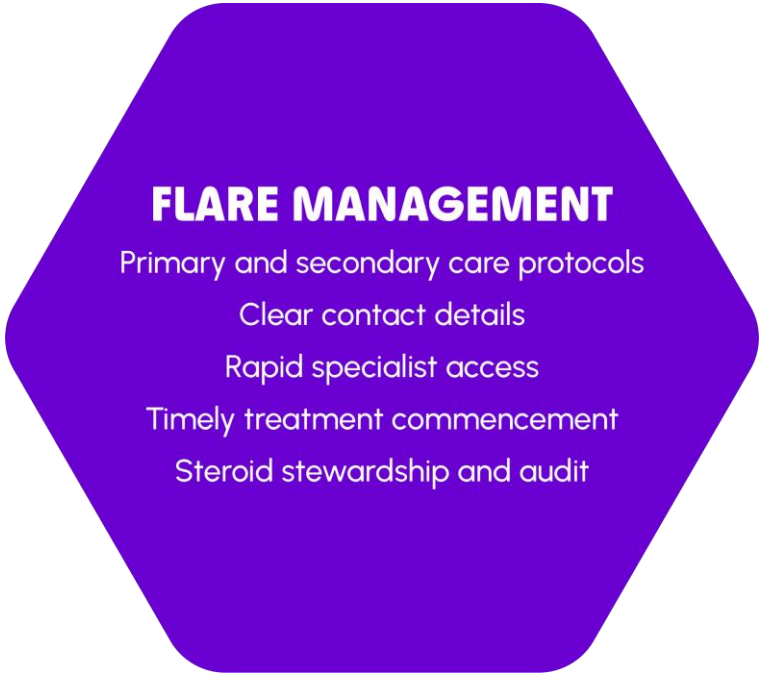
SECTION 4: FLARE MANAGEMENT

Summary of changes in 2026 Standards

- **All 5 statements were amended for wording, detail, and/or to bring in line with contemporary best practice.**

2019 v 2026 deep dive

2019 statement	2026 statement
Local treatment protocols and clear pathways should be in place for the management of IBD patients experiencing flares and include advice for primary care.	Statement 4.1 - Local **primary and secondary care** treatment pathways and protocols should be in place for the management of IBD patients experiencing flares.
All patients with IBD should be provided with clear information to support self-management and early intervention in the case of a flare.	Statement 4.2 - All patients with IBD should be **given advice about what to do in the case of a flare and who to contact**.



IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 4: FLARE MANAGEMENT

2019 v 2026 deep dive

2019 statement	2026 statement
Rapid access to specialist advice should be available to patients to guide early flare intervention, including access to a telephone/email advice line with response by the end of the next working day.	Statement 4.3 - **Access** to specialist advice should be available to patients to guide early flare intervention, including access to a telephone/email advice line with response by the end of the next working day.
Patients with IBD should have access to review by the IBD team within a maximum of five working days and be able to escalate/start a treatment plan within 48 hours of review.	Statement 4.4 - Following initial advice-line response for a flare, further review should be planned at a clinically indicated interval and communicated to the patient. Where a treatment plan is agreed it should be initiated within 2 days.
Steroid treatment should be managed in accordance with guidelines and audited on an ongoing basis, with clear guidance to primary care.	Statement 4.5 - Steroid treatment should be managed in accordance with guidelines and audited on an ongoing basis, with clear guidance to primary care **and patients**.

SECTION 5: SURGERY

What the Benchmarking told us

- Adult patients reported waiting a median of 4 months for their operation; 36% considered their operation as not taking place within an appropriate timescale
- Two-thirds reported that the option of laparoscopic surgery was not discussed
- 19% reported not being given sufficient information to help understand the benefits and risks of surgery; only 3% reported being offered other support opportunities, such as counselling and psychologists
- Access to IBD nurse in post-surgery reported in only 20% of adult services

The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 5: SURGERY

Summary of changes in 2026 Standards

- **2 new statements added in 2026**

- **8 statements amended for wording, detail, and/or to bring in line with contemporary best practice**

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 5: SURGERY

2019 v 2026 deep dive

2019 statement	2026 statement
Patients should have access to coordinated surgical and medical clinical expertise, including regular combined or parallel clinics with a specialist colorectal surgeon (paediatric colorectal surgeon where appropriate) and IBD gastroenterologist.	Statement 5.1 - Patients should have access to coordinated surgical and medical clinical expertise **pre- and post- operatively**, which should include regular combined or parallel clinics with a specialist colorectal surgeon (paediatric colorectal surgeon where appropriate), IBD gastroenterologist **and clinical nurse specialist**.
Elective IBD surgery should be performed by a recognised colorectal surgeon (paediatric colorectal surgeon where appropriate) who is a core member of the IBD team in a unit where such operations are undertaken regularly.	Statement 5.2 - Elective IBD surgery should be performed by a colorectal surgeon **with expertise in IBD** (paediatric colorectal surgeon where appropriate) who is a core member of the IBD team in a unit where such operations are undertaken regularly.
In the absence of relevant local expertise, paediatric patients or adult patients requiring complex surgery should be referred to a specialist unit.	Statement 5.3 - In the absence of relevant local expertise **in complex IBD**, paediatric patients or adult patients requiring complex surgery should be referred to a specialist unit.

SECTION 5: SURGERY

2019 v 2026 deep dive

2019 statement	2026 statement
Patients with IBD being considered for surgery should be provided with information in a format and language they can easily understand to support decision making and informed consent and offered psychological support.	Statement 5.4 - Patients with IBD being considered for surgery should be provided with information in a format and language they can easily understand to support decision making and informed consent. **All patients should have access to stoma nurse support pre-operatively where indicated. Psychological support should be available where needed**.
Prior to elective surgery, a full assessment and optimisation of medical treatment and physical condition should be undertaken to minimise risk of complications and aid post-operative recovery.	Statement 5.5 - Prior to elective surgery, a full assessment and optimisation of medical treatment, physical condition **and nutritional status** should be undertaken to minimise risk of complications and aid post-operative recovery.
Patients should be counselled about laparoscopic resection as an option, when appropriate, in accordance with clinical guidelines.	Statement 5.6 - Patients should be counselled **about minimally invasive options (e.g. laparoscopic, robotic surgery)**, when appropriate, in accordance with clinical guidelines.

SECTION 5: SURGERY

2019 v 2026 deep dive

2019 statement	2026 statement
NEW STATEMENT IN 2026	Statement 5.7: Surgery for IBD should incorporate a pathway for enhanced recovery when appropriate.
Patients and parents/carers should be provided with information about post-operative care before discharge, including wound and stoma care, and offered psychological support.	Statement 5.8 - Patients and parents/carers should be provided with information about postoperative care before discharge, including wound care. **Stoma care and psychological support should be available where needed.**
Elective surgery for IBD should be performed as soon as the patient's clinical status has been optimised and within 18 weeks of referral for surgery.	Statement 5.9 - **Planned** surgery for IBD should be performed **within 4 weeks from the decision to operate** or as soon as the patient's clinical status has been optimised.
NEW STATEMENT IN 2026	Statement 5.10: Patient safety incidents should be recorded and actioned, including delays in surgical treatment for patients with IBD on an elective surgery list that subsequently results in emergency surgery due to a disease complication.

SECTION 6: INPATIENT CARE

What the Benchmarking told us

- 22% of patients reported spending time in hospital because of their IBD in last 2 years.
- 42% reported they did not stay on a specialist IBD ward.
- 20% also reported only being moved to a specialist ward after more than 24 hours on another ward.
- 16% reported not having an easily accessible toilet.
- Only 14% of services agreed their mental health is being assessed using validated tools on admission.
- Only half of patients reported clear discharge info; 31% reported not knowing who to contact with concerns post-discharge.

The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 6: INPATIENT CARE

Summary of changes in 2026 Standards

- **3 statements deleted from 2019, as already covered by clinical guidelines**
- **1 statement deleted because applicable to all inpatients (not IBD-specific)**
- **1 new statement added in 2026**
- **5 statements amended for wording, detail, and/or to bring in line with contemporary best practice**
- **2 statements kept the same:**
-

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 6: INPATIENT CARE

2019 v 2026 deep dive

2019 statement	2026 statement
Patients requiring inpatient care relating to their IBD should be admitted directly, or transferred within 24-48 hours, to a designated specialist ward area under the care of a consultant gastroenterologist and/or colorectal surgeon.	Statement 6.1 - Inpatients should be seen by a specialist gastroenterologist or colorectal surgeon within 24 hours of admission and transferred to a specialist ward area within 2 days of admission to ensure regular specialist review.
STATEMENT KEPT THE SAME IN 2026	Statement 6.2: Where ensuite rooms are not available, inpatients with IBD should have a minimum of one easily accessible toilet per three beds on a ward.
NEW STATEMENT IN 2026	Statement 6.3: For inpatients admitted with an IBD flare, initial management should be guided by an agreed local protocol.
STATEMENT KEPT THE SAME IN 2026	Statement 6.4: Children and adults admitted as inpatients with acute severe colitis should have daily review by appropriate specialists.

SECTION 6: INPATIENT CARE

2019 v 2026 deep dive

2019 statement	2026 statement
On admission, patients with IBD should have an assessment of nutritional status, mental health and pain management using validated tools and be referred to services and support as appropriate.	Statement 6.5 - On admission to hospital, nutritional status, mental health, pain and **extra intestinal manifestations** should be assessed using validated tools, **where available**. **Pathways should be in place for onward referral as appropriate.**
All IBD inpatients should have access to an IBD nurse specialist.	Statement 6.6 - All IBD inpatients should have access to an IBD nurse specialist **who should be notified of all IBD admissions**.
All IBD inpatients should have their prescribed and over the counter medications reviewed on admission by a pharmacist who has access to an expert pharmacist in IBD for advice, with regular review of medications during their inpatient stay and at discharge.	Statement 6.7 - Pharmacists reviewing IBD inpatients should have access to an expert IBD pharmacist for advice. A locally agreed policy should be in place for the perioperative management of IBD medicines.
Clear written information about follow up care and prescribed medications should be provided before discharge from the ward and communicated to the patient's IBD clinical team and GP within 48 hours of discharge.	Statement 6.8 - **Before discharge**, patients should be provided with clear, written information about follow up care**, including a telephone number/email address to contact in the event of clinical queries**. Patients should be **counselled on discharge regarding new medications and appliances**.

SECTION 6: INPATIENT CARE

2019 v 2026 deep dive

2019 statement	2026 statement
For patients with acute severe colitis, stool culture and Clostridium difficile assay should be performed upon admission to exclude infectious.	STATEMENT DELETED – ALREADY COVERED BY CLINICAL GUIDELINES
For patients admitted with acute severe colitis, limited flexible sigmoidoscopy, when indicated, should be performed without bowel preparation by an experienced endoscopist.	STATEMENT DELETED – ALREADY COVERED BY CLINICAL GUIDELINES
All patients with acute severe colitis not settling on intravenous steroids should be assessed regularly by a consultant adult or paediatric colorectal surgeon and a decision made with the patient and adult or paediatric gastroenterologist on day three to escalate to rescue therapy or undertake a colectomy.	STATEMENT DELETED – ALREADY COVERED BY CLINICAL GUIDELINES
Inpatients with IBD must have 24-hour rapid access to critical care services if needed	STATEMENT DELETED – NOT AN IBD-SPECIFIC STANDARD

SECTION 7: ONGOING CARE AND MONITORING

What the Benchmarking told us

- Only 6.7% of adults reported having a personalised care plan in place.
- 37% of adults did not think their care was well organised between their GP and IBD team.
- Only 64% of patients agreed they had the information and skills to confidently manage everyday symptoms and live as well as possible.
- Less than 25% felt their wider life goals and priorities were discussed in the planning of their care.
- 31% reported not having reviews as often as they would like, and 15% reported never having a review.

The State of IBD Care, November 2024: ibduk.org
IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 7: ONGOING CARE AND MONITORING

Summary of changes in 2026 Standards

- **2 new statements added in 2026**
- **7 statements amended for wording, detail, and/or to bring in line with contemporary best practice**
- **1 statement deleted as already covered by 7.1 and 7.7 in 2026**

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

SECTION 7: ONGOING CARE AND MONITORING

2019 v 2026 deep dive

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

2019 statement	2026 statement
A personalised care plan should be in place for every IBD patient, with access to an IBD nurse specialist and telephone/email advice line.	Statement 7.1 - A personalised care plan **agreed by the patient**, **communicated and accessible to primary and secondary care** should be in place for every IBD patient.
Patients should be supported in self-management, as appropriate, through referral or signposting to education, groups and support.	Statement 7.2 - Patients should be supported in self-management, as appropriate, through referral or **personalised** signposting to education, groups and support.
Clear protocols should be in place for the supply, monitoring and review of medication across primary and secondary care settings.	Statement 7.3 - Clear **shared care** protocols should be in place for the monitoring, prescribing and supply of IBD medicines across primary and secondary care settings **with a clear pathway for advice or referral back to the specialist team where necessary**.
NEW STATEMENT IN 2026	Statement 7.4: Arrangements should be in place to monitor and review patients started on nutritional therapies and supplements to assess their ongoing needs across primary and secondary care.
NEW STATEMENT IN 2026	Statement 7.5: Patients should understand how, when and who to contact in the event of clinical queries about their IBD and/or their medicines.

SECTION 7: ONGOING CARE AND MONITORING

2019 v 2026 deep dive

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

2019 statement	2026 statement
Pain and fatigue are common symptoms for IBD patients and should be investigated and managed using a multidisciplinary approach including pharmacological, non-pharmacological and psychological interventions where appropriate.	Statement 7.6 - **Full consideration should be given to identify and manage symptoms of most importance to the patient e.g. pain, fatigue, comorbidities, extra-intestinal manifestations, continence and sexual function**. IBD patients should be investigated and managed using a multidisciplinary approach including pharmacological, non-pharmacological, **dietary** and psychological interventions where appropriate.
Any reviews and changes of treatment in primary or secondary care should be clearly recorded and communicated to all relevant parties within 48 hours.	Statement 7.7 - Any reviews and changes of treatment in primary or secondary care should be clearly recorded and communicated to all relevant parties **including GPs, patients and parents/ carers within 2 days.**
All IBD patients should be reviewed at agreed intervals by an appropriate healthcare professional and relevant disease information recorded.	Statement 7.8 - Review frequency should be agreed with the patient on an ongoing basis, including access to supported self-management and Patient Initiated Follow Up (PIFU) pathways.

SECTION 7: ONGOING CARE AND MONITORING

2019 v 2026 deep dive

IBD UK Standards 2026: BMJ Open Gastroenterology 2026

2019 statement	2026 statement
A mechanism should be in place to ensure that colorectal cancer surveillance is carried out in line with national guidance and that patients and parent/carers are aware of the process.	Statement 7.9 - A mechanism should be in place to ensure that colorectal cancer (CRC) surveillance is carried out in line with national guidance and that patients and parent/carers are aware of the process **and their individual risk factors for CRC**.
Patients or parents/carers should be offered copies of clinical correspondence relating to their/their child's treatment and care.	STATEMENT DELETED – ALREADY COVERED IN **STATEMENT 7.1** AND **STATEMENT 7.7**.

IBD UK ALLIANCE

ibduk.org

info@ibduk.org

01727 830 038

IBD UK Alliance is hosted by Crohn’s & Colitis UK.