CROHN'S & COLITIS UK RESPONSE TO THE 10 YEAR WORKFORCE PLAN

SECTION 1: THE 3 SHIFTS

Crohn's and Colitis, the two most common forms of Inflammatory Bowel Disease (IBD) are complex and fluctuating, and their physical and emotional effects can vary hugely from one person to another. This means that good multidisciplinary team working is essential to deliver high-quality care. This relies on sub-specialty expertise, especially for core members of the IBD service such as consultants and IBD Clinical Nurse Specialists, to deliver the three shifts.

SICKNESS TO PREVENTION

In summary DHSC should:

- **Implement the '**National Primary Care Diagnostic Pathway for Lower Gastrointestinal Symptoms**'** to guide testing and referral decisions quickly.
- **Improve access to specialist advice, such as from IBD Nurses, for primary care providers** to support early diagnosis and treatment
- **Expand Advanced clinical practice training enable nursing** to lead service redesign and make independent treatment decisions.

Prevalence and complexity of Crohn's and Colitis has been rising steadily in the UK as the population ages. Research published in 2021, revealed that over 450,000 people in England live with Crohn's or Colitis, twice as high as the previous NHS estimates.[1] This raises concerns about the health service capacity to meet the needs of these patients, meaning thousands of people may be left untreated and experience severe disease.

Recent groundbreaking research by scientists at the Francis Crick Institute has identified a critical genetic factor of Crohn's and Colitis.[2] However growing evidence suggests that Crohn's and Colitis are influenced not only by genetics, but also by environmental factors such as diet, gut microbiome balance, and early-life experiences, offering real opportunities for prevention and earlier intervention. With the right investment, the NHS can also speed up diagnosis, and support people to manage symptoms before they escalate.

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[1] Crohn's & Colitis UK. Epidemiology summary: incidence and prevalence of IBD in the United Kingdom. Available at: https://www.crohnsandcolitis.org.uk/media/4e5ccomz/epidemiology-summary-final.pdf. [Last accessed: October 2025]

[2] Stankey, C.T., Bourges, C., Haag, L.M. et al. A disease-associated gene desert directs macrophage inflammation through ETS2. Nature 630, 447–456 (2024). https://doi.org/10.1038/s41586-024-07501-1

Prompt diagnosis and treatment can lessen the significant costs and potentially worse outcomes associated with delayed diagnosis. These include reduced response to medical treatments and higher incidence of urgent and emergency surgery.

Currently:

- **1 in 7 people are diagnosed during an emergency hospital admission.**[3]
- **Delays to diagnosis make surgery 2 to 4 times more likely**[4]

Each delay increases the likelihood of emergency surgery, permanent bowel damage, and long-term health complications, adding to NHS cost pressures.

Diagnosing bowel conditions can be difficult. Symptoms can present atypically and can be associated with a range of other conditions, including irritable bowel syndrome, bowel cancer and coeliac disease. Delays and variation in diagnosing Crohn's and Colitis are common across the NHS. Many people wait months for an endoscopy, and some are referred unnecessarily because GPs lack consistent guidance on which tests to use first. This leads to avoidable procedures, wasted capacity and worsening symptoms, all of which increase cost and delay treatment.

However, there is **currently no national pathway guiding GPs** on how to assess and refer patients with lower gastrointestinal symptoms. Confidence in using and interpreting key diagnostic tools like faecal calprotectin tests varies widely, creating delays and duplication. Without clear guidance and access to specialist advice, patients fall through the gaps and costs rise.

Case Studies: Improving the initial referral pathways

York Teaching Hospital NHS Foundation Trust

Yorkshire & Humber Academic Health Science Network developed its own regional faecal calprotectin pathway to help GPs distinguish between inflammatory and non-inflammatory bowel conditions.[5]

- Adopted by **71 Integrated Care Boards**, the pathway included GP templates, patient leaflets and clinical support.
- For every 1,000 patients tested, **289 unnecessary colonoscopies** and **267 outpatient appointments** were avoided.
- Each 1,000 tests delivered **£42,000 in annual savings**.

[3] IBD UK (2024), 'The State of IBD Care in the UK', p. 22.
[4] 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. Aliment Pharmacol Ther. Doi: 10.1111/apt.17370.
[5] IBD UK (2021), 'Case study: Faecal calprotectin pathway, Yorkshire & Humber AHSN'. Available at https://ibduk.org/resources-for-ibd-services/pre-diagnosis/case-study-faecal-calprotectin-pathway [Last accessed November 2025]

This shows how consistent early testing can cut invasive procedures, speed up diagnosis and release capacity across the system.

University Hospital Southampton Consultant-Delivered Endoscopy Pathway

At Southampton, GP referrals with suspected IBD are triaged directly to consultant-delivered endoscopy, where patients receive same-day assessment and treatment initiation.[6]

- Referral-to-treatment time fell by 86% (177 to 24 days).
- Diagnostic yield increased by 26%, while traditional outpatient appointments were eliminated.

This significantly reduced IBD outpatient waiting times, and enabled up-skilling of IBD nurses, IBD-focused gastroenterology training, the introduction of subspecialty specific IBD lists and optimisation of the IBD service in the post-covid recovery era. However, this relies on dedicated IBD physicians being available to deliver specialised endoscopy lists.[14]

Both of these initiatives demonstrate how clear diagnostic pathways and collaboration between primary and secondary care can prevent escalation of disease, reduce waiting times, and improve system efficiency embodying the NHS's ambition to move from sickness to prevention.

Policy Recommendations

DHSC should:

1. **Implement the 'National Primary Care Diagnostic Pathway for Lower Gastrointestinal Symptoms'.**

Crohn's & Colitis UK, in partnership with other gut related charities and clinicians, have developed this pathway, including supporting information for GPs and patients, integrating with local pathways, and providing guidance for a range of non-specific symptoms to ensure the right tests are taken at the right time.

Having an effective diagnostic and referral pathway, alongside appropriate staffing will help reduce delays to diagnosis, enable earlier intervention, supporting the governments aims to reduce waiting times and move from sickness to prevention.

2. **Improve access to specialist advice, such as from IBD Nurses, to help encourage communication across primary and secondary care.**

Primary care professionals need quick access to expert guidance when assessing or managing patients with potential Crohn's or Colitis. Establishing formal routes for GPs to seek remote or in-person advice from IBD Nurse Specialists would prevent unnecessary

[6] IBD UK, 'Case study: Direct to Endoscopy pathway, University Hospital Southampton'. Available at: https://ibduk.org/resources-for-ibd-services/pre-diagnosis/case-study-direct-to-endoscopy-pathway [Last accessed November 2025]

referrals, support early flare management, and strengthen continuity of care between primary and secondary services.

3. **Expand Advanced clinical practice training enable nursing to lead service redesign and make independent treatment decisions.**

Specialist nurses are already driving service redesign, leading rapid-access clinics and triage systems that shorten referral-to-treatment times. However, many lack access to accredited Advanced Clinical Practice training.[7] Expanding these programmes would allow nurses to practice independently, make complex clinical decisions, and lead quality-improvement projects that deliver measurable gains in productivity and patient outcomes.

The case for change

Emerging research offers hope for future prevention through better understanding of the impact of diet, environment and genetics. But the NHS can act now by preventing disease escalation faster diagnosis, earlier treatment, and stronger workforce capacity reduce harm, improve quality of life and lower long-term cost.

Embedding standardised diagnostic pathways, expanding specialist nurse training and linking primary and secondary care will help the NHS deliver on its core prevention and productivity goals, keeping people well for longer and ensuring care is delivered in the right place, at the right time.

HOSPITAL TO COMMUNITY

In summary DHSC should:

- **Allocate targeted funding to recruit, retain, and train more IBD Nurse Specialists,** ensuring all services meet the recommended staffing levels (currently set at 2.5 WTE per 250,000 people).[8] This is essential to improve access to expert care and reduce emergency admissions.
- **Embed supported self-management and patient-initiated follow-up (PIFU) as standard models of care for stable patients,** taking from the examples of best practice given.
- **Ensure the new KPIs for homecare strengthen regulation and accountability of homecare medicine providers.** They should be robust, outcomes-based KPIs focused on patient experience and treatment continuity.
- **Expand the recruitment of pharmacists with a special interest in IBD,** enabling multi-disciplinary team participation

[7] Crohn's & Colitis UK 2023. Inflammatory bowel disease nurse specialists, national workforce audit 2023. Available at: https://crohnsandcolitis.org.uk/media/gtznp30q/ c-cuk-audit-report-3pp-a4-final.pdf. [Last accessed: October 2025]
[8] IBD UK (2019), IBD Standards. Available at: https://ibduk.org/ibd-standards. [Last accessed: October 2025]

Managing Crohn's and Colitis is complex. Whilst care is predominantly delivered and co-ordinated by specialist teams in secondary care, much of the support and care for those living with Crohn's or Colitis can be delivered without requiring hospital admission, through IBD nurse led advice lines for patients, supported self-management programmes and homecare medicines services.

IBD nurses play a critical role in IBD Care

The availability of IBD Nurse Specialists across the UK is vital for people living with Crohn's and Colitis to be able to access responsive health services and improved clinical outcomes. They deliver high quality patient care and experience, lead patient centred service redesign, improve the quality of care and represent excellent value for money.

However our research has found that the unsustainable pressure on services has left many IBD Nurses feeling the strain.

- **Only 20% of IBD services meet recommended staffing levels for specialist IBD nurses, leaving gaps in care.[9]**
- **One quarter of the nurses we surveyed told us that they were thinking of leaving their job. [10]**
- **Nearly 1 in 5 (18%) of the services who responded to the survey told us they had vacancies, and more than half of those were finding those vacancies difficult to fill.[11]**

If someone becomes unwell between appointments, many IBD services across the UK provide an IBD Advice Line that you can call or message for help. The advice lines are mostly run by IBD Nurse Specialists who provide expert support and advice about Crohn's and Colitis, they have advanced knowledge of IBD and they can assess and advise patients over the phone.

They may also help organise appointments if they think they're needed. However, too often running the advice line is an 'unseen workload', and just under half of those who responded (42%) to our survey rated their stress levels associated with advice line provision as high.[12]

We know that timely advice and intervention can prevent an escalation of a flare. For example, if a patient calls the advice line early in a flare, an IBD nurse can adjust medications or arrange tests within 48 hours, often avoiding an A&E visit.

[9] IBD UK (2024), 'The State of IBD Care in the UK', p. 64.
[10] Crohn's & Colitis UK 2023. Inflammatory bowel disease nurse specialists, national workforce audit 2023. Available at: https://crohnsandcolitis.org.uk/media/gtznp30q/ c-cuk-audit-report-3pp-a4-final.pdf. [Last accessed: October 2025]
[11] Ibid
[12] Ibid

- **Where people living with IBD report having contact with an IBD nurse specialist, they are more likely to have the information and skills to manage their condition.[13]**
- **When advice lines are well-staffed, they significantly improve patient experience, however 32% of patients did not receive a timely response whilst in a flare.[14]**

An audit of the specialist IBD nurse-led telephone advice line in the NHS Greater Glasgow & Clyde region reported notable system-level benefits of a well-run helpline. The helpline, managed by IBD clinical nurse specialists, was associated with a reduction in secondary care usage with annual cost savings of approximately £42,890 through avoided GP, outpatient and hospital attendances. Therefore showing that they not only provide an excellent benefit to patients but are also cost effective.[15]

Therefore, expanding the workforce of IBD nurses could:

- **Reduce Emergency Admissions:** Patients with direct access to an IBD nurse are able to get specialist advice they need and will therefore be less likely to require A&E visits or unplanned hospital stays.
- **Improve Primary Care Management:** Equipping GPs and other primary care providers with the support of specialist nurses could reduce unnecessary referrals to secondary care.
- **Enhance Patient Wellbeing and Self-Management:** Timely intervention and structured support through well-resourced IBD helplines will empower patients to manage their condition proactively, reducing reliance on other NHS resources.

Policy Recommendations

DHSC should:

- **Allocate targeted funding to recruit, retain, and train more IBD Nurse Specialists, ensuring all services meet the recommended staffing levels (currently set at 2.5 WTE per 250,000 people).[16]**

Investing in IBD Nurse Specialists will improve access for patients, bring care closer to home, and reduce pressure on wider gastroenterology services. It aligns with NHS priorities for personalised care, community care, and digital transformation.

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[13] IBD UK (2021), 'Crohn's and Colitis Care in the UK – The Hidden Cost and a Vision for Change', p. 31.
[14] IBD UK (2024), 'The State of IBD Care in the UK', p. 32.
[15] Squires, S. I., Boal, A. J. & Naismith, G. D. 2016. The financial impact of a nurse-led telemedicine service for inflammatory bowel disease in a large district general hospital. Frontline Gastroenterology, 7, 216.
[16] IBD UK (2019), IBD Standards. Available at: https://ibduk.org/ibd-standards. [Last accessed: October 2025]

Supported self-management and Patient Initiated Follow-Up (PIFU)

Being diagnosed with Crohn's or Colitis can be an incredibly stressful time and overwhelming for patients. 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. All patients with Crohn's and Colitis should be provided with clear information to support self-management and early intervention in the case of a flare.

Personalised care and self-management approaches have been shown to reduce admissions and contact with the NHS.[17] Self-management in Crohn's and Colitis enables people to have more control over their lives, by giving them the knowledge and skills to develop life goals, make healthy choices and manage their condition.

Case Study: Virtual Self-Management Programme- Cardiff and Vale University Health Board

An IBD Clinical Nurse Specialist in Cardiff and Vale University Health Board, has developed a virtual self-management programme that now supports around 400 of the approximately 7,000 patients cared for across the area.[18]

Patients who are well or not on any regular medication, are monitored virtually. They are reviewed annually and have a clear flare management plan. If they become unwell, they have rapid access back into the service, ensuring they are seen at the right time.

The approach mirrors a Patient-Initiated Follow-Up (PIFU) model, where patients who are well are not scheduled for routine appointments but remain under virtual surveillance with clear guidance on how to re-enter the service if symptoms return or a flare develops. Self-management with an annual check-in maintains regular contact with the IBD service while freeing up clinic time for patients who need it most.

- **Removing hundreds of routine follow-up appointments freed clinic capacity for new patients awaiting treatment.**
- **The introduction of administrative support has been essential in growing the population supported by this project from 200 in 2022, to around 400 in 2024. Without this the project was becoming unsustainable.**
- **The team estimate that up to 50 % of patients in Cardiff could ultimately be eligible for virtual self-management.**

This model demonstrates that virtual supported self-management can safely reduce unnecessary follow-ups, improve access for newly diagnosed and flaring patients, and

[17] NHS England. Personalised care: evidence and case studies. Available at: www.england.nhs.uk/personalisedcare/evidence-and-case-studies. Last accessed: April 2024

[18] Woolley, K., Palmer, D., Dale, M., (2023), 'Inflammatory Bowel Disease (IBD) service development by reinvesting cost saving; impact on patient outcomes'. Available at: cedar.nhs.wales/files/ibd-service-evaluation-report/ [Last accessed: November 2025].

strengthen coordination with primary care, while freeing hospital capacity for those who need it most.

Case study: Education Clinics – Warrington & Halton Teaching Hospitals

At Warrington & Halton Teaching Hospitals NHS Foundation Trust, the IBD service established dedicated *Education Clinics* to give newly diagnosed patients rapid access to focused support and information without overloading routine outpatient lists.[19] Three additional clinic appointments were introduced each week, allowing patients to be seen quickly, often within the same week, for an extended education session led by the IBD nurse specialist.

These appointments provide time to explain results, discuss medications and blood monitoring, and address lifestyle and self-management questions. The clinics were designed to replace some routine review appointments for stable patients, instead focusing on equipping individuals with the skills and confidence to self-manage.

- **Routine clinics were no longer overbooked, allowing sufficient time for complex or unwell patients**
- **Patients were able to access an education appointment in the same week as diagnosis or therapy change, improving experience and reducing anxiety.**
- **Referral pathways were streamlined, with new patients referred directly from endoscopy for early education rather than waiting weeks for follow-up**
- **A successful business case secured an additional IBD nurse post, recognising that increased capacity was essential to sustain the service.**
- **The model was subsequently expanded to the Trust's second site, improving equity of access and reducing the need for patients to travel.**

The Warrington & Halton model demonstrates that timely, specialist-led education can strengthen supported self-management while improving system efficiency. By creating protected clinic capacity and investing in nurse staffing, the service reduced delays, improved treatment safety, and empowered patients to take a more active role in their own care.

Policy Recommendations

DHSC should:

- **Embed supported self-management and patient-initiated follow-up (PIFU) as standard models of care for stable patients, using the examples of best practice given.**

[19] IBD UK, 'Case study: Education Clinics, Warrington and Halton Teaching Hospitals'. Available at: https://ibduk.org/resources-for-ibd-services/personalised-care/case-study-education-clinics [Last accessed: November 2025]

Together, these examples show that supported self-management is a practical and effective way to help people with Crohn's and Colitis stay well and avoid unnecessary hospital care. However, these benefits depend on sufficient specialist nurse and other staffing capacity to deliver.

Homecare

When homecare medicine services work well they offer people the opportunity to continue their treatment in the comfort of their own home, reducing the impact on work or education, and costs to both patients and the NHS. However, evidence from people living with Crohn's and Colitis and clinicians highlight deep, systemic and long-standing failures in homecare medicine services.

Failures in homecare medicine services, which can result in a relapse of symptoms, flares, emergency treatment or surgery, increase costs to the NHS and add resource pressures on already stretched IBD services. Not only do IBD teams need to react quickly to treat flares, patients who have difficulty in contacting homecare medicine services to report and investigate issues, turn to their IBD service, specifically their IBD nurses, for help.

- **Half (49%) of the nurses responding to our survey told us they spend at least half a day every week supporting patients having difficulties with their homecare medicine service with 12% spending a day or more each week.**

Integrating specialist pharmacist support in to multidisciplinary teams has been seen in a number of areas, including Brighton and Sussex University Hospitals Trust where it has improved the consistency and safety of drug monitoring and counselling, and released consultant time.[20]

- **However, only 17% of IBD Services across the UK reported that an expert pharmacist in IBD working at least 06.WTE was part of their multidisciplinary team.[21]**

The support of a specialist IBD pharmacist can support improved medicines utilisation, management of patients on advanced therapies, and utilisation of homecare services, relieving pressure on other members of the multidisciplinary team, particularly IBD Nurses and consultants.

[20] IBD UK, 'Case study: IBD Specialist Pharmacy Service'. Available at: https://ibduk.org/resources-for-ibd-services/the-ibd-team/case-study-ibd-specialist-pharmacy-service-brighton-sussex-university-hospitals-trust [Last accessed: November 2025]
[21] IBD UK (2024), 'The State of IBD Care in the UK', p.64.

Case Study - Lancashire Teaching Hospitals

Lancashire Teaching Hospitals gastroenterology team introduced a virtual biologic clinic to meet the growing demands of the local population, ensuring prescribing and monitoring of biological therapies is in line with national and regional guidelines.[22]

This intervention meant that during the review period,

- **97.4% of patients now have regular review on their biological therapies compared to 60% prior to introduction of the virtual biologic clinic,**
- **An estimated £100k in annual savings to the Trust.**
- **Compliance with national and regional pathways improved from 58% to 90% and the high-cost drug funding completion rate has also risen from 46% to 96%.**
- **There was a 20% increase in homecare referrals have been observed since the introduction of virtual biologic clinic as the team actively transfer all eligible patients onto the homecare pathway, giving patients the option to have treatment at home.**

Homecare medicines are a vital enabler of modern, efficient care but the system's chronic failings are undermining patient safety and wasting specialist capacity. The introduction of a robust, outcomes-based KPI framework, alongside clear accountability, workforce investment and patient involvement, is essential to restoring confidence and ensuring that homecare medicine services deliver the value and quality patients deserve.

Policy Recommendations

DHSC should:

- **Ensure the new KPIs for homecare strengthen regulation and accountability of homecare medicine providers. They should be robust, outcomes-based KPIs focused on patient experience and treatment continuity.**
- **Expand the recruitment of pharmacists with a special interest in IBD, enabling multi-disciplinary team participation.**

[22] IBD UK, 'Case study: The role of a specialist IBD pharmacist in a virtual biologic clinic, Lancashire Teaching Hospitals' Available at: https://ibduk.org/resources-for-ibd-services/the-ibd-team/case-study-the-role-of-a-specialist-pharmacist-2 [Last accessed: November 2025]

CROHN'S & COLITIS UK

ABOUT CROHN'S AND COLITIS

Crohn's and Colitis, the two most common forms of Inflammatory Bowel Disease (IBD) are complex and fluctuating, and their physical and emotional effects can vary hugely from one person to another. Research published in 2021, revealed that over 450,000 people in England live with Crohn's or Colitis – twice as high as the previous NHS estimates.[23] This raises concerns about the health service capacity to meet the needs of these patients, meaning thousands of people may be left untreated and experience severe disease. Lifetime costs for Crohn's and Colitis are comparable to major diseases including heart disease and cancer.[24]

Improvements in the effective use of high-cost advanced therapies, which have significantly increased in the last decade, provides an opportunity for savings in medicine costs to be reinvested back into IBD services and the wider NHS. This could support the three shifts, reduce costly intervention, and deliver better patient outcomes.

Crohn's and Colitis affect people of all ages, but most people are diagnosed between the ages of 15 and 30, meaning it has a significant impact on their working life. The cause is not fully understood but is thought to be a mix of genetic susceptibility, abnormal gut microbiome, environmental factors and a dysregulated immune response. They are painful, debilitating and lifelong conditions, with periods of relapse (called "flares") and remission. There is also significant variation in the pattern and complexity of the symptoms both between people and in the individual at different times in their life. Crohn's and Colitis can affect almost every part of the body and every aspect of life: from digestion and joints to energy levels, mental health, education, and the ability to work. Treatment aims to induce and maintain remission, manage and reduce the number of flares, prevent complications and enhance quality of life.[25]

Delays to diagnosis, often caused by low public awareness of symptoms, ineffective pathways, and long waits for gastroenterology and endoscopy appointments, result in significant extra costs for the NHS and can make surgery 2 to 4 times more likely.[26] One in seven adults (14%) with Crohn's and Colitis are currently diagnosed during an emergency hospital admission.[27] NHS England's RightCare scenario for IBD shows that

[23] Crohn's & Colitis UK. Epidemiology summary: incidence and prevalence of IBD in the United Kingdom. Available at: https://www.crohnsandcolitis.org.uk/media/4e5ccomz/epidemiology-summary-final.pdf. [Last accessed: October 2025]
[24] Luces C, Bodger K. Economic burden of inflammatory bowel disease: a UK perspective. Expert Rev Pharmacoecon Outcomes Res 2006;6: 471–482.
[25] Turner D, Ricciuto A, Lewis A, et al. STRIDE-II: An Update on the Selecting Therapeutic Targets in Inflammatory Bowel Disease (STRIDE) Initiative of the International Organization for the Study of IBD (IOIBD): Determining Therapeutic Goals for Treat-to-Target strategies in IBD. Gastroenterol 2021;160:1570–1583
[26] 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. Aliment Pharmacol Ther. Doi: 10.1111/apt.17370.
[27] IBD UK (2024), 'The State of IBD Care in the UK, p.22.

suboptimal care for Crohn's and Colitis can cost four times as much as optimal care in primary care and double in secondary care.[28]

People living with Crohn's or Colitis may face a lifetime of medication and, in many cases, major surgery. 26% of people with Crohn's disease will have resection surgery within 10 years.[29] For those with ulcerative colitis, 10–15% are likely to require surgery after 5–10 years.[30] Left untreated, complications from Crohn's or Colitis can be life-threatening. Medical treatment includes steroids, traditional immunosuppressants, novel small molecules, biologic medicines and surgery to remove damaged bowel.[31]

The IBD Standards define what a good IBD service should look like at all stages of a patient's journey, and have been updated to reflect changing models of care.[32] Care is predominantly delivered or co-ordinated by staff in specialist services based in secondary care, from endoscopic investigation at diagnosis, prescription of advanced therapies to manage disease, to ongoing support for self-management with quick access back into IBD services when required. Reinvesting a proportion of savings from the more effective use of advanced therapies can help services to meet the IBD Standards, reduce costs and deliver better patient outcomes.

[28] NHS England (2024), RightCare scenario: Inflammatory bowel disease, Available at: https://www.england.nhs.uk/wp-content/uploads/2024/06/RightCare-IBD-scenario-summary-slide-pack.pdf [Last accessed November 2025]
[29] Burr NE, Lord R, Hull MA, et al. Decreasing risk of first and subsequent surgeries in patients with Crohn's disease in England from 1994 through 2013. Clin gastroenterol hepatol 2019;17:2042–2049.E4.
[30] Fumery M, Singh S, Dulai PS, et al. Natural history of adult ulcerative colitis in population-based cohorts: a systematic review. Clin gastroenterol hepatol 2018;16:343–356.E3.
[31] Crohn's & Colitis UK 2023. Biologics and other targeted medicines. Available at: https://crohnsandcolitis.org.uk/info-support/information-about-crohns-andcolitis/all-information-about-crohns-and-colitis/treatments/biologics-and-othertargeted-medicines. [Last accessed: October 2025]
[32] IBD UK 2019. IBD Standards. Available at: https://ibduk.org/ibd-standards. [Last accessed: October 2025]