

National Early Inflammatory Autoimmune Diseases Audit (NEIAA)

State of the Nation Summary Report 2026

Data collection period: 1 April 2025 – 31 March 2026

Geographical coverage: England, Wales, Jersey

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The National Early Inflammatory Autoimmune Diseases Audit (formerly known as the National Early Inflammatory Arthritis Audit) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales and Jersey as part of the [National Clinical Audit and Patient Outcomes Programme](#).

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In line with the NHS commitment to paperless 2020, this report is only available in a digital format.

Further information about the content of this report can be found in the online [appendices](#).

Introduction

The National Early Inflammatory Autoimmune Diseases Audit (NEIAA) is the only national clinical audit examining how quickly people with inflammatory arthritis, connective tissue diseases and systemic vasculitis are diagnosed, assessed and treated across England, Wales and Jersey. By measuring access to specialist care and patient outcomes, NEIAA supports providers, commissioners and policymakers to identify unwarranted variation, benchmark performance and drive improvements in the quality of care.

This State of the Nation report presents key findings from NEIAA Year 8 data, covering diagnoses recorded between 1 April 2025 and 31 March 2026. It highlights areas of progress, identifies opportunities for improvement, and sets out five national recommendations. Integrated Care Boards (ICBs), Welsh Health Boards and the Getting It Right First Time (GIRFT) national improvement programme, working in collaboration with the British Society for Rheumatology, are encouraged to use these recommendations to drive operational and clinical improvement and to learn from examples of best practice.

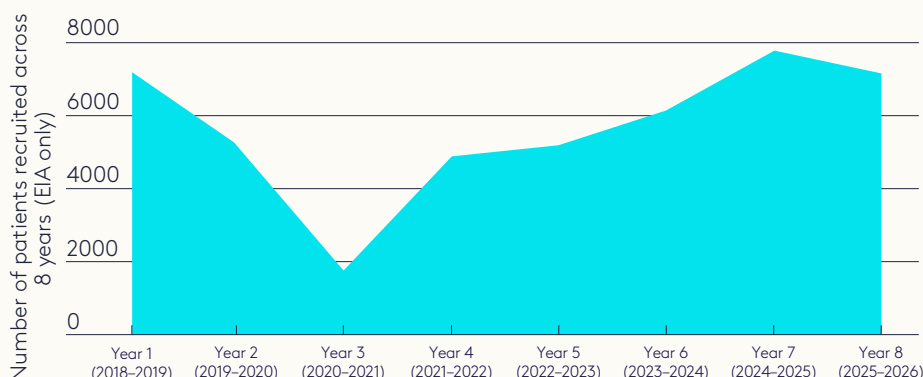
Alongside this national report, individual trust and health board reports are available, providing local data for key performance metrics and enabling trusts and health boards to benchmark performance, monitor progress and support local quality improvement activity.

Year 8 findings demonstrate that earlier assessment and treatment continue to be associated with better patient outcomes. Patients who start disease-modifying anti-rheumatic drug (DMARD) treatment at their first rheumatology appointment are significantly more likely to achieve early clinical remission, while patients presenting with higher disease activity are substantially less likely to respond to treatment. The report also shows that dedicated early inflammatory arthritis pathways are associated with faster access to care, and that achieving clinical remission is linked to improved employment outcomes. Despite examples of outstanding practice, considerable variation persists between providers, highlighting opportunities to improve referral pathways, expand early inflammatory arthritis services, strengthen multidisciplinary support and improve use of patient-reported outcome measures.

The performance of individual healthcare providers is measured against the National Institute for Health and Care Excellence (NICE) quality standard QS33, *Rheumatoid arthritis in over 16s* (last updated in 2020). NEIAA also identifies providers whose performance is significantly below the national average for timely treatment of early inflammatory arthritis, enabling targeted support and improvement activity. Providers with very low case ascertainment are also highlighted because incomplete audit participation limits the ability to assess and improve service performance.

National Early Inflammatory Autoimmune Diseases Audit (NEIAA) State of the Nation 2026: Summary Report Infographic

NEIAA recruitment for Early Inflammatory Arthritis (EIA) patients is broadly consistent with last year



96%
of eligible providers
participated

10,695 patients
recruited across England,
Wales and Jersey

Early clinical remission is linked to better work outcomes

49%

Among patients who achieved clinical remission at three months, 49% were in employment at 12 months following assessment

44%

Among patients who had not achieved clinical remission at three months, 44% were in employment at 12 months following assessment

2,536

patients returned
patient reported
outcome measures
in Year 8 (35% of
those eligible)

53%

of EIA patients
received treatment
within 6 weeks
overall

Wide variation remains across providers

Percentage of patients receiving
treatment within 6 weeks, by provider

4%

98%

Patients referred through designated EIA pathways are seen and treated more quickly

45%
assessed in
3 weeks

33%
assessed in
3 weeks

↑
+12% for
referrals
via an EIA
pathway

57%
treated
within 6
weeks

43%
treated
within 6
weeks

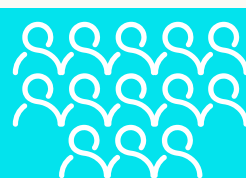
↑
+14% for
referrals
via an EIA
pathway

Modelling suggests over 500 additional patients may have achieved early clinical remission with same-day treatment initiation



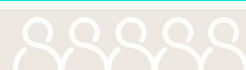
2,806

Did not achieve clinical
remission at 3 months



1,396

Achieved clinical
remission at 3 months



534

May have achieved clinical
remission at 3 months

Patients who commenced treatment at their first appointment had 48% higher odds of achieving clinical remission at 3 months compared with those who did not

National recommendations

1

Use NEIAA findings to identify providers without effective referral and triage pathways and work with them to implement standardised referral processes and triage tools, reducing unwarranted variation and enabling timely specialist assessment for people with suspected inflammatory arthritis, connective tissue disease and systemic vasculitis.

Action by: ICBs, Welsh Health Boards and GIRFT

Key messages 1, 2 and 7



2

Use NEIAA findings to identify providers that do not offer dedicated EIA clinics and same-day treatment, and work with them to implement sustainable service models that enable rapid assessment, earlier treatment and improved patient outcomes.

Action by: ICBs, Welsh Health Boards and GIRFT

Key messages 3 and 4



3

There is a clear link between higher disease activity at diagnosis and a reduced likelihood of achieving early clinical remission. National guidance should be strengthened to emphasise the importance of early treatment escalation for patients with poor prognostic factors.

Action by: NICE, BSR

Key messages 3 & 4



4

Ensure PROMs are routinely collected, reviewed and incorporated into clinical decision-making alongside disease activity measures to inform treatment decisions and identify unmet patient need.

Action by: NHS Trusts, ICBs, Welsh Health Boards

Key messages 5 and 6



5

Commission and maintain sufficient administrative and data management resource to ensure accurate, timely NEIAA data submission and the effective use of audit findings to inform local quality improvement.

Action by: NHS Trusts, ICBs, Welsh Health Boards, NHS England, Welsh Government, DHSC and the Government of Jersey

Key message 4



Participation, ethnicity and demography

NEIAA aims to improve the quality of care for people living with rheumatic diseases by providing national data on timeliness of diagnosis, access to specialist care and patient outcomes. The audit collects information on all eligible patients aged 16 years and over who are newly diagnosed with inflammatory arthritis, vasculitis and connective tissue diseases within rheumatology services across England, Wales and Jersey.

In Year 8, participation remained high, with 96% (122 of 127) of eligible providers submitting data for a total of 10,695 patients to the audit. This included 114 of 117 eligible providers in England, seven Welsh health boards and the Jersey service. This high level of engagement enables NEIAA to provide a comprehensive picture of variation in care and outcomes across participating nations and to support local and national quality improvement activity.

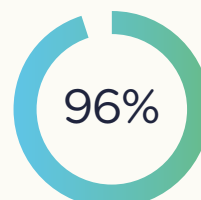
Although EIA recruitment was broadly unchanged from Year 7, overall audit recruitment increased in Year 8.

Patient demographics for EIA remained stable compared with previous audit years, suggesting that the audit continues to capture a representative population of patients receiving rheumatology care.

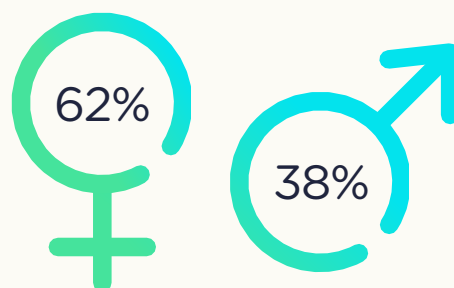
In Year 8:

- 62% of patients were female and 38% were male
- The mean age at diagnosis was 57 years
- 47% of patients were in employment for more than 20 hours per week at diagnosis
- Ethnic diversity broadly reflected the populations served by participating providers, with 80% of patients recorded as White, 10% Asian, 3% Black, 1% of mixed ethnicity and 6% recorded as another ethnic group or with unknown ethnicity.

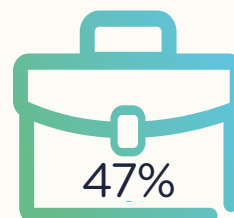
These data provide important context for the findings presented in this report and demonstrate that NEIAA continues to capture a large and diverse patient population across England, Wales and Jersey.



of eligible providers in England, Wales and Jersey participated in the audit, reflecting continued high levels of engagement across the sector



Mean age at diagnosis



were in employment for more than 20 hours per week at diagnosis

Key messages

1. Symptom duration

Time from symptom onset to assessment by a rheumatology service can be divided into three stages:

- 1) Symptom onset to first presentation in primary care
- 2) Primary care assessment to referral
- 3) Referral to rheumatology assessment

Figure 1: Time from symptom onset to presentation in primary care (median months)

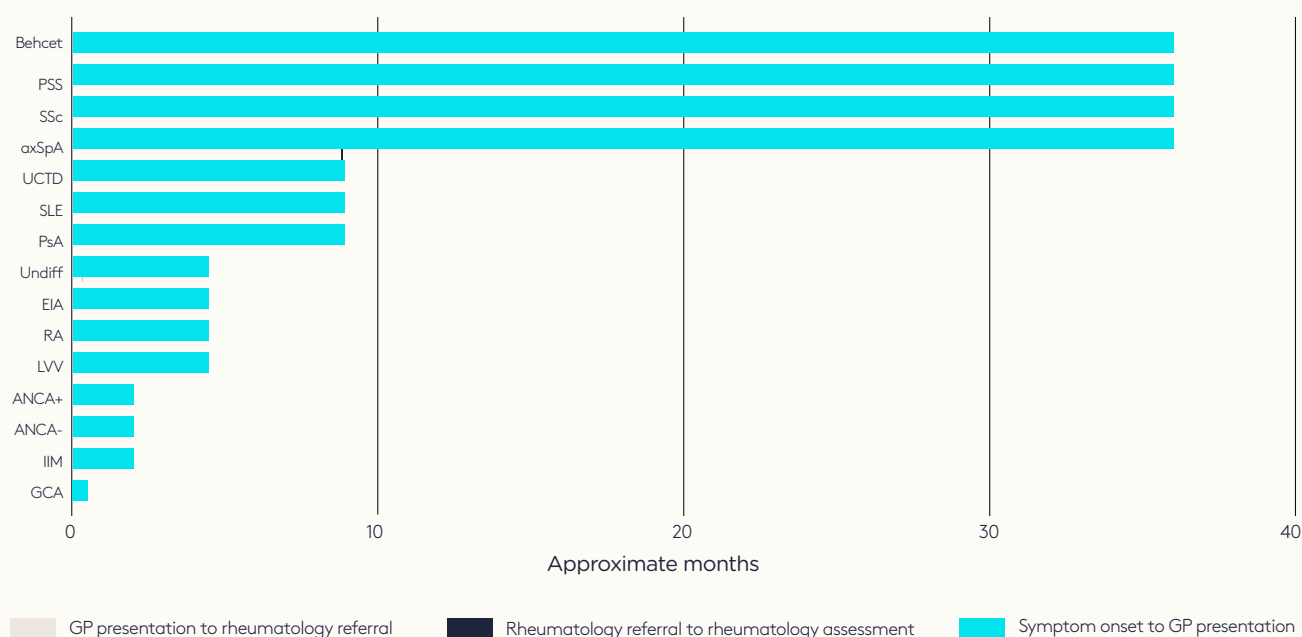
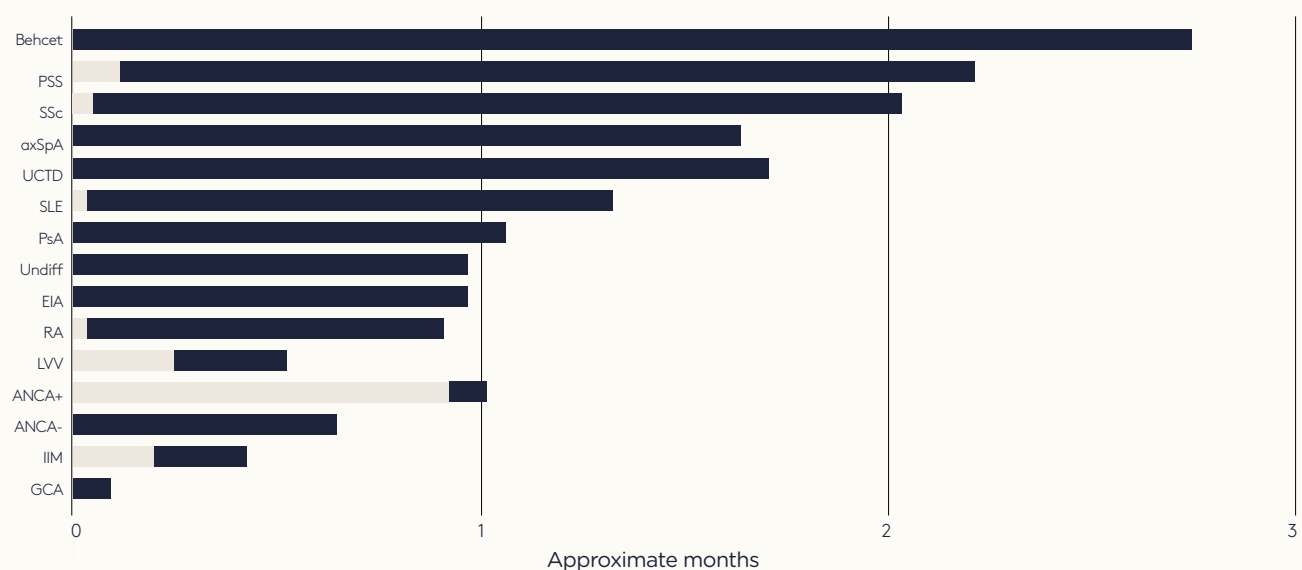


Figure 2: Time from presentation in primary care to assessment in secondary care (median months)



Behcet = Behçet's syndrome
PSS = Primary Sjogren's syndrome
SSc = Systemic sclerosis
axSpA = Axial spondyloarthritis
UCTD = Undifferentiated connective tissue disease/overlap syndrome
SLE = Systemic lupus erythematosus
PsA = Psoriatic arthritis
Undiff = Undifferentiated inflammatory arthritis

EIA = Early inflammatory arthritis
RA = Rheumatoid arthritis
LVV = Large vessel vasculitis (excluding giant cell arteritis)
ANCA+ = Anti-neutrophil cytoplasmic antibody associated vasculitis
ANCA- = Small/medium vessel vasculitis (anti-neutrophil cytoplasmic antibody-negative)
IIM = Idiopathic inflammatory myopathy
GCA = Giant cell arteritis

Figures 1 and 2 show that delays occur at different stages of the patient journey and vary considerably between conditions.

While the overall pathway from symptom onset to rheumatology assessment is longest for conditions such as Behçet's syndrome, systemic sclerosis and axial spondyloarthritis, the interval following first presentation to primary care is considerably shorter for most conditions .

For most conditions, delays occur before patients present to healthcare services (as shown in Figure 1). Larger delays between GP presentation and referral are seen for ANCA-associated vasculitis, large vessel vasculitis and idiopathic inflammatory myopathy (as shown in Figure 2).

These findings suggest that opportunities exist to reduce delays both before patients present to healthcare services and within NHS referral and assessment pathways.

Although disease processes often begin before diagnostically specific signs and symptoms develop, early presentation to primary care remains important. For some conditions, patients may experience symptoms for many months or years before seeking medical advice.

Long symptom duration before presentation was highlighted in the [Year 7 State of the Nation report](#) and continues to be evident in Year 8 data.

A range of tools and resources are available to support earlier recognition and referral of inflammatory rheumatic disease. These include [NICE quality standard QS33](#), the [GIRFT/NASS Axial SpA Playbook](#), [BSR specialist advice and triage resources](#) and [GIRFT Advice and Guidance templates](#).

Together, these resources support earlier identification of suspected inflammatory disease and more timely referral to specialist care.

Reducing the duration of the entire diagnostic pathway is important because prolonged delays are associated with poorer patient outcomes. In early inflammatory arthritis, longer symptom duration before treatment initiation is associated with poorer treatment response. Patients who experience longer diagnostic delays or present with higher baseline disease activity are less likely to achieve an optimal response to treatment once seen in secondary care.

Earlier recognition, timely referral and rapid access to specialist assessment therefore remain key priorities for improving long-term outcomes. For patients who present with more severe disease, timely access must be accompanied by treatment strategies that support earlier escalation of therapy, as standard treatment approaches may be less likely to achieve remission in this group.

2. Time to assessment

In Year 8, 42% of patients with EIA were assessed by a rheumatology specialist within three weeks of referral. This is a modest increase from Year 1 of the audit, when 40% of patients were seen within the national standard. Although national performance has remained broadly stable, variation between providers has increased, indicating that timely access is achievable but not yet consistently delivered across services. The widening gap between the highest- and lowest-performing services suggests that performance is influenced by local pathway design, workforce capacity and service organisation.

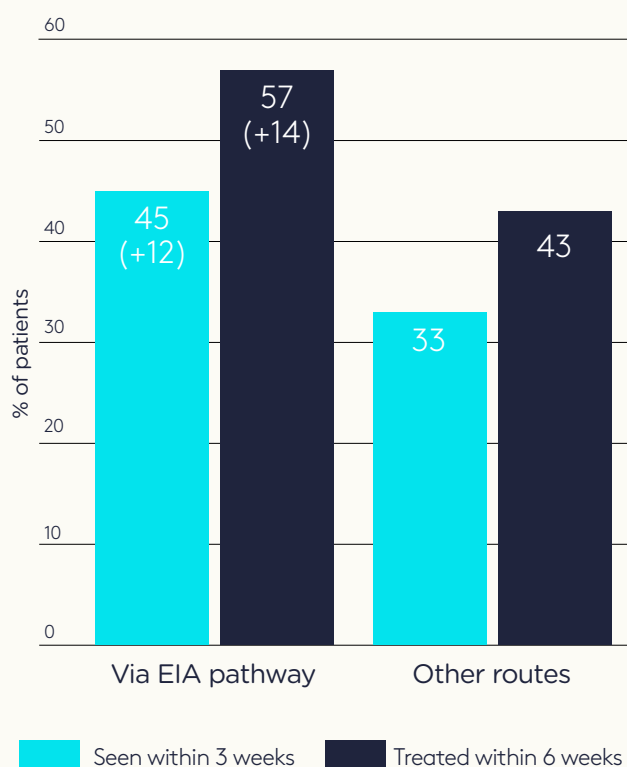
Experience from University Hospitals of Leicester NHS Trust demonstrates that sustained improvement is achievable through service redesign. Dedicated consultant triage time within job plans, designated EIA clinics and same-day disease-modifying anti-rheumatic drug (DMARD) treatment initiation have enabled the trust to consistently achieve the national standard. As described in the [Year 7 State of the Nation report](#), Leicester has maintained assessment within three weeks for almost all patients and achieved the six-week treatment target in 98% of cases in Year 8. Leicester demonstrates that national standards are achievable when services implement EIA pathways, protected consultant triage capacity and rapid access clinics. The challenge now is to spread this model more consistently across providers.

Across England, Wales and Jersey, patients referred through a designated EIA pathway were substantially more likely to receive timely care than those referred through other routes. In Year 8, 45% of patients referred via an EIA pathway were assessed

within three weeks, compared with 33% referred through other routes (+12 percentage points). Similarly, 57% received treatment within six weeks, compared with 43% of patients referred outside an EIA pathway (+14 percentage points).

These findings indicate that service design influences patient outcomes. Dedicated referral pathways, consultant triage and protected EIA clinic capacity are associated with faster access to specialist assessment and treatment initiation. As demand for rheumatology services continues to increase, wider adoption of these approaches offers a practical opportunity to reduce unwarranted variation and support improved outcomes for patients with EIA.

Figure 3: Impact of designated EIA pathways on timely assessment and treatment



3. Time to treatment

In Year 8, 53% of patients with EIA commenced DMARD treatment within six weeks of referral. The median time from referral to treatment was 40 calendar days, equivalent to approximately six weeks.

Although national performance has remained stable over time, considerable variation between providers indicates that timely treatment is achievable but not yet delivered consistently.

Evidence from high-performing services demonstrates that better performance is associated with well-defined service models, including effective consultant triage, dedicated EIA clinics and initiation of DMARD therapy on the day of diagnosis ("same-day treatment").

Initiating treatment at the first rheumatology appointment is associated with improved patient outcomes. In Year 8, patients who commenced DMARD therapy on the day of their first rheumatology appointment had an estimated 38% probability of achieving clinical remission at three months, compared with 27% for those who did not start treatment on the day of first appointment.¹ After adjustment for other factors, this equates to 48% higher odds of achieving early clinical remission. This association is also observed across rheumatology services (Figure 5).

Services with higher rates of same-day DMARD initiation generally achieve higher proportions of patients with an early clinical response, supporting the adoption of service models that facilitate treatment on the day of diagnosis. Although these findings do not prove that same-day treatment directly causes improved outcomes, they are consistent with patient-level findings showing that prompt treatment is associated with improved remission rates.

Disease severity at presentation also influences outcomes. Patients presenting with high disease activity (DAS28 > 5.1) were approximately half as likely to achieve clinical remission at three months as those with lower disease activity (22% vs 43%).²

Patients with severe disease at diagnosis or other poor prognostic factors may therefore require not only timely access to care, but also earlier treatment escalation and more intensive management approaches if remission rates are to improve.

These findings reinforce the importance of ensuring patients are assessed promptly, started on treatment without unnecessary delay and offered appropriate escalation where clinically indicated. Earlier treatment and effective disease control provide the best opportunity to improve remission rates and long-term outcomes.

Table 1: Performance against key quality metrics: Year 1 to Year 8

Quality Standards	Year 1	Year 8	Trend
GP referral ≤ 3 days	39%	54%	↑
Assessment ≤ 3 weeks	40%	42%	↑
Treatment ≤ 6 weeks	53%	53%	→

Figure 4: Percentage of EIA patients receiving DMARD treatment within six weeks by audit year

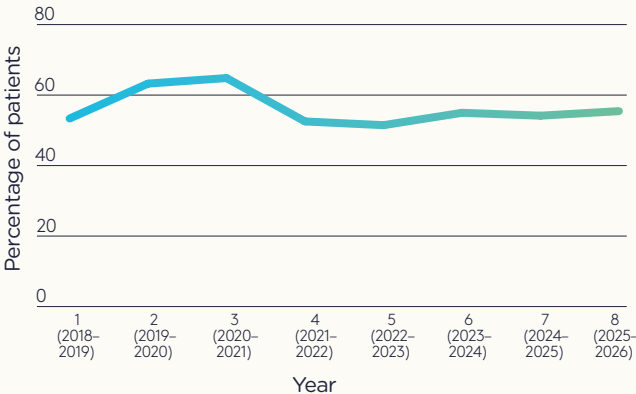
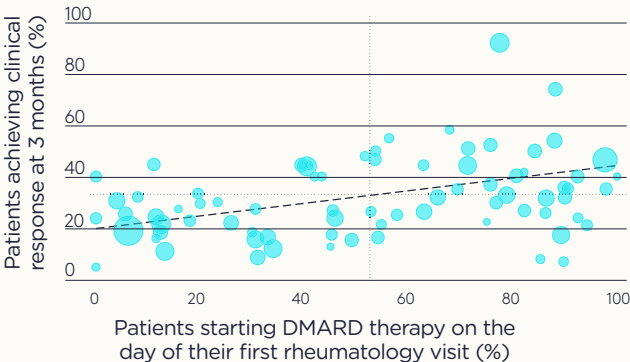


Figure 5: Association between DMARD initiation and clinical response



Each circle represents a trust; circle size reflects the number of patients

¹ OR 1.48 (95% CI 1.26-1.74; $p < 0.001$).

² OR 0.37 (95% CI 0.32-0.43; $p < 0.001$).

Case study: Oxford University Hospitals NHS Foundation Trust

From audit to action

NEIAA provides a valuable benchmark for how effectively rheumatology services diagnose and treat early inflammatory arthritis. Like many trusts, Oxford University Hospitals NHS Foundation Trust experienced a deterioration in performance following the COVID-19 pandemic. By 2024, it had become a national outlier, with only 6% of patients seen within three weeks of referral and 17% commencing DMARD therapy within six weeks.

The team saw NEIAA as an opportunity to drive quality improvement using routinely collected audit data. Within 12 months, performance improved substantially, and the trust is now one of the most improved in the audit.

Table 2: Improvement in treatment timeliness

	Year 7	Year 8
EIA patients recruited	115	101
Treatment timeliness performance	20%	65%

Starting with the data

NEIAA became a standing item at monthly management meetings, allowing performance to be reviewed regularly and progress to be monitored using the NEIAA performance dashboard. This increased visibility, strengthened accountability and maintained engagement across the multidisciplinary team.

Increasing capacity where it mattered most

The team mapped the patient pathway from referral through to treatment initiation to identify bottlenecks and delays. A new consultant post (5 PAs) helped restore lost capacity, while registrar and fellow job plans were redesigned to expand dedicated EIA

clinic provision. This ensured that increased demand for new patient appointments was matched with senior clinical decision-making capacity.

Making better use of the multidisciplinary team

Nurse-led follow-up clinics, supported by targeted training and competency development, took on routine follow-up care. This released consultant and registrar capacity for new referrals, improving access while strengthening the nursing workforce and overall clinic efficiency.

Transforming data collection

NEIAA data collection was embedded within departmental digital outcome forms using an electronic template. This enabled data to be captured as part of routine clinical care rather than retrospectively. Standardisation improved data quality, reduced clinician workload, and increased audit participation.

Maintaining focus on continuous improvement

Audit data is now used as a live quality improvement tool, with NEIAA metrics reviewed alongside operational performance indicators at routine departmental meetings. This enables the team to evaluate the impact of service changes rapidly and sustain momentum for improvement.

What made the difference

Oxford's improvement was driven by a series of practical service changes:

- Using NEIAA data as a monthly management tool
- Mapping the patient pathway to identify bottlenecks
- Increasing senior clinical capacity
- Expanding nurse-led follow-up clinics
- Embedding routine NEIA data collection

4. Treatment response

Clinical remission rates have remained largely unchanged since the start of the audit. In Year 8, 33% of patients achieved clinical remission (DAS28 < 2.6) three months after assessment. While national performance has remained stable, substantial variation between providers demonstrates that better outcomes are achievable.

NEIAA findings suggest that improving access to timely treatment is an important opportunity to improve remission rates. Patients who commenced DMARD therapy on the day of their first appointment were considerably more likely to achieve clinical remission at three months than those whose treatment was delayed. Modelling suggests that same-day treatment initiation could have resulted in up to 534 additional patients achieving early clinical remission in Year 8.

Disease severity at presentation also affects outcomes. Patients presenting with high disease activity were approximately half as likely to achieve clinical remission as those with lower disease activity. These findings suggest that timely access alone may not be sufficient for patients with poor prognostic factors, who may also require earlier escalation of therapy.

Improving access to timely treatment offers one of the clearest opportunities to increase clinical remission rates, but services must also be able to measure whether patients are achieving these outcomes. In Year 8,

50% of eligible records had a completed DAS28 score at three months, providing important insight into treatment response.

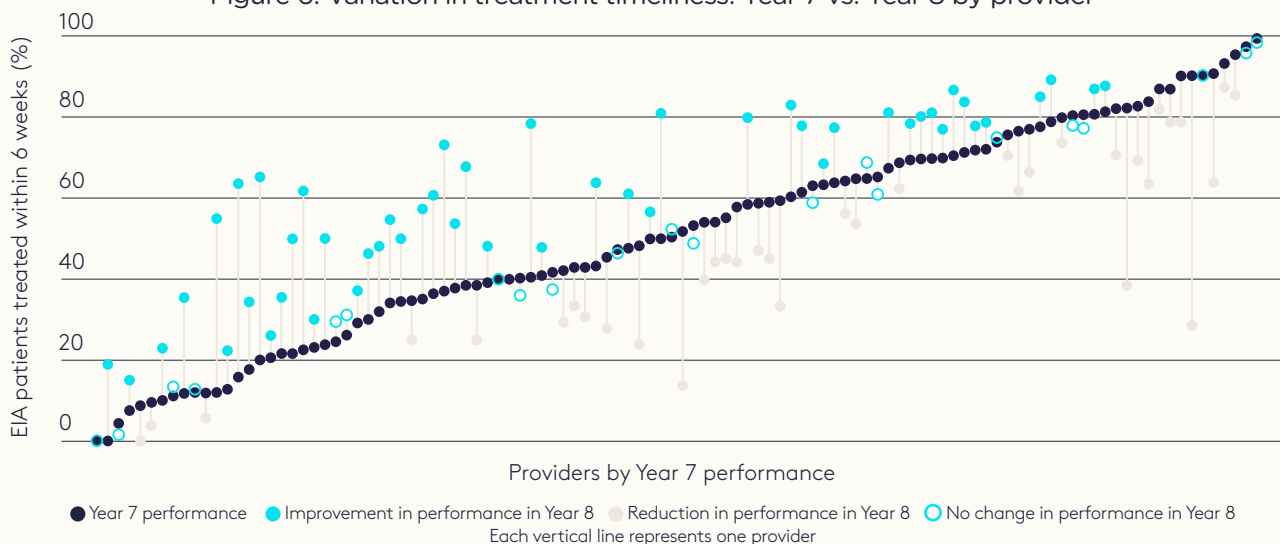
Increasing the completeness of outcome data would strengthen local quality improvement and national benchmarking through NEIAA. Findings from the organisational audit suggest that administrative and data management capacity remains a challenge for many services and may affect the completeness of audit submissions. Planning and commissioning sufficient administrative, informatics and audit support should be considered integral to improving patient outcomes.

Disease activity in rheumatoid arthritis is measured using the **Disease Activity Score in 28 joints** (DAS28) and combines information from swollen joints, tender joints, the acute phase response and general health.

"Clinical remission doesn't mean that you are symptom free. There may be damage that has been done that is irreversible. And with this, you have to live all your life. That's the reality. We need people to adjust around us as we adjust to new jobs as well."

Patient Panel member

Figure 6: Variation in treatment timeliness: Year 7 vs. Year 8 by provider



5. Patient-reported outcome measures (PROMs): work outcomes

PROMs demonstrate the impact of disease activity on outcomes that matter most to patients, including their ability to work. Among patients living with EIA who achieved clinical remission at three months, 49% were in employment at 12 months following assessment, compared with 44% of those who had not achieved clinical remission.

Similarly, among patients who were in employment at diagnosis, 49% of those who achieved remission reported that they had stopped working due to arthritis by 12 months, compared with 64% of those who had not achieved remission.

These differences have important implications for patients, employers and the wider economy, highlighting the value of early diagnosis and effective treatment in helping people remain in work.

While sample sizes limit analysis of employment cessation at earlier time points, there are strong indications that work loss may occur early in the disease pathway, in some cases before patients receive effective treatment. This reinforces the importance of timely diagnosis, rapid access to specialist care and prompt initiation of appropriate therapy.

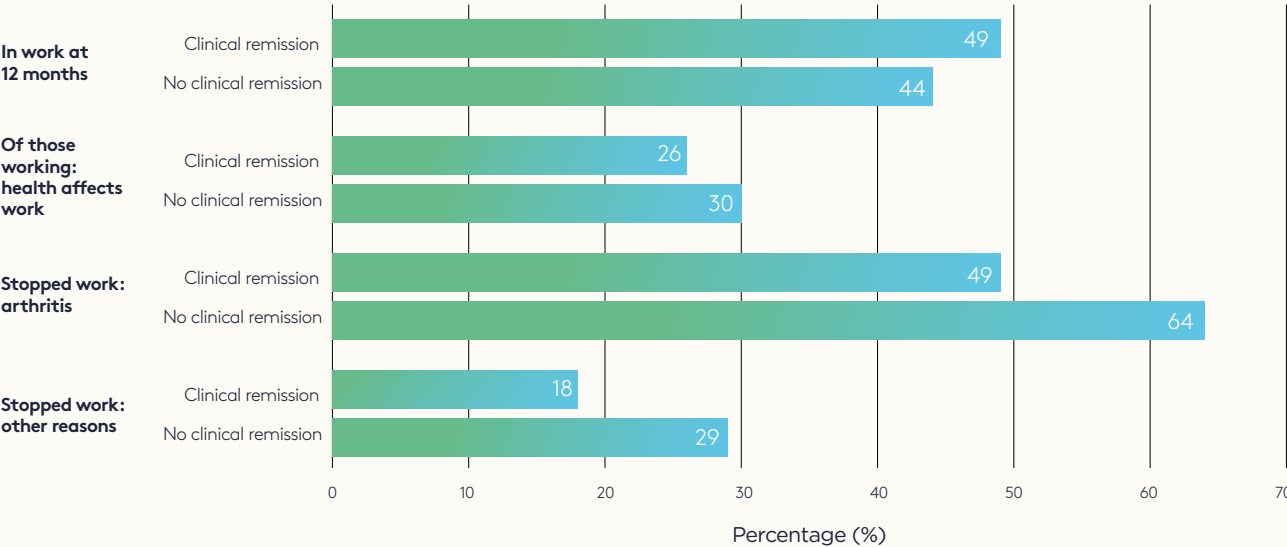
The benefits of effective treatment extend beyond employment. PROMs show that patients experience improvements in both

productivity and overall musculoskeletal health during the first year following diagnosis. Median work impairment decreased from 30% at presentation to around 20% by 12 months, while median MSK Health Scores improved from 24 to 37 over the same period. These findings suggest that treatment can have a meaningful impact on patients’ daily lives, helping them maintain function, independence and participation in work and social activities.

However, clinical remission does not necessarily equate to full recovery. Many patients who achieve clinical remission at three months continue to report significant symptom and functional impact, demonstrating that clinical remission alone does not fully capture the lived experience of disease. PROMs therefore provide an important complement to clinical measures. Used routinely, they can help clinicians assess treatment response, support decisions about treatment escalation, identify patients who may benefit from occupational therapy, physiotherapy or psychological support, and ensure that care is focused on outcomes that matter most to patients.

MSK Health Score is collected as part of the MSK-HQ: patient-reported score of overall musculoskeletal health from 0–56 (higher = better).

Figure 7: Work outcomes at 12 months by clinical remission status



6. Access to allied health services

Early inflammatory arthritis affects many aspects of patients' lives, including their ability to work, carry out everyday activities and manage the psychological impact of a long-term condition. While timely diagnosis and treatment are essential, multidisciplinary support also plays an important role in helping patients achieve the best possible outcomes. Occupational therapy, physiotherapy, psychological support and specialist nursing can help patients manage symptoms, maintain independence and develop the skills needed to live well with their condition.

Occupational therapy is available in 89% of responding services, an increase from 83% in the previous year. Where occupational therapy is available, referral at the point of diagnosis – rather than waiting until disability is established – offers an important opportunity to support self-management, maintain function and reduce the risk of work loss.

In contrast, formal psychological support embedded within rheumatology services remains limited, with provision reported by only 20% of services. Although **NHS Talking Therapies** services are widely available, patients may benefit from clear referral pathways to ensure that the psychological impact of inflammatory arthritis is recognised and addressed alongside physical symptoms.

Findings elsewhere in this report demonstrate that disease control is associated with better employment outcomes and improvements in patient-reported measures of health and productivity. Ensuring timely access to occupational therapy, physiotherapy and psychological support alongside medical treatment has the potential to further improve patient experience, functional outcomes and quality of life.

"When I was first diagnosed with inflammatory arthritis, the pain, stiffness, fatigue, and uncertainty made daily life difficult, but occupational therapy, patient education, and support from rheumatology nurses made a real difference. Practical advice helped me feel more in control and able to manage better. I also struggled with anxiety and low mood, so being referred for psychological assessment and support was important because it helped me cope. The guidance and reassurance from nurses and helplines were essential, not optional."

Patient Panel member

"The six CBT [Cognitive Behavioural Therapy] sessions, that I was referred to by my rheumatologist, really helped me understand the need to pace myself to help combat the fatigue associated with RA. They also taught me how to say "no" to friends and family and accept that I needed to moderate my activity levels if I was to continue to enjoy the things in life that remain important to me."

Patient Panel member

7. Access to specialist care for connective tissue diseases and systemic vasculitis

Because patient numbers are smaller for connective tissue diseases (CTDs) and systemic vasculitis, data from Years 6 to 8 have been analysed collectively to enable meaningful assessment of access to care and variation between regions.

CTDs include systemic lupus erythematosus, primary Sjogren's syndrome, systemic sclerosis, idiopathic inflammatory myopathy and undifferentiated CTDs or overlap syndromes.

Across Years 6 to 8, the median waiting time for a first rheumatology appointment for patients with a CTD was 36 working days. However, there was substantial regional variation, ranging from a median of 26 working days in London to 113 working days in the East of England. In Wales, the median waiting time was 50 working days. This variation suggests that timely access to specialist assessment is achievable but not consistently delivered. Delays may prolong symptoms, increase uncertainty for patients and delay access to appropriate treatment, monitoring and support. Understanding the factors associated with shorter waiting times may help identify opportunities for service improvement.

Systemic vasculitis includes giant cell arteritis, large vessel vasculitis, anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis, small- and medium-vessel vasculitis, and Behcet's syndrome. Across Years 6 to 8, the median waiting time for a first appointment for systemic

vasculitis was 12 working days. While access was generally more rapid than for CTDs, there was still considerable regional variation ranging from three working days in the South West to 34 working days in the North West.

Although the urgency and clinical presentation of these conditions vary, the variation in waiting times suggests differences in referral pathways, service configuration and access to specialist expertise. For some forms of vasculitis, delays in assessment and treatment can lead to serious complications, making timely access to specialist care particularly important.

The [NICE quality standard for rare diseases \(QS214\)](#), published in February 2026, identifies the importance of timely diagnosis, treatment and data collection for people living with rare conditions. As the only national audit routinely capturing early access to specialist care for many patients with CTDs and systemic vasculitis, NEIAA is well placed to support improvement against this new standard.

The variation observed across regions suggests that further investigation is warranted. Continued participation in the audit will strengthen national understanding of access to care for these conditions, support benchmarking and quality improvement, and help identify opportunities to improve outcomes for people living with CTDs and systemic vasculitis.

Summary

In summary, NEIAA Year 8 data show that earlier referral and assessment help patients start treatment sooner, particularly where dedicated pathways and rapid access services are in place. Earlier treatment is associated with a greater likelihood of patients achieving clinical remission within three months, while early disease control is linked to improved employment and patient-reported outcomes. Together, these findings highlight the association between timely access to care and improved outcomes throughout the patient journey from diagnosis to longer-term health, wellbeing and participation in work.



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