British Society for
Rheumatology

National Early Inflammatory Autoimmune Diseases Audit (NEIAA)

State of the Nation Summary Report 2025

Data collection period: 1 April 2024 – 31 March 2025

Geographic coverage: England and Wales

October 2025

HQIP
Healthcare Quality
Improvement Partnership

Contents

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) as part of the National Clinical Audit and Patient Outcomes Programme and funded by NHS England and the Governments of Wales and Jersey as part of the **National Clinical Audit and Patient Outcomes Programme**.

This report was produced in collaboration with the audit's governance committees and patient panel, and was co-authored by the following individuals:

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A full list of contributors to the report can be found in **the appendices**.

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

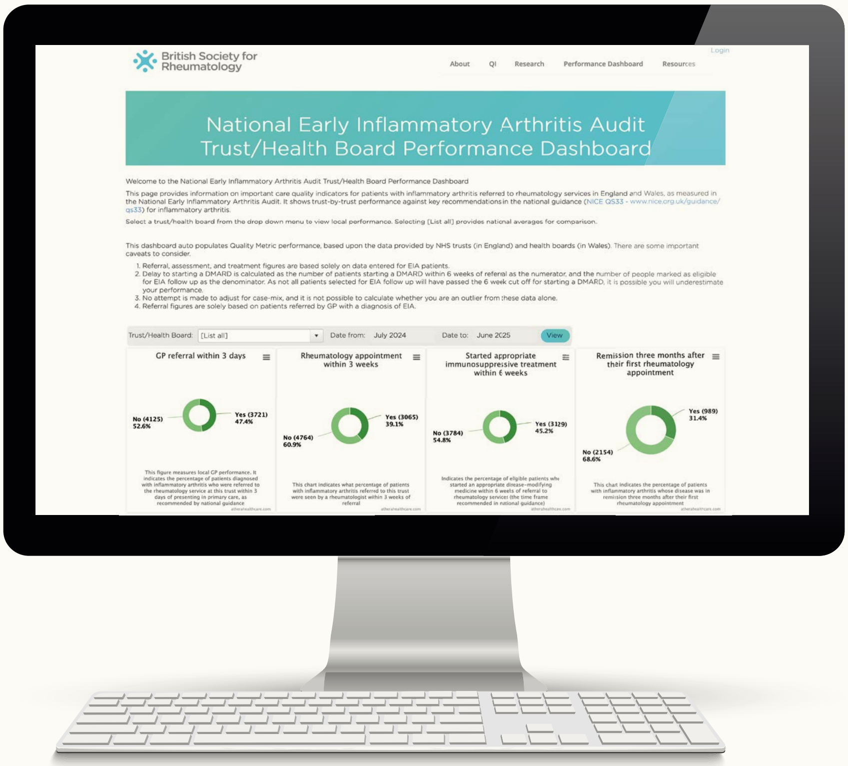
Inflammatory arthritis, including rheumatoid arthritis (RA), is a significant disease burden in the UK, affecting over 400,000 people(1). Delays in treatment can lead to disability, reduced quality of life and loss of productivity in the workforce(2)(3). Treatment delays for rare autoimmune rheumatic diseases (RAIRDs) such as systemic vasculitides are also associated with adverse outcomes including permanent disability(4), organ failure and death.

NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients over the age of 16 in rheumatology departments across England, Wales and, from April 2025, Jersey. **Diagnoses required for enrolment** in the audit include inflammatory arthritides, systemic vasculitides and connective tissue diseases.

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(5). Our outlier analysis (as described in our **outlier policy**) uses Quality statement two **(QS2)**. There is a strong research evidence base suggesting that prompt treatment of early inflammatory arthritis (EIA) improves patient outcomes(6)(7). Outlier status is attributed to any unit whose performance against QS2 is more than three standard deviations below the national average*. Units are also treated as an outlier if they recruit fewer than 30 patients into the audit.

Public facing **dashboards** with near-real time data on key NEIAA metrics are available and are intended to facilitate local and national quality improvement (QI) initiatives. Previous annual reports are also available via the same link. Further resources to support QI can be found on our **QI resources webpage**, including data analysis tools, case studies, video guides and template documents such as driver diagrams

The NEIAA Performance Dashboard



National Early Inflammatory Arthritis Audit
Trust/Health Board Performance Dashboard

Welcome to the National Early Inflammatory Arthritis Audit Trust/Health Board Performance Dashboard

This page provides information on important care quality indicators for patients with inflammatory arthritis referred to rheumatology services in England and Wales, as measured in the National Early Inflammatory Arthritis Audit. It shows trust-by-trust performance against key recommendations in the national guidance (NICE QS33 - www.nice.org.uk/guidance/qs33) for inflammatory arthritis.

Select a trust/health board from the drop down menu to view local performance. Selecting [List all] provides national averages for comparison.

This dashboard auto populates Quality Metric performance, based upon the data provided by NHS trusts (in England) and health boards (in Wales). There are some important caveats to consider.

1. Referral, assessment, and treatment figures are based solely on data entered for EIA patients.
2. Delay to starting a DMARD is calculated as the number of patients starting a DMARD within 6 weeks of referral as the numerator, and the number of people marked as eligible for EIA follow up as the denominator. As not all patients selected for EIA follow up will have passed the 6 week cut off for starting a DMARD, it is possible you will underestimate your performance.
3. No attempt is made to adjust for case-mix, and it is not possible to calculate whether you are an outlier from these data alone.
4. Referral figures are solely based on patients referred by GP with a diagnosis of EIA.

Trust/Health Board: [List all] Date from: July 2024 Date to: June 2025

This figure measures local GP performance. It indicates the percentage of patients diagnosed with inflammatory arthritis who were referred to the rheumatology service at this trust within 3 days of presenting in primary care, as recommended by national guidance

This chart indicates what percentage of patients with inflammatory arthritis referred to this trust were seen by a rheumatologist within 3 weeks of referral

Indicates the percentage of eligible patients who started an appropriate disease-modifying medicine within 6 weeks of referral to rheumatology services (the time frame recommended in national guidance)

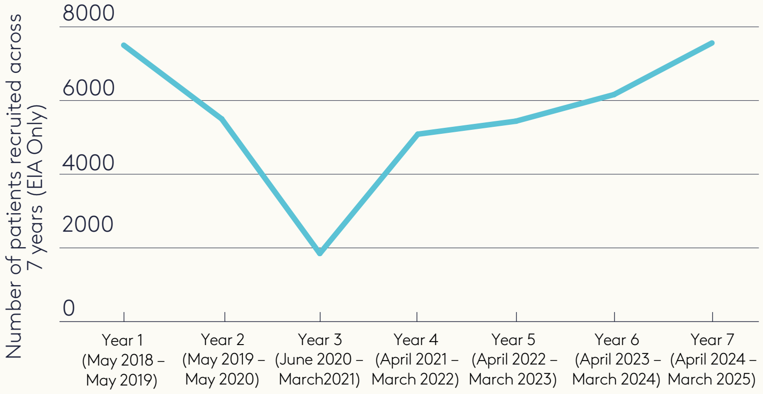
This chart indicates the percentage of patients with inflammatory arthritis whose disease was in remission three months after their first rheumatology appointment

*In this report, the term 'average' refers to the mean.

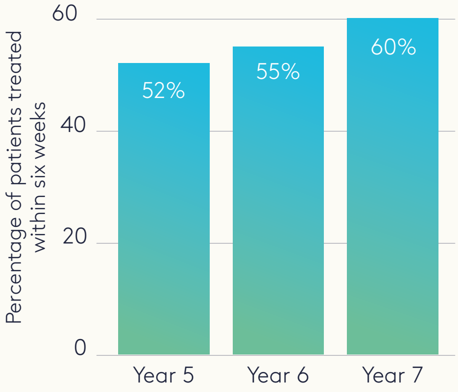
National Early Inflammatory Autoimmune Diseases Audit (NEIAA) State of the Nation Summary Report 2025 Infographic

NEIAA recruitment rates for EIA continue to improve post-pandemic

Recruitment rates are the highest we have seen since the audit started.



Treatment timeliness for early inflammatory arthritis is improving

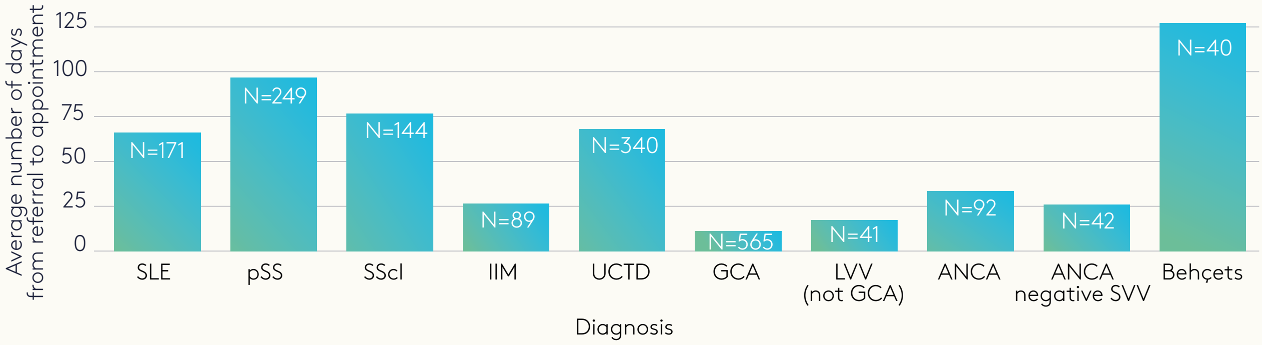


Patients report significant impact on mental and physical health at diagnosis

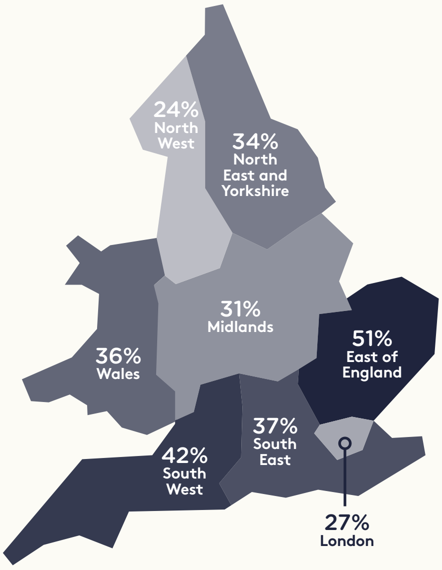
of patients demonstrate high anxiety and depression scores at baseline

of patients had moderate to severe musculoskeletal symptoms with a MSK-HQ* of less than 35

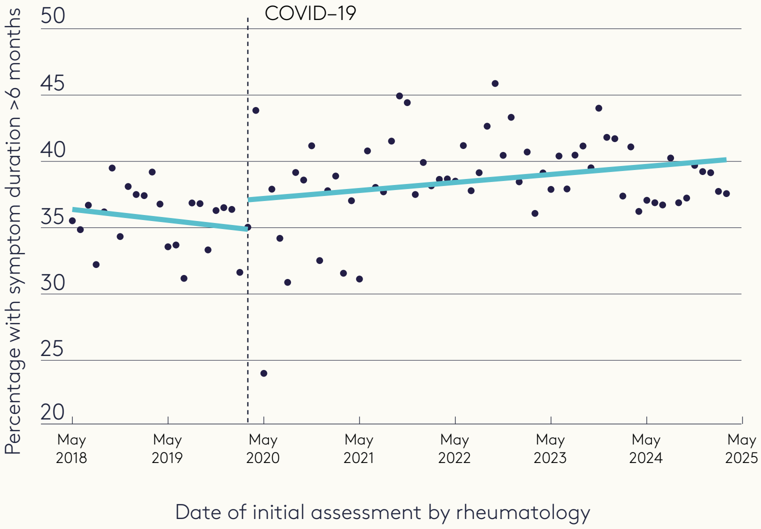
Waiting times for RAIRDs are highly variable (see list of diagnoses)



Overall remission rates at 3 months remain static at 34% but this disguises significant geographic variation



Following the COVID-19 pandemic, patients with EIA have longer symptom durations at diagnosis



*MSK-HQ: Musculoskeletal Health Questionnaire. A tool used to assess the impact of musculoskeletal conditions on a person's health and well-being.

National recommendations

1. **Provision of specific funding to support awareness-raising of the importance of early presentation to primary care of people with symptoms of suspected EIA. Key message 3**

   Action by: Department of Health and Social Care/NHSE and Welsh Health Boards

2. **NEIAA dashboard data should be used to support rheumatology departments and specialist centres to pinpoint unwarranted variation, track improvement over time and inform planning and investment. Key messages 4, 5, 6, 11 and 12**

   Action by: Integrated Care Boards, Welsh Health Boards

3. **Patient-reported outcome measures (PROMs) should be integrated into clinical pathways to identify individuals experiencing significant psychological burden and facilitate their timely referral to appropriate mental health support services. Key messages 7 & 8**

   Action by: Integrated Care Boards, Welsh Health Boards

4. **National guidance should be developed and implemented to ensure timely treatment of EIA and minimise regional disparities in care delivery. Key messages 5, 6 and 7**

   Action by: British Society for Rheumatology, DHSC/NHSE, GIRFT and Welsh Health Boards

5. **Widespread implementation of the Getting it Right First Time (GIRFT)/National Axial Spondyloarthritis Society (NASS) National Playbook on Axial Spondyloarthritis within primary care. Key message 9**

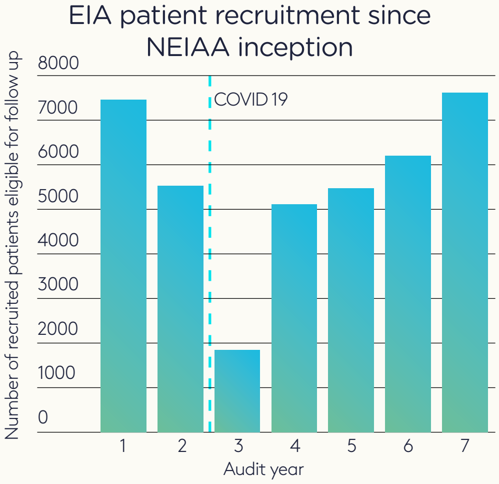
   Action by: Royal College of General Practitioners, Integrated Care Boards

Key messages

Full data tables and clinical interpretation can be found in the appendices

1. Audit participation

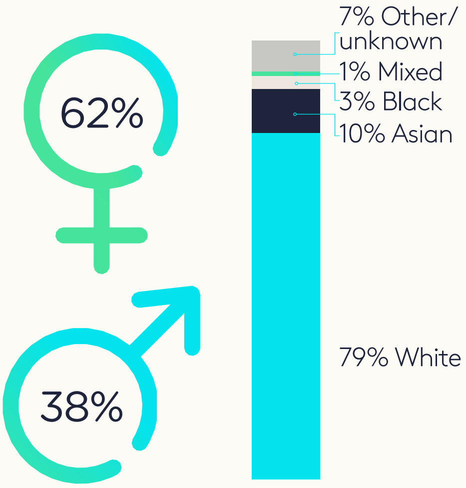
Recruitment to NEIAA is better than ever with 7,565 EIA patients recruited vs 6,158 in year 6 and 7,505 in year 1. 96% of eligible trusts have returned data. However, fewer than half of patients are being captured based on estimated number of EIA cases from primary care data sources(8).


EIA patient recruitment since NEIAA inception

2. EIA Demography and Ethnicity

Patient characteristics in year 7 remain similar to previous years:

- More females (62%) than males (38%)
- Average age is 56 years
- 48% of patients work >20 hours per week at diagnosis
- The ethnicity breakdown of patients in NEIAA is similar to that of **England and Wales** as a whole. 79% of patients were White, 10% Asian, 3% Black, 1% Mixed ethnicity and 7% other or unknown



3. Increasing symptom duration at referral

Since the COVID-19 pandemic, patients with EIA are experiencing symptoms for longer before being referred to rheumatology services (38% of people had symptom durations of 6 months or more when referred to a rheumatology service). It remains unclear whether this represents delays in initial presentation, or delays within primary care before EIA is recognised.

After recognising the symptoms of EIA, the data suggest that increasing numbers of patients are being referred within the recommended time frame. The proportion of patients referred by their GP to a rheumatology service within the national target of three working days (**QS33:QS1**) is 53%, vs 39% in year 1. 76% of recruited patients are referred via an EIA pathway, vs. 60% in year 1.

38%

of people with symptom durations of 6 months or more when referred to a rheumatology service

4. Access to assessment

The proportion of patients seen for their first appointment in Rheumatology within three weeks of receipt of referral is 43%. This is a slight improvement vs year 1 (40%). The average wait time from referral to appointment in working days is 32 vs 27 in year 1 across England and Wales.

32 days

average wait time
across England
and Wales

5. Access to treatment

This has improved over the course of the audit with 60% of patients receiving DMARD treatment within 6 weeks of referral compared to 53% in year 1. The average time to treatment is 57 working days with regional variation from 34 days in the South West to 69 days in the East of England.

57 days

average time
from referral to
treatment

6. Remission

Overall remission rates* have not improved since the audit began in 2018, but this masks substantial regional variation. Increasing delays from symptom onset to referral have potentially hindered efforts to improve remission rates(9), though a review of treatment strategies could also be considered in light of these outcomes.

Remission rates* by region

7. Patient-reported outcome measures (PROMs)

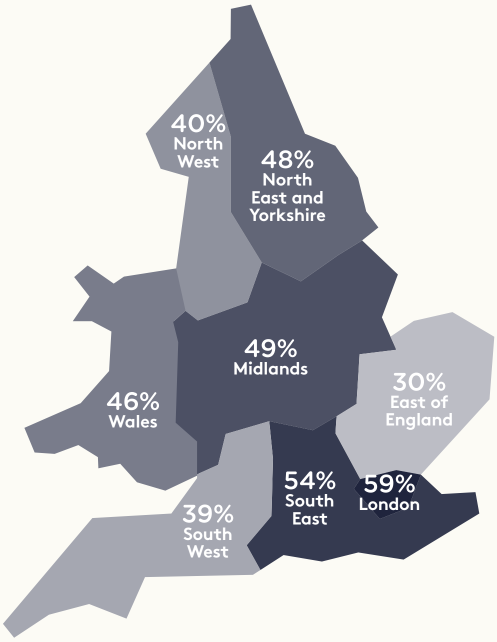
Year 6 and Year 7 data have been looked at collectively to allow for more robust understanding of patient outcomes throughout the critical first year of treatment.

Overall scores for both mental and physical health improve over the 12 months of data collection. However there is clearly still a significant burden of anxiety and depression 12 months after diagnosis.

People who started treatment within 6 weeks have better mental health outcomes as per PROMs.

Patients in London and the South East have higher levels of depression and anxiety than other regions.

Percentage of patients with probable anxiety or depression at 3 months



*Remission is defined by patients achieving a **DAS28** score less that 2.6 at 3 months.

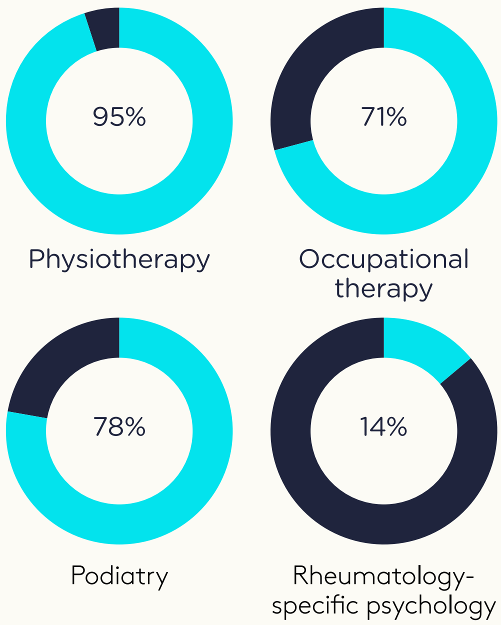
8. Organisational metrics

To complement NEIAA clinical data, BSR conducted an organisational audit during year 7. Eighty services across England and Wales returned data this year. The results showed:

- 42% of services do not typically start DMARDs on the same day as diagnosis
- Same-day ultrasound is available in only 44% of services
- Physiotherapy is near universal (95%) whilst occupational therapy (71%) and podiatry (78%) are less widespread
- Rheumatology-specific psychology is available in only 14% services. This is particularly concerning given 42% of patients experience anxiety/depression at three months

More findings can be found in the **data tables**.

Organisational metric rates



9. Axial spondyloarthritis (axSpA)

479 axSpA patients were recruited to the audit in year 7.

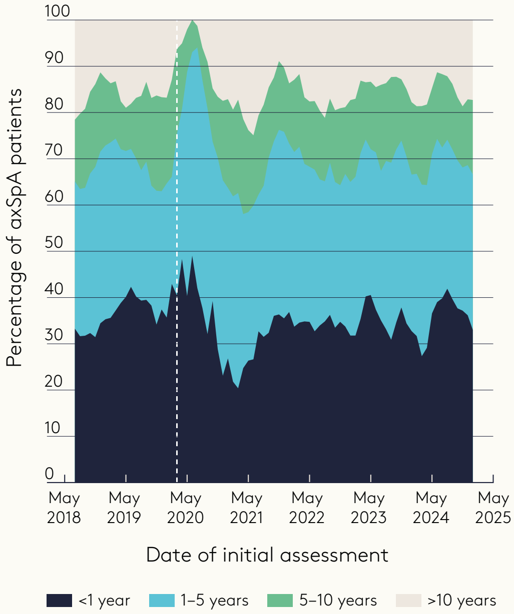
The average age is 40 years and 57% of patients recruited are male.

Compared to the general population, the patient demographic included a higher proportion of individuals from minority ethnic backgrounds, with 65% recorded as White, 16% Asian, 7% Black, 1% Mixed, 10% Other, and 1% not known.

30% of individuals with axSpA enrolled in NEIAA in year 7 had symptom durations of 5 years or more prior to being referred to rheumatology services. Symptom durations temporarily improved for axSpA patients referred during the early pandemic (although the small numbers of patients recruited during this period may have contributed to the variation). However, these symptom durations remain relatively unchanged in year 7 compared with year 1 of the audit.

There is wide variation in average time from presentation to referral to specialist care (8 days for East of England and 92 days in Wales). This is longer than for other EIA groups and could indicate the need for enhanced axSpA training in primary care.

How long patients had symptoms before being referred – Trends over time

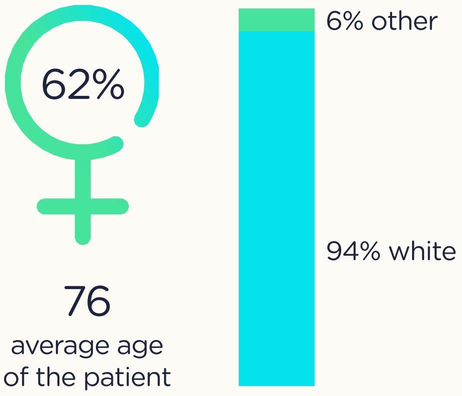


10. Giant Cell Arteritis (GCA)

Of the patients recruited to the audit with GCA in year 7, 62% are female and 94% were of white ethnicity. The average age is 76.

GCA is a potential medical emergency as treatment delay can lead to blindness. This is reflected in the median being 0 days from presenting to GP to referral to specialist care. The median time from referral to assessment is 3 days although 25% of reported patients waited more than 8 days. 80% of patients are referred via a GCA pathway.

While GCA patients experience shorter wait times for rheumatology assessment than people with other rheumatology conditions, assessment delays are still longer in some cases than the recommended 3 days (ideally 1 day) specified in the **BSR GCA guideline** More detail can be found in the **data tables**.



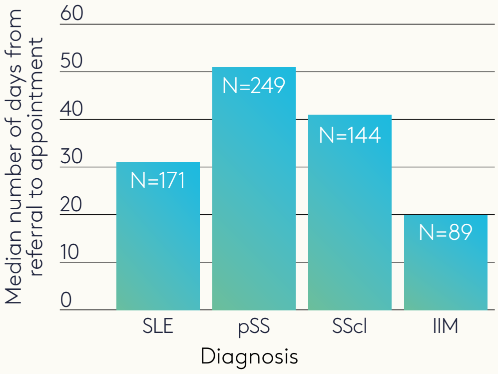
11. Connective tissue diseases

Systemic lupus erythematosus (SLE), primary Sjögren's syndrome (pSS), systemic sclerosis (SScl) and Idiopathic inflammatory myopathy (IIM)

There is variation between diagnoses from presentation to rheumatology referral for this group of conditions (20–51 days). Variation is more marked for time to rheumatology assessment, with sjogren's patients waiting almost 100 days on average to be seen while those with IIM typically wait less than a month.

While patients diagnosed with conditions that are more likely to cause irreversible harm tend to be seen earlier, there remains a substantial number of patients waiting long periods for the diagnosis of a disease (e.g. SLE) that carries significant potential for morbidity. Further breakdown can be found in the **data tables** and in **the infographic**.

Median number of working days from referral to rheumatology appointment

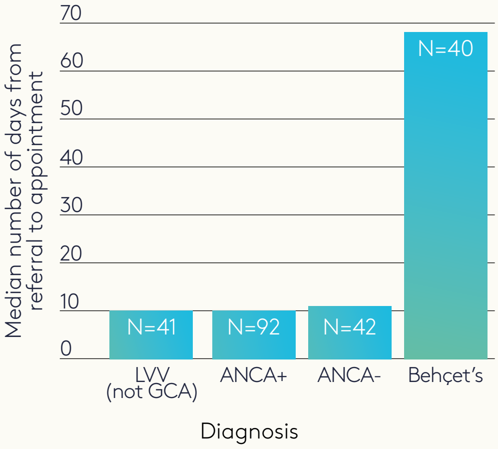


12. Systemic vasculitidies

Large vessel vasculitis (excluding GCA), Anti-aeutrophil cytoplasmic antibody (ANCA) – associated vasculitis, ANCA-negative small/medium vessel vasculitis (SVV) and Behçet's syndrome

There is variability in the time it takes for GP's to make a referral to specialist care, and whilst many patients are referred on the day of assessment some referrals are delayed by days or weeks – a quarter of patients with LVV waited more than 22 days. The longest waits for rheumatology assessments were experienced by the small number of patients with Behçet's syndrome. Further breakdown can be found in the **data tables** and in **the infographic**.

Median number of working days from referral to rheumatology appointment



Case study: University Hospitals of Leicester NHS Trust

From outlier to exemplar in 18 months

In 2023, Leicester's EIA service faced a crisis. Despite serving 1.1 million people with a team of 12 consultants and 9 specialist nurses, only 11% of patients were seen within three weeks of referral, triggering outlier status and urgent need for transformation. Leicester's population is 43.4% Asian, requiring culturally responsive care that previous service models had not adequately addressed.

Metric	2023	2024–25	Improvement
Seen within 3 weeks	55.7%	98.3%	+42.6%
DMARD within 6 weeks	73.8%	95.7%	+21.9%
Remission at 3 months	36.2%	41.4%	+5.2%

Three critical interventions drove Leicester's transformation:

- Protected time investment: triage to eliminate bottlenecks, monthly team meetings with data review to enable responsive problem solving and same-day DMARD initiation.
- Cultural competency: **NRAS Apni Jung** initiative, enhanced interpreter services, cultural awareness training to understand varying attitudes to medication and support for shared decision making.
- Service model innovation: registrar-led EIA clinic to expand capacity, enhanced referral criteria, dynamic appointment scheduling.

Key lessons

- Systematic governance beats resource increases alone
- Protected time for quality improvement yields measurable returns
- Cultural competency essential for equitable outcomes in diverse populations
- Outlier status can become a foundation for excellence with proper support
- Multi-phase approaches transform even significantly underperforming services
- Transparency and team ownership drive sustainable change

Impact

Leicester now serves as an exemplar, demonstrating that systematic quality improvement can transform care delivery. The service maintains exceptional performance whilst supporting peer learning across rheumatology networks.

The Leicester model shows how excellence in EIA care is achievable through coordinated effort, cultural responsiveness, and sustained commitment to improvement.

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