Resource impact summary report

Resource impact
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The guideline covers managing and monitoring diabetic retinopathy in people under the care of hospital eye services. This includes non-proliferative and proliferative diabetic retinopathy, and diabetic macular oedema.

Around 95,000 people have sight loss caused by diabetic retinopathy that is severe enough to significantly impact on their daily life. It causes 1,280 new cases of blindness and puts 4,200 people at risk of visual impairment each year in England alone.

Diabetic retinopathy is currently treated when sight-threatening complications (diabetic macular oedema and proliferative diabetic retinopathy) have developed. Treatments include laser treatment, eye injections and eye surgery.

Most of the recommendations in the updated guideline reinforce best practice and should not need any additional resources to implement. However, some of the guideline areas and recommendations may represent a change to current local practice. Where a change is required to current practice, this may require additional resources to implement, which may be significant at a local level. Benefits derived from the change in practice may help mitigate any additional costs.

There is uncertainty regarding the uptake for the 3 consider recommendations discussed below, users should update the market share in the resource impact template to reflect local assumptions.

Depending on current local practice, recommendations/areas which may require additional resources and result in additional costs include:

Ophthalmologists should consider fenofibrate for people with non-proliferative retinopathy and type 2 diabetes to reduce the progression of diabetic retinopathy (recommendation 1.1.9)

This recommendation is likely to increase the use of fibrates in people with non-proliferative diabetic retinopathy. Evidence shows fibrates may reduce the risk of progression, thereby reducing the time and costs associated with additional treatment.

The number of people in England eligible for fibrates is estimated to be 1 million. If an additional 10,000 people were to receive fibrates this would equate to a drug cost of around £400,000 per year. Fibrates are administered orally but there may be capacity implications because of a potential increase in GP consultations and monitoring for fibrates.

For people with centre-involving diabetic macular oedema and good vision (79 letters or better) consider either macular laser treatment or observation. Discuss these 2 options with the person with macular oedema (recommendation 1.6.4)

The committee highlighted that macular laser may have benefits for people who still have good vision.

These recommendations are different to current practice and may increase the number of people who are given macular laser. However, this may reduce the number of people who progress to having visual impairment, thereby reducing the number of anti–vascular endothelial growth factor medicine (anti-VEGF) injections that need to be provided to these people, which may have a cost-saving benefit.

The number of people In England with centre-involving diabetic macular oedema and good vision and therefore eligible for macular laser is estimated to be 132,500.

For people with centre-involving diabetic macular oedema, visual impairment and central retinal thickness of less than 400 micrometres, consider anti-VEGF treatment or macular laser treatment. Discuss with the person the advantages and disadvantages of all available treatments (recommendation 1.6.6)

Although limited, some evidence shows that anti-VEGFs are clinically and cost effective for people with central retinal thickness of less than 400 micrometres. Macular laser is also recommended as an alternative treatment option because the evidence and committee's experience indicated that this can also be effective and is current practice for many people in this group. It also has the benefit of delaying the need for anti-VEGF treatment for some people.

This recommendation may increase the number of people who are initially offered anti-VEGFs, as this can include people with a central retinal thickness of less than the 400-micrometre threshold. However, with the additional option of macular laser for people who have thinner retinas, and the recommendations to switch treatments if there is a suboptimal response after 12 months, this impact may not be substantial.

The number of people in England with centre involving diabetic macular oedema and visual impairment with a central retinal thickness of 400 micrometres or less and therefore eligible for anti-VEGF or macular laser treatment is estimated to be 75,000. Around 7 outpatient procedure appointments per patient are required in year 1 to administer the anti-VEGF treatment. The average annual cost per administration is £108 (2024/25 NHS payment scheme. Outpatient procedure HRG code BZ87A Minor Vitreous Retinal Procedures, 19 years and over). The number of administrations steadily reduces and by year 5 of treatment the outpatient procedure appointments are estimated to reduce to 1.

Implementing the guideline may lead to the following benefits:

- Slowing down the rate of retinopathy progression thereby reducing the time and costs associated with additional treatment.
- Better pre-operative and follow-up care, which will reduce their risk of future complications.
- Better health outcomes and care experience.

These benefits may also provide some savings to offset some of the potential costs identified above.

A local resource impact template is available to help organisations estimate the resource impact of these recommendations.

Diabetic retinopathy services are commissioned by integrated care boards and NHS England. Providers are NHS hospital trusts, community providers and primary care providers.