GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Specialised Services
Service Specification: CP183b

Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus in Adults

April 2020

Version 1.0

Document information	
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Description	NHS Wales will routinely commission this specialised service in accordance with the criteria described in this document
Document No	CP183b
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Contents

Statement

Welsh Health Specialised Services Committee (WHSSC) will commission Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus in Adults in accordance with the criteria outlined in this specification.

In creating this document WHSSC has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

WHSSC assumes that healthcare professionals will use their clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

WHSSC disclaims any responsibility for damages arising out of the use or non-use of this document.

1. Introduction

This document has been developed as the Service Specification for the planning and delivery of Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus in Adults for people resident in Wales.

1.1 Background

Plain Language Summary

What is Barrett's Oesophagus?

The oesophagus is the muscular tube that carries food from the mouth to the stomach. Barrett's Oesophagus is a condition where the normal lining, coating the lower part of the oesophagus changes to being a thin membrane like the lining of the stomach or intestine. This condition was named after a London surgeon called Norman Barrett in the 1950's, who was amongst the first to discover it.

What causes Barrett's Oesophagus?

The cause of the condition is not known. It is believed that many years of acid reflux of stomach contents into the oesophagus (sometimes perceived as heartburn) causes injury to the lining of the oesophagus (oesophagitis). This inflammation may lead to damage to the oesophagus cells, causing the change known as Barrett's Oesophagus. Sometimes bile-containing juices in the small intestine may work their way backwards into the stomach and oesophagus. It is possible that this mixture of stomach and intestinal juices is more damaging to the oesophagus than acid alone.

In normal circumstances the oesophagus heals and returns to normal, but sometimes the oesophagus does not heal in the usual way. How or why this change happens is not known. It appears that this change may be more common in patients who are male, and/or overweight. It has been shown that smoking can accelerate any change in Barrett's Oesophagus.

What are the usual symptoms?

The condition often has no symptoms, but Barrett's Oesophagus is sometimes found when a person is examined by means of an endoscopy for symptoms of heartburn and acid indigestion. Sometimes Barrett's Oesophagus is found in people undergoing endoscopy for some other reason, e.g. to investigate anaemia.

Other symptoms are those associated with reflux, such as hoarse voice and chronic cough.

What are the complications?

Barrett's Oesophagus can rarely cause a complication. Possible complications, which are usually due to chronic reflux, include:

- Ulcers in the oesophagus
- Inflammation of the lining of the oesophagus
- Narrowing of the oesophagus
- Rarely, pre-cancerous changes and cancer of the oesophagus.

Most patients with Barrett's Oesophagus will never experience any of the above complications.

What is dysplasia in the oesophagus?

Dysplasia is the term used to describe cells in the lining of the oesophagus that look abnormal under a microscope, and can occur in patients with Barrett's Oesophagus. Patients with Barrett's Oesophagus typically undergo surveillance endoscopy with multiple biopsies of the diseased tissue every one to three years in order to detect cancer at the earliest possible tumour stage. Development of dysplastic cellular changes within the Barrett's epithelium (lining) precedes the development of cancer. Intramucosal carcinoma describes an early cancer which develops within the mucous membrane (thin tissue) lining the alimentary canal.

Diagnosis of Barrett's Oesophagus is confirmed through histopathology following biopsy, with intestinal metaplasia (IM) graded according to the presence or absence of dysplasia from:

- No dysplasia
- Indefinite for dysplasia
- Low-grade dysplasia (LGD)
- High-grade dysplasia (HGD)

The presence of HGD or persistent LGD can signify that the cells have the potential to become cancerous. Oesophageal cancer is a serious condition, but if changes are caught at an early stage, it can be successfully treated. Less than 1 out of every 100 people (less than 1%) in the UK have Barrett's oesophagus. And very few people with this condition develop cancer. About 3 in every 100 people (3%) who have Barrett's oesophagus will develop oesophageal cancer during their lifetime.[1]

The aim of Radiofrequency Ablation (RFA)

Dysplasia and very early oesophageal cancer affects only the cells lining the oesophagus. These abnormal cells can be destroyed by performing RFA. Once performed, the oesophagus lining is expected to heal with normal cells. By treating the abnormal cells and preventing the development of cancer, the aim is to prevent the need for major surgery.

[1] Macmillan Cancer Support

Radiofrequency energy (radio waves) is delivered via a catheter to the oesophagus to remove diseased tissue while minimising injury to healthy oesophagus tissue. This is called ablation, which means the removal or destruction of abnormal tissue.

Epidemiology

Barrett's oesophagus is prevalent in 1.5–2.5% of the adult population in the UK[2] with around 60,000 new cases per year (annual incidence around 0.1%). In around 60% of cases, Barrett's oesophagus is associated with chronic gastro-oesophageal reflux, which is a major risk factor[3]. Barrett's oesophagus is found in 15–20% of adults undergoing endoscopic investigation of symptomatic chronic reflux. The condition can, however, develop in the absence of symptoms and only 5–10% of adults with reflux develop Barrett's oesophagus[4]. Other factors associated with increased risk of developing Barrett's oesophagus are Caucasian race, male sex, and older age.[2,5]

Men with Barrett's oesophagus have an absolute lifetime risk of developing oesophageal adenocarcinoma of about 5% compared with 3% for women[4]. In studies of patients with Barrett's oesophagus with HGD undergoing surveillance, approximately six patients per 100 patient-years develop oesophageal adenocarcinoma. The combined incidence of HGD and oesophageal adenocarcinoma in patients under surveillance is estimated to be higher in the UK (13.0/1,000 patient-years; 95% CI 7.4 to 22.8) than in other European countries (7.3/1,000 patient-years; 95% CI 3.6 to 15.0)[6].

The rate of progression to cancer among patients with Barrett's oesophagus in the UK as a whole is approximately 1% per year[1]. The average risk of mortality attributable to oesophageal adenocarcinoma among Barrett's oesophagus patients under surveillance has been estimated at 0.3% per year (incidence 3.0/1,000 patient-years; 95% CI 2.2 to 3.9)[5].

Current Service

RFA for Barrett's Oesophagus/Upper Gastrointestinal (GI) cancer is currently commissioned directly by Health Boards for their resident

[2] Jankowski JA. Barrett esophagus and surveillance in the United Kingdom. Gastroenterol Hepatol. 2009;5(11):766-8
[3] Jankowski J, Barr H, Wang K, Delaney B. Diagnosis and management of Barrett's oesophagus. BMJ. 2010;341:c4551
[4] Wild CP, Hardie LJ. Reflux, Barrett's oesophagus and adenocarcinoma: burning questions. Nat Rev Cancer. 2003;3(9):676-84
[5] DynaMed. Barrett esophagus. Ipswich (MA): EBSCO Publishing; 2012.
[6] Sikkema M, de Jonge PJ, Steyerberg EW, Kuipers EJ. Risk of esophageal adenocarcinoma and mortality in patients with Barrett's esophagus: a systematic review and meta-analysis. Clin Gastroenterol Hepatol. 2010;8(3):235-44

populations from Gloucestershire Hospital NHS Foundation Trust for south Wales and Royal Liverpool for north Wales.

Currently the referral pathway varies across south Wales. Cardiff & Vale UHB currently offer Endoscopic Mucosal Resection (EMR) for appropriate cases referred via the Regional Upper GI Cancer MDT for patients. These include patients from Cwm Taf Morgannwg UHB, Aneurin Bevan UHB and Cardiff & Vale UHB. Following EMR, patients are then referred out of Wales to Gloucestershire Hospital NHS Foundation Trust for the RFA treatment.

Patients from Hywel Dda UHB (HDUHB) requiring EMR have this carried out locally within HDUHB; patients requiring RFA are referred following IPFR to Gloucestershire Hospital NHS Foundation Trust.

Patients from Swansea Bay (SBUHB) follow a different pathway. Patients who are identified as requiring treatment by the Upper GI Cancer MDT in SBUHB are managed within SBUHB receiving Argon Plasma Coagulation (APC). SBUHB are also able to offer EMR locally.

Patients from north Wales are referred to Wrexham Maelor Hospital for EMR. Once they have had the EMR, patients are then referred to Liverpool for RFA treatment.

1.2 Aims and Objectives

The aim of this service specification is to define the requirements and standard of care essential for delivering RFA for the Management of Barrett's Oesophagus.

The objectives of this service specification are to:

- detail the specifications required to deliver RFA services for people who are resident in Wales
- ensure the required standards of care are met for the use of RFA
- ensure equitable access to safe and effective RFA services
- ensure that RFA services align with Upper GI cancer pathways and services
- identify centres that are able to provide RFA services for Welsh patients
- improve outcomes for people accessing RFA services.

1.3 Relationship with other documents

This document should be read in conjunction with the following documents:

- **NHS Wales**
  - All Wales Policy: Making Decisions in Individual Patient Funding requests (IPFR).

- **WHSSC policies and service specifications**
  - WHSSC Commissioning Policy: CP183a Radiofrequency Ablation (RFA) for the management of Barrett's Oesophagus in Adults

- **National Institute of Health and Care Excellence (NICE) guidance**
  - Epithelial radiofrequency ablation for Barrett's oesophagus Interventional Procedures Guideline (IPG344] Published 26 May 2010 https://www.nice.org.uk/guidance/ipg344

  - Barrett's oesophagus: ablative therapy Clinical Guideline [CG106] Published 11 August 2010 https://www.nice.org.uk/Guidance/CG106

  - Endoscopic radiofrequency ablation for Barrett's oesophagus with low-grade dysplasia or no dysplasia Interventional Procedures Guideline (IPG496] Published 23 July 2014 https://www.nice.org.uk/guidance/ipg496

- **Other published documents**
  - British Society of Gastroenterology/ Fitzgerald RC, di Pietro M, Ragunath K, et al.: Guidelines on the diagnosis and management of Barrett's oesophagus Gut. 2013; 63(1): 7–42. https://www.bsg.org.uk/resource/bsg-guidelines-on-the-diagnosis-and-management-of-barrett-s-oesophagus.html

  - Addendum to the British Society of Gastroenterology: Guidelines on the diagnosis and management of Barrett's oesophagus (2015) https://www.bsg.org.uk/resource/bsg-guidelines-on-the-diagnosis-and-management-of-barrett-s-oesophagus.html

  - Revised British Society of Gastroenterology recommendation on the diagnosis and management of Barrett's oesophagus with low-grade dysplasia (2017) https://www.bsg.org.uk/resource/bsg-guidelines-on-the-diagnosis-and-management-of-barrett-s-oesophagus.html

  - Healthcare Quality Improvement Partnership: National Oesophago-Gastric Cancer Audit: Annual report 2018 https://www.hqip.org.uk/resource/national-oesophago-gastric-cancer-audit-annual-report-2018

2. Service Delivery

The Welsh Health Specialised Services Committee will commission the service of RFA for adults aged 18 years and over with Barrett's Oesophagus, in-line with the criteria identified in this specification.

2.1 Access Criteria

This service is for adults aged 18 years and over with Barrett's Oesophagus with:

- Intramucosal carcinoma
- High Grade Dysplasia (HGD)
- Persistent Low Grade Dysplasia (LGD)

For detailed definitions and further information see:

- WHSSC Commissioning Policy CP183a for Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus in Adults[7]

2.2 Service description

In addition to the standards required within the Contract, specific quality standards and measures will be expected. The provider must also meet the standards as set out below.

Clinical Standards

The following section has been based upon the

- British Society of Gastroenterology/ Fitzgerald RC, di Pietro M, Ragunath K, et al.: Guidelines on the diagnosis and management of Barrett's oesophagus Gut. 2013; 63(1): 7–42. https://www.bsg.org.uk/resource/bsg-guidelines-on-the-diagnosis-and-management-of-barrett-s-oesophagus.html and
- 2015 Addendum to the British Society of Gastroenterology: Guidelines on the diagnosis and management of Barrett's oesophagus https://www.bsg.org.uk/resource/bsg-guidelines-on-the-diagnosis-and-management-of-barrett-s-oesophagus.html

Specialist RFA team

- The team should include:
  - consultant interventional endoscopist
  - Upper GI cancer surgeon (if the endoscopist is a gastroenterologist)
  - radiologist
  - GI pathologist

[7] http://www.whssc.wales.nhs.uk/specialised-services-commissioning-polic-4

  - consultant gastroenterologist (if the endoscopist is a surgeon)
  - specialist Upper GI nurse

- The team should have a named clinical lead at consultant level. This should be a gastroenterologist or Upper GI surgeon.

- The nurse should act as liaison between the treatment centre and the local health boards.

- The service provider should ensure a sustainable and resilient rota of trained RFA endoscopists to provide cover for planned or unplanned leave to enable continuity of service.

- A sustainable rota requires a minimum of three RFA endoscopists.

- The RFA rota may include endoscopists from the RFA centre and/or endoscopists from referring organisations in a network arrangement.

- All treatments for high-grade dysplasia and intramucosal cancer in Barrett's oesophagus should be performed by specialist oesophago-gastric cancer teams with the experience and facilities to deliver the treatments recommended in this guideline *(Barrett's oesophagus: ablative therapy Clinical Guideline [CG106] Published 11 August 2010)*.

Treatment Centre

- RFA should be performed in centres equipped with endoscopic resection (ER) facilities and expertise. ER should be performed in high-volume tertiary referral centres *(British Society of Gastroenterology Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 22)*.

- ER should be performed in tertiary referral cancer centres for oesophageal cancer disease. These specialist cancer centres should perform at least 15 ERs per annum for HGD or early cancer *(British Society of Gastroenterology Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 21)*.

- Endoscopic therapy of Barrett's neoplasia should be performed at centres where endoscopic and surgical options can be offered to patients (British Society of Gastroenterology Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 21).

- Endoscopic radiofrequency ablation for dysplastic Barrett's oesophagus should only be done by endoscopists experienced in treating Barrett's oesophagus, as described in the British Society of Gastroenterology guidelines.

- The provision of endoscopic treatment must be aligned and integrated with the wider Upper GI cancer pathway.

Facilities

- Access to general anaesthetic/propofol theatre lists to enable the timely treatment of patients.
- Access to Upper GI day case treatment ward.
- Immediate access to Upper GI surgery (for major acute complications).
- The facility to appropriately manage delayed complications such as severe Upper GI bleed (consultant gastroenterologist Upper GI bleed rota).
- Expertise in terms of staff, equipment and training.

Patient information

- Patients with dysplasia or early cancer should be informed of treatment options and have access to all specialists if required.
- Patients should be allowed time to weigh up options for treatment and discuss further if needed.
- Patients should be provided with an information leaflet, which should include information on what to do if problems arise and where to report to.

Follow-up

- Once treatment sessions are completed, follow-up should be carried out at the local health board where further surveillance and its frequency should be decided.

2.3 Interdependencies with other services or providers

Endoscopic therapy in the oesophagus carries a low but significant risk of complication. It is important that therapy is carried out in centres that have the specialist expertise to offer and the necessary back-up if required.

RFA should be performed in centres equipped with endoscopic resection (ER) facilities and expertise. ER should be performed in high-volume tertiary referral centres *(British Society of Gastroenterology Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 22)*.

ER should be performed in tertiary referral cancer centres for oesophageal cancer disease. These specialist cancer centres should perform at least 15 ERs per annum for HGD or early cancer *(British Society of Gastroenterology*

Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 21).

Endoscopic therapy of Barrett's neoplasia should be performed at centres where endoscopic and surgical options can be offered to patients (British Society of Gastroenterology Guidelines on the diagnosis and management of Barrett's oesophagus 2013, p 21).

2.4 Exclusion Criteria

This policy excludes patients with Barrett's oesophagus:

- with intestinal metaplasia (IM) alone, i.e. without dysplasia
- indefinite for dysplasia
- non-persistent LGD (i.e. present on one occasion only or not confirmed by a second Upper GI pathologist).

Please see WHSSC commissioning policy: CP183a, Radiofrequency Ablation (RFA) for the Management of Barrett's Oesophagus in Adults for further information[8].

2.5 Acceptance Criteria

The service outlined in this specification is for patients ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes patients who whilst resident in Wales, are registered with a GP practice in England, but includes patients resident in England who are registered with a GP Practice in Wales.

2.6 Patient Pathway (Annex i)

- Patient with suspected dysplasia referred to local upper gastrointestinal MDT.

- Patient selection for endoscopic radiofrequency ablation for Barrett's oesophagus with high-grade dysplasia or low-grade dysplasia should be made by a multidisciplinary team experienced in managing Barrett's oesophagus, as described in the British Society of Gastroenterology guidelines. This will be the regional Upper GI MDT.

- Referral to the ER/RFA treatment centre for further assessment for suitability for endoscopic treatment.

- If the patient is assessed as suitable for ER/RFA, s/he is listed for treatment.

- Patients typically require an average of 3 sessions of RFA treatment over a 12 week period to successfully treat the affected area.

[8] http://www.whssc.wales.nhs.uk/specialised-services-commissioning-polic-4

- Following the conclusion of treatment, the patient is referred back to their local Upper GI service for on-going monitoring and surveillance.

Responsibilities of referrers

- Each Health Board should designate a local clinical lead for Barrett's Oesophagus to ensure patients are monitored appropriately through surveillance endoscopy and referred at the right time for consideration of endoscopic treatment.

- Local surveillance services should ensure that patients are appropriately monitored in the period following endoscopic treatment.

2.7 Service provider/Designated Centre

For people in North Wales:

Royal Liverpool University Hospital
Prescot Street
Liverpool
L7 8XP

For people in South Wales:

University Hospital of Wales
Heath Park Way
Cardiff
CF14 4XW

2.8 Exceptions

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

3. Quality and Patient Safety

The provider must work to written quality standard and provide monitoring information to the lead commissioner. The quality management systems must be externally audited and accredited.

The centre must enable the patients, carers and advocates informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

3.1 Quality Indicators (Standards)

Providers should:

- have a structured clinical outcomes collection and analysis programme
- audit practice to inform change
- report and learn from treatment error and near-miss events, to inform practice
- enter Barrett's oesophagus patients with intramucosal cancer onto the Cancer Network Information System Cymru (CaNISC)
- have a structured patient experience data collection and analysis programme
- describe links to clinical trials, national registries and academic studies

3.2 National Standards

Providers should:

- Be accredited by relevant national regulatory authorities
- Provide assurance that endoscopic treatment is delivered according to national and international standards where appropriate and applicable
- Meet the national standards of the relevant professional bodies such as the British Society of Gastroenterologists
- Comply with the appropriate data protection and information governance requirements.

4. Performance monitoring and Information Requirement

4.1 Performance Monitoring

WHSSC will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

For the services defined in this policy the following approach will be adopted:

- Service providers to evidence quality and performance controls
- Service providers to evidence compliance with standards of care

WHSSC will conduct performance and quality reviews on an annual basis

4.2 Key Performance Indicators

The providers will be expected to monitor against the full list of Quality Indicators derived from the service description components described in Section 2.2.
The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

The provider will record and report to the commissioner on:

Activity and waiting times

- Numbers of patients treated and number of treatments delivered
- The provider will be expected to comply with the Single Cancer Pathway for patients who have, or are suspected to have, intramucosal carcinoma
- Proportion of patients assessed as suitable who progress to treatment

Clinical outcomes

- Adverse incidents or SUIs
- Complication rates (acute and delayed)
- All complications should be reported, particularly development of strictures
- Treatment success rates (complete resolution of Barrett's oesophagus) after 12 months, 3 years and 5 years
- For patients with intramucosal carcinoma:
    - % successful tumour control/cure
    - Disease free survival
- For patients with HGD or persistent LGD:
    - % to progress to cancer
    - % who go on to develop HGD/persistent LGD and are re-referred for further ER/RFA
- Patient reported outcomes

4.3 Date of Review

This document is scheduled for review before 2023, where we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

5. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

6. Putting Things Right: Raising a Concern

6.1 Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure, with a copy of the concern being sent to WHSSC.

6.2 Individual Patient Funding Request (IPFR)

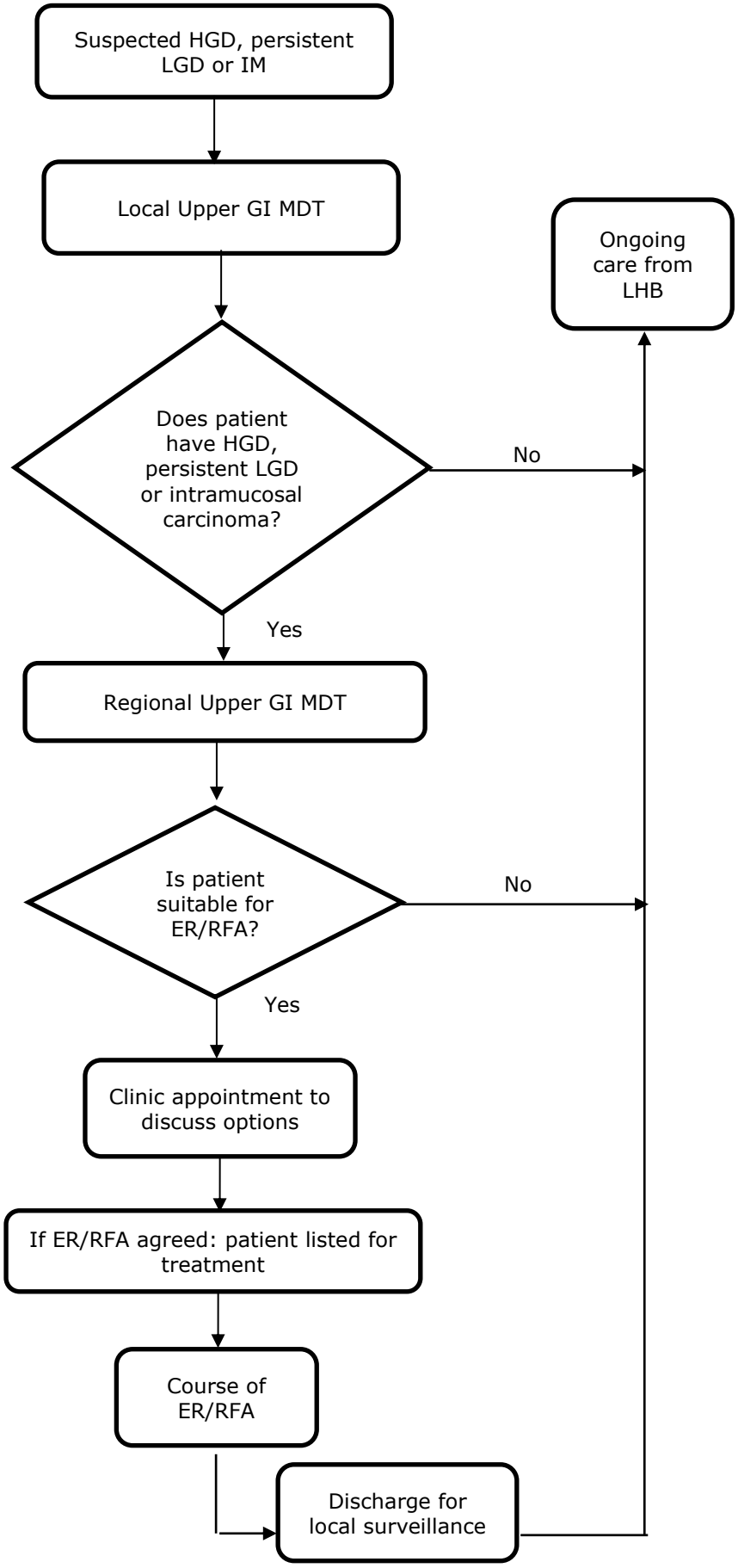
If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, arrangements can be made for an independent review of the process to be undertaken by the patient's Local Health Board. The ground for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

Annex i Patient Pathway



Annex ii Codes

Code Category	Code	Description
OPCS	G14.5	Fibre optic endoscopic destruction of lesion of oesophagus NEC
	Y13.4	Radiofrequency controlled thermal destruction of lesion of organ NOC
	G43.5	Fibre optic endoscopic destruction of lesion of upper gastrointestinal tract NEC
	G14.3	Fibre optic endoscopic cauterisation of lesion of oesophagus
	Z27.1	Oesophagus

Annex iii Abbreviations and Glossary

Abbreviations

AWMSG All Wales Medicines Strategy Group

IPFR Individual Patient Funding Request

SMC Scottish Medicines Consortium

WHSSC Welsh Health Specialised Services

Glossary

Individual Patient Funding Request (IPFR)

An IPFR is a request to Welsh Health Specialised Services Committee (WHSSC) to fund an intervention, device or treatment for patients that fall outside the range of services and treatments routinely provided across Wales.

Welsh Health Specialised Services Committee (WHSSC)

WHSSC is a joint committee of the seven local health boards in Wales. The purpose of WHSSC is to ensure that the population of Wales has fair and equitable access to the full range of Specialised Services and Tertiary Services. WHSSC ensures that specialised services are commissioned from providers that have the appropriate experience and expertise. They ensure that these providers are able to provide a robust, high quality and sustainable services, which are safe for patients and are cost effective for NHS Wales.