PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

Summary of Proceedings

Public Hearing

Held on **Wednesday, June 26, 2024, from 10:45 a.m. to 12:57 p.m.**

Venue: J. Hamilton Maurice Meeting Room, Ground Floor, Parliamentary Complex, Cabildo Building, St Vincent Street, Port of Spain.

Subject matter: An inquiry into Trinidad and Tobago's response to the prevalence of non-communicable diseases with a specific focus on diabetes, cardiovascular diseases and cancer.

The **objectives of the inquiry** are as follows:

1. To examine the efforts of the state to counteract the effects of specific non-communicable diseases, NCDs, within the population, including diabetes, heart disease and cancer;
2. To examine the efforts of civil society to counteract the effects of non-communicable diseases or specific non-communicable diseases within the population, including diabetes, heart disease and cancer; and
3. To determine the main policy changes, actions, and interventions that are necessary to effectively respond to the increase in non-communicable diseases in Trinidad and Tobago.

Committee Members

The following Committee Members were present:

- Dr. Paul Richards –Chairman
- Ms. Pennelope Beckles, MP – Member
- Ms. Vandana Mohit, MP – Member
- Mr. David Nakhid – Member

The following Committee Members were excused:

- Mr. Roger Monroe, MP – Vice Chairman
- Mr. Avinash Singh - Member
- Mr. Rohan Sinanan – Member
- Mr. Esmond Forde, MP –Member

Witnesses who appeared

The following officials of the **Ministry of Health** (MOH) appeared:

- **Mr. Asif Ali**
  Permanent Secretary
- **Dr. Roshan Parasram,** ORTT
  Chief Medical Officer
- **Dr. Stewart Smith**
  Senior Health System Advisor
- **Dr. Maria Clapperton**
  Director, Non-Communicable Diseases Unit
- **Mrs. Anesa Doodnath-Siboo**
  Principal Pharmacist (Ag.)

The following officials of the **North-Central Regional Health Authority** (NCRHA) appeared:

- **Mrs. Stacy Thomas-Lewis**
  Chief Operating Officer (Ag.)
- **Dr. Abdul Hamid**
  General Manager – Primary Health Care Services
- **Dr. Kimani White**
  Medical Chief of Staff (Ag.) EWMSC

The following officials of the **Eastern Regional Health Authority** (ERHA) appeared:

- **Mrs. Angelina Rampersad-Pierre**
  Chief Executive Officer (Ag.)
- **Dr. Rajiv Bhagaloo**
  Medical Director
- **Dr. Jamila Augustine**
  County Medical Officer of Health

The following officials of the **South-West Regional Health Authority** (SWRHA) appeared:

- **Dr. Brian Armour**
  Chief Executive Officer
- **Mrs. Michelle Murray-La Foucade**
  General Manager, Policy Planning and Research
- **Mrs. Rachel Jardine-Burkett**
  General Manager, Nursing

The following officials of the **North-West Regional Health Authority** (NWRHA) appeared:

- **Mr. Anthony Blake**
  Chief Executive Officer
- **Dr. Keisha Gangaram**
  Director of Health
- **Dr. Kellie Alleyne-Mike**
  Medical Director, Cancer Centre of Trinidad and Tobago (Oncology)
- **Dr. Keegan Baggan**
  General Manager, Primary Care Services

Opening Statements

The chief officials of the aforementioned entities made brief opening remarks.

Key Issues Discussed

The following are the main themes arising from discussions with the Regional Health Authorities (RHAs):

The challenges facing RHAs - Delayed Appointment Times

General Comments

i. RHAs without operational machinery face challenges in servicing their patients.
ii. Collaboration with other RHAs may provide a temporary solution. Both SWRHA and ERHA collaborate with NCRHA for Magnetic Resonance Imaging (MRI).
iii. Clinical prioritisation among all RHAs ensures that severe and urgent cases, such as oncology patients, are seen more quickly. However, gaps in the system may still exist.

NCRHA

i. The NCRHA is currently attempting to reduce the appointment backlog by redirecting some patients to Arima General Hospital, the Couva Hospital, and the Multi-Training Facility.

SWRHA

i. The SWRHA indicated that there is an eight to nine-month delay for MRI appointments until a new machine is commissioned. However, the Authority stated that this wait time will not affect patient diagnoses, as there is a prioritised list for urgent and elective procedures.

ERHA

i. The lack of an MRI machine in the ERHA causes appointment delays.
ii. The ERHA stated that their Quality Department follows up with the respective RHAs regarding scans done for their outpatient clinics, but acknowledges there may be challenges.

The challenges facing RHAs - Delayed Service Times

NWRHA

i. The NWRHA faces challenges with A&E wait times due to having just over 100 beds, down from 500-600 before the central block was condemned. This has significantly affected ward admission times.
ii. The MOH assisted the NWRHA by providing a 60-bed unit at the St. James Medical Complex to compensate for the bed shortage at the Port of Spain General Hospital. The NWRHA acknowledged that there will be limitations until the central block becomes operational in March 2025.

Challenges facing RHAs - Resource limitations

General Comments made about the RHAs

i. RHAs acknowledged that they are aware that some doctors clock in at public healthcare and then leave for their private practices.
ii. According to NWRHA, management must pay attention to the return of personnel. The Finance and Human Resources department also is responsible for monitoring punctuality and attendance.

NCRHA

i. The NCRHA completed quality improvement audits and scheduled staff training as a result.

NWRHA

i. According to the NWRHA, there is a lack of management training among middle managerial staff.
ii. A Memorandum of Understanding was signed with the University of Trinidad and Tobago (UTT) to train clinical professionals in middle management.
iii. The NWRHA stated that there is a nursing staff shortage due to pull factors from the United States. It was also stated that the nurse-to-patient ratio is insufficient.
iv. According to the NWRHA, nurse retention strategies are being examined, and a permanency exercise is underway.
v. One hundred nurses are currently enrolled in full-time specialist training.
vi. Issues related to doctors' attendance and punctuality are being noted and addressed.

Challenges facing RHAs - Equipment Shortages

General Comments

i. It was stated that planning machinery maintenance is difficult due to patient needs.
ii. The stipulated hours of machinery use are often surpassed due to patient load, shortening the typical period for servicing needs.
iii. It was noted that challenges with foreign exchange led local suppliers to refrain from stocking additional parts.
iv. These parts must then be sourced internationally, resulting in longer wait times for machines to be operational.
v. Equipment challenges cause significant delays in appointment times, as multiple RHAs rely on those with operational machinery.

NWRHA

i. The NWRHA noted difficulties with equipment and currently has two operational computed tomography (CT) scan machines.
ii. The NWRHA indicated that a significant challenge of having only one type of machine, such as a single CT scan or dialysis machine, is that patient load exhausts the machine at a faster rate.
iii. Critical MRIs are sent to the private sector through a referral agreement with the NWRHA.
iv. A new radiology suite was commissioned.

SWRHA

i. The SWRHA stated there were challenges with the aged MRI and CT scan machines. Collaboration with the Ministry of Health (MOH) is ongoing to source a new MRI, and a new CT scan has been commissioned.
ii. The SWRHA indicated that they collaborate with the NCRHA to address MRI needs for outpatients, while inpatient patients can use the functional MRI.

ERHA

i. The ERHA currently lacks an MRI machine and relies on collaboration with other RHAs until the new Sangre Grande Hospital becomes operational.

NCRHA

i. The NCRHA stated that their equipment has a 98% uptime, due to planned preventative maintenance. They are currently in a positive stage regarding medical equipment.

Challenges facing RHAs – Patient Access to Treatment

General Comments

i. Patients can lodge complaints with the Quality Department, but some may fear victimisation from the medical professionals providing their care.
ii. Evidence of misconduct is needed to enforce consequences against employees.
iii. If a patient lodges a formal complaint, the Quality Department investigates and produces a report. If there is a case to answer, it is reviewed through the RHA's code of conduct mechanism, which can result in consequences, including referral to a disciplinary tribunal.
iv. Criminal offenses are referred to the Trinidad and Tobago Police Service (TTPS). The RHA's code of conduct does not explicitly cite a doctor's redirection or recommendation to their private practice as misconduct.
v. According to collective agreements in doctors' contracts, junior doctors are prohibited from engaging in private practice between 8:00 a.m. and 4:00 p.m.
vi. For senior doctors, due to a lack of specialists and high demand in both the public and private sectors, there is no specific agreement in their contracts to provide a full 40-hour workweek based on their specialty skills.
vii. Persons can make complaints orally or in writing through the Quality Department.

ERHA

i. According to the ERHA, some patients in rural areas have difficulty accessing the Sangre Grande Hospital for secondary healthcare.

NRCHA

i. The NCRHA launched the 'Walk De Talk' programme in 2016 in partnership with religious organisations. The programme conducted mass screenings for over 50,000 people at approximately 500 religious organisations and offered various interventions and services.
ii. The NCRHA also runs a Men's Wellness Initiative that offers mass screenings for men once a year.

SWRHA

i. The SWRHA acknowledges that patient redirection occurs.
ii. SWRHA stated that staff sometimes inform patients that tests are unavailable when, in fact, they are available. To prevent this, the SWRHA provides daily alerts to staff and a public notice in the A&E Department regarding available and unavailable tests, as well as the corresponding time frames. In the future, a notice will be provided when a machine is not operational to raise public awareness.

NWRHA

i. The NWRHA received formal complaints from the MOH, including one about patient redirection to private care for a surgery that could be done in the public health care system. There is an ongoing investigation regarding the complaint.
ii. The NWRHA noted having difficult conversations with doctors to inform them that patient redirection for services available in public health care is misconduct.

ERHA

i. All doctors in the ERHA are notified that redirection of patients to private practice is against the code of conduct and have received consequence management training. While the ERHA has not observed the issue, they have systems in place to address it.

Regarding Patient Record Management at the RHAs

General Comments

i. Loss of records can result from patients attending multiple clinics, making file transfers challenging. Challenges also arise in the courier system between outpatient clinics. The ongoing digitisation initiative will resolve these issues.
ii. Patients must apply for the release of their records through a form at the Records department of their respective RHA.

Regarding Patient Confidentiality at RHAs

SWRHA

i. SWRHA stated that there are safeguards in the medical records department, including confidentiality measures for reviewing, transferring, and accessing patient records under the Freedom of Information Act (FOIA).

Regarding the digitisation of patient records at various RHAs

NWRHA

i. NWRHA has completed approximately 60% of its records digitisation exercise.

ERHA

i. ERHA has begun phase one of digitising records in the A&E department.
ii. ERHA has established a protocol for the release of patient records.

NCRHA

i. NCRHA partnered with NWRHA for patient registration and pharmacy modules at Arima General Hospital under Newfields technology.
ii. In 2023, NCRHA introduced the Eric Williams Medical Science Complex (EWMSC) Medical Records Patient Referral Unit.
iii. NCRHA noted that it has completed 100% of its digitisation process using an in-house system.

The following are the main themes arising from discussions with the **Ministry of Health:**

The Ministry's opinion on delayed service times

i. The MOH indicated that wait times in the Accident and Emergency (A&E) Department are related to the high prevalence of NCDs in Trinidad and Tobago.

Resource challenges

i. The MOH stated that training of local nurses in sub-specialties is ongoing across all RHAs.
ii. The MOH highlighted regional and local challenges in retaining medical professionals and sub-specialists, such as intensive care unit (ICU) nurses.
iii. It was noted that the nurse-to-patient ratio varies across RHAs and departments/units.
iv. Collaboration is ongoing with the Ministry of Foreign and CARICOM Affairs through the MOH's International Cooperation Desk and bilateral agreements for the intake of nurses from countries such as Cuba.
v. The MOH is currently exploring bilateral agreements to recruit nurses from other regional countries.
vi. Providing universal healthcare access for both local and international individuals within a finite budget is challenging.

Challenges facing MOH – Patient Access to treatment

i. No cases have been tried thus far regarding a doctor's redirection of patient/s to their private practice.

Challenges facing MOH - Access to Medication

i. The MOH reports periodic reductions in drug supply within the secondary healthcare system.
ii. A system is being implemented to track the supply of drugs and their locations across RHAs, to inform patients accordingly.
iii. There is a general shortage of drugs due to global factors; however, all medications within the CDAP are available.
iv. All drugs procured by the Ministry of Health for the public sector must come from a WHO-approved laboratory, undergo a strict registration process, and comply with the country's legal requirements.
v. Side effects of drugs vary among individuals. Under the CDAP, the basket of purchased drugs is a subset of those available for the public sector. The acquisition of these drugs involves the same tender evaluation process.

Assessment and expansion of CDAP

i. The CDAP has significantly expanded its operations and hours through a public-private partnership.
ii. The CDAP was assessed in February 2003 and expanded to provide access to all.
iii. Initially covering eight (8) disease states, the programme now includes 11 disease states.
iv. The latest addition of medication to the CDAP was in 2019 through the HEARTS Initiative for hypertension management.
v. Clients can access CDAP items from any CDAP partnered pharmacy, except glucose test trips.
vi. CDAP monitors have the authority to redirect stock as needed.
vii. The Ministry intends to review the CDAP shortly.

CDAP Success

i. According to the MOH, success can be measured by the number of clients registered and using the programme.
ii. From January 1, 2024, to June 26, 2024, 87,050 persons accessed CDAP, with a total of 186,050 clients registered since its inception.

CDAP Challenges and Solutions

i. Challenges affecting the programme were addressed by implementing mechanisms to enhance service delivery.
ii. Pharmacies were encouraged to join CDAP to improve citizen accessibility.
iii. Efforts to increase and improve medication provision to pharmacies were examined and utilised, including increased delivery schedules and increased supplies based on consumption patterns.

CDAP Sustainability

i. Regarding sustainability, private pharmacies must pay a fee of 68,000 TTD to join CDAP.
ii. There has been a change in the dispensing fee, where pharmacists receive a fee for each CDAP item dispensed. When CDAP began, the dispensing fee was $15 TTD; it has since been reduced to $8 TTD.
iii. As part of the monitoring and evaluation system, each patient under CDAP is assigned a Unique Identification Code (UIC) to prevent duplication and ensure accurate reporting. Real-time data on programme access is available.
iv. A survey was conducted to assess the most frequently consumed items.
v. There were slight increases in medication costs due to freight and insurance expenses.

CDAP Shortages and pharmacy management

i. There are 52 items on CDAP. Occasionally, complaints about drug shortages under the programme are received through the corporate communications unit.
ii. Complaints are forwarded to NIPDEC's CDAP unit for resolution, which has knowledge of stock levels at each pharmacy. The principal pharmacist of MOH also follows up.
iii. Clients are prevented from hoarding drugs through the unique identifier code (UIC).

iv. According to the MOH, the same basket of drugs is available for purchase by both the public and private sectors, which explains why a pharmacy may have the drugs available both for sale and under CDAP.
v. The MOH will accept complaints about CDAP and pharmacies and forward them to NIPDEC.
vi. Monitors from the CDAP investigate complaints, and the mechanism within the pharmacy board can address the issues.
ix. Insulin R is expiring on 30/06/2024, however, there is stock available with an expiration of 02/2025 in circulation. The mechanism used for dispensing and distribution is 'first expiry, first out'.
x. Monitors recall or retain batches of expired items by requesting pharmacists to store expired drugs separately. Monitors retrieve these items from pharmacies and return them to NIPDEC. This procedure is communicated to CDAP-registered pharmacies three months in advance, along with a request for requisition of new, unexpired stock.
xi. Based on complaints received, some pharmacies have received warnings from monitors about the contracts signed with NIPDEC on behalf of the MOH for the provision of CDAP services. Errant pharmacies were notified in writing.
xii. A media release is issued to notify the public and provide necessary details whenever an item needs to be recalled.
xiii. Some pharmacies sell unapproved or expired drugs and pharmaceuticals.
xiv. Inspectors from the Chemistry, Food, and Drug Division of the MOH visit pharmacies to ensure compliance with regulations, assess recalls, expired drugs, and the status of registered and unregistered drugs. Drugs found in breach are confiscated and referred to the Trinidad and Tobago Police Service (TTPS).
xv. Pharmacists are responsible for dispensing medication and are directly responsible for any inaccuracies. Issues with dispensing require the prompt involvement of the client, doctor, and pharmacist for resolution.
xvi. According to the principal pharmacist of MOH, there have been no inaccuracies in medication dispensing.

Awareness and Education Programmes

i. The MOH noted it is shifting towards a preventative approach to address the high prevalence of NCDs, acknowledging that results may take 5-10 years to manifest.
ii. There was recognition of the need to sensitise clients on avenues for lodging complaints in the RHAs, as well as educating them on reading labels and product packages.
iii. District Health Visitors are based in each health centre and visit individuals at home who cannot leave to access care or medication, sometimes accompanied by physicians from the District Health Facilities.
iv. The Ministry of Education (MOE) hired nurses for schools in recent years. MOH has been collaborating with the MOE through its School Health Visitor's programme, led by District Health Visitors. The programme includes assessments for development, examinations, and immunisation.
v. The NCD Inspector Academy was developed during the Easter vacation period of 2024 by the RHAs in collaboration with the MOE for children aged 5-11. The programme aims to empower children as agents of change in adopting healthy lifestyle habits, exposing them to food and nutrition, meal preparation, gardening, and physical activity.

Digitisation of patient records

i. There is currently a national effort led by the MOH for digitising records within RHAs. This includes converting medical records, as well as other aspects of care, such as laboratory results and radiology reports.

Dengue

i. The MOH has been conducting sensitisation exercises, starting with clinicians in February 2024, to mitigate the risk of illnesses from various origins.
ii. According to the MOH, there have been 147 confirmed cases of Dengue in 2024 to date.
iii. The MOH and Insect Vector Control lead public awareness campaigns about Dengue, in collaboration with regional corporations through the Ministry of Rural Development and Local Government.

Regulation of labelling requirements of Food items

i. The MOH stated that CARICOM is currently discussing legislation for a regulatory framework to enforce compliance with food item labelling requirements.

Key Recommendations based on discussions

The following are key recommendations proposed based on the discussions:

i. Delayed Appointments and Long Wait Times

- RHAs should implement specific and transparent strategies to reduce wait times at outpatient clinics and emergency departments.
- Introduce clinic-by-clinic audits and tracking dashboards to monitor actual patient throughput and improve scheduling efficiency.
- Prioritise patient triaging and optimise the use of all functioning diagnostic equipment to address backlogs in imaging and testing services.
- Collect and use patient feedback and metrics to improve service delivery timelines.

ii. Medical Equipment Shortages

- RHAs should improve procurement planning by submitting clear, needs-based proposals through the Public Sector Investment Programme (PSIP).
- Advocate for increased budgetary support to replace ageing diagnostic tools such as MRIs and CT scanners.
- Develop a national equipment redundancy framework to ensure backup capacity across RHAs and prevent service disruptions during maintenance or breakdowns.
- Improve internal communication to publicly display available tests to prevent misinformation about equipment availability.

iii. Staffing and Nurse-to-Patient Ratios

- Conduct a comprehensive audit of current nurse-to-patient ratios by facility type (ICU, general ward, outpatient).
- Compare these ratios with international best practices, and prioritise vulnerable departments (e.g., ICUs) for staffing improvements.
- Expand investment in training and certification programmes for nursing specialities to address retention and migration challenges.
- Collaborate with foreign governments to recruit and retain international nurses under bilateral agreements while bolstering local training.

iv. Conflict of Interest and Referrals to Private Practice

- Acknowledge the widespread complaint that public health professionals redirect patients to their private practices.
- Enforce stricter conflict-of-interest policies, including specific codes that prohibit redirection while on public duty.
- Initiate a formal investigation to determine the extent of the practice and recommend appropriate systemic reforms.
- Improve monitoring of clinic attendance, including the use of "return of personnel" records to address absenteeism during scheduled duty hours.
- Encourage patients to lodge formal complaints and implement anonymous reporting mechanisms to ease fears of victimisation.

v. Governance and Disciplinary Mechanisms

- Review and, where necessary, revise the RHA Codes of Conduct to explicitly include disciplinary actions for private referrals during public time.
- Clarify employment contract terms to require disclosure of any private medical practice by public healthcare workers.
- Strengthen the role of Quality Departments in tracking misconduct and supporting disciplinary procedures.
- Ensure consequence management training is ongoing and understood by all staff as part of clinical governance.

This public hearing can be viewed on demand via our YouTube Channel.

22nd Meeting - JSC Social Services & Public Administration - June 26, 2024 - NCDs (youtube.com)

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Committees Unit

July 03, 2024.