PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

LASCSA

JOINT SELECT COMMITTEE ON

LOCAL AUTHORITIES, SERVICE COMMISSIONS AND STATUTORY AUTHORITIES *(INCLUDING THE THA)*

13th Report

on an

Inquiry into the Efficiency and Effectiveness of the National Emergency Ambulance Service

Fifth Session (/2019/2020), 11th Parliament

Thirteenth Report

Of the

Joint Select Committee on Local Authorities, Service Commissions and Statutory Authorities (including the THA)

on an

Inquiry into the Efficiency and Effectiveness of the National Emergency Ambulance Service

Fifth Session (2019/2020), Eleventh Parliament

HOR PAPER NO: **SENATE PAPER NO.:**

PARL NO: 14/3/48-14

Ordered To Be Printed

Committee Membership

Dr. Varma Deyalsingh[1]	Chairman
Ms. Ramona Ramdial, MP	Vice-Chairman
Mr. Darryl Smith, MP	Member
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Ms. Khadijah Ameen	Member
Dr. Lovell Francis, MP	Member
Mr. Esmond Forde, MP	Member

Secretariat Support

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Terriann Baker	Graduate Research Assistant
Ms. Janelle Mills	Parliamentary Intern

Publication

An electronic copy of this report can be found on the Parliament website using the following link:

Contacts

All correspondence should be addressed to:

The Secretary
Joint Select Committee on Local Authorities, Service Commissions and Statutory Authorities (including the THA)
Office of the Parliament
Level 3, Tower D
The Port of Spain International Waterfront Centre
1A Wrightson Road Port of Spain Republic of Trinidad and Tobago
Tel: (868) 624-7275 Ext 2277; 2627 Fax: (868) 625-4672
Email: jsclascsa@ttparliament.org

Date Laid in HOR: 22.11.2019 **Date Laid in Senate:** 12.11.2019

[1] Dr. Varma Deyalsingh replaced Mr. H.R. Ian Roach w.e.f. 19.10.2018

ACRONYMS AND ABBREVIATIONS

ABBREVIATION	MEANING
ACEP	The American College of Emergency Physicians
ALS	Advanced Life Support
CAAS	Commission on the Accreditation of Ambulance Services
ESF	Emergency Support Function
IAED	the International Academy of Emergency Dispatch
NAEMSP	The National Association of EMS Physicians
NCTI	the National College of Technical Instruction
NEOC	the National Emergency Operations Centre
ODPM	Office of Disaster Preparedness and Management
GMRTT	Global Medical Response of Trinidad and Tobago
MOH	Ministry of Health
MONS	Ministry of National Security
PSAP	Public Safety Answering Point
TEMS	Tobago Emergency Medical Services
TRHA	Tobago Regional Health Authority

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

1.1 At its twenty-third meeting held on Wednesday 27th June 2018, the Committee resolved to conduct an **Inquiry into the Efficiency and Effectiveness of the National Emergency Ambulance Service** and agreed that the following three (3) objectives would guide the inquiry:

- **To assess the capacity of the National Emergency Ambulance Services in Trinidad and Tobago;**
- **To understand how the resources associated with this service are deployed throughout the country;**
- **To determine areas of inefficiency in the service and the critical factors/conditions which are required for its success.**

1.2 To this end, the Committee obtained evidence from the Global Medical Response of Trinidad and Tobago, the line Ministry, the Tobago Regional Health Authority and the Division of the THA responsible for health services. Some of the major issues that were highlighted/identified during the course of the inquiry included:

1. **Fleet Management- in the last 5 years, there was an increase from 30 to 40 ambulances under the purview of GMRTT. Under the TEMS there are 18 ambulances, however, only 8 are currently operational;**
2. **Maintenance –the maintenance and replacement of ambulances is undertaken at a significant cost;**
3. **Technical Requirements for the Ambulances – Ambulances operated by GMRTT and the TRHA are adequately equipped in accordance with the provisions of the Emergency Ambulance Services and Emergency Medical Personnel Act. This includes Basic and Advanced Life support;**
4. **Emergency Dispatch System –Trinidad dispatch system utilizes a Centralised Command system which is inclusive of triage and GPS system, while operations in Tobago are guided by the established**

Protocols outlined by the National Academy of Emergency Medical Dispatch[2] which seek to dispatch the closest ambulance to the situation;

5. **Monitoring and Evaluation of GMRTT – GMRTT is audited by the Ministry of Health's Directorate for Health Policy Research and Planning Unit. The operations of the TRHA are subjected to the provisions of the THA Act.**
6. **Training- GMRTT employees undergo an annual Emergency Medical Training (EMT) Training Program. TEMS staff under the TRHA receive in-house training and re-certification in Basic Life Support and First Aid;**
7. **Human Resources- GMRTT has recorded an annual turnover rate of 9.5 % while the turnover rate of the EMTs employed by the TRHA is 1.6 per annum;**
8. **Incorporation of paramedics within the current ambulance service.**
9. **Global trends- GMRTT became the first and only accredited ambulance operator in the region outside of the North America.**
10. **Legislative Review- Upon review, the Committee noted that several provisions, including oversight arrangements articulated in the Act have not been implemented;**
11. **The Contractual Agreement between GMRTT and the MOH was last renewed on September 1st 2015.**
12. **Licenses - It was revealed that none of the entities that operate an ambulance service is in possession of a licenses as prescribed by the Emergency Ambulance Services and Emergency Medical Personnel Act.**

1.1 Based on the evidence received and the conclusion derived from such evidence, the Committee has proffered recommendations which it believes will appropriately address the issues highlighted. A summary of these recommendations follow this Executive Summary.

[2] https://www.emergencydispatch.org/TheAcademy

1.2 We anticipate that the Parliament, the Ministry of Health, the GMRTT, the Division of Health and Wellness and Family Development (Tobago House of Assembly) would give due consideration to the findings and recommendations contained in this Report with a view to improving the provision of the National Emergency Ambulance Service in Trinidad and Tobago. The Committee looks forward to reviewing the Ministry's response to this Report, which becomes due, sixty (60) days after it is presented to the Houses of Parliament.

SUMMARY OF RECOMMENDATIONS

The following is a consolidated list of recommendations proposed by the Committee:

The Committee recommended that the following be implemented in the short-term (3-6 months):

i. **The GMRTT should collaborate with the Ministry of Health and RHAs to augment on the advance patient arrival communication protocols observed.**

ii. **A mechanism must be introduced to allow complaints to be shared with the Ministry of Health by way of requiring GMRTT to submit Quarterly Complaints Reports.**

iii. **The Ministry of Health must ensure that the standards and practices obtained from the Commission on the Accreditation of Ambulance Services (CAAS) are being maintained.**

iv. **As a means of curtailing the misuse and abuse of its services, GMRTT should seek to strengthen its triage system in order to prioritise critical cases.**

v. **Every effort should be made to ensure that the driving practices of ambulance drivers and equipment usage are managed efficiency.**

vi. **The Ministerial response of the Ministry of Health should advise on the components of the new deployment Centre in South and the specific services that will be replicated at this location.**

vii. **A system should be developed where paramedics are assigned in critical areas. This will be hinged upon the development of effective prioritization and triage systems.**

viii. **The Committee recommends that the MOH seek to prioritise the establishment of the outstanding Boards and Committees stipulated by the**

Act in order to expedite the allocation of licenses and to provide oversight to the relevant ambulance service providers.

ix. **The Ministerial Response should contain an update on the establishment and functioning of the statutory bodies proposed in the Act, including the output (if any) of each body and the hindering factors to their establishment.**

x. **GMRTT in collaboration with the MoH should conduct a public awareness campaign to sensitise the public about some of the challenges Emergency Medical Response Personnel experience in locating properties that are unmarked or unidentifiable.**

The Committee recommended that the following be implemented in the medium term(7-12 months):

xi. **The Ministry of Health should foster greater collaboration between GMRTT and other ambulance operators for the purpose of inter alia:**

a) **Establishing a means/channel for supplementing the response efforts during the course of a major disaster event or major force majeure event;**
b) **Promoting knowledge transfer and compliance with internationally recognized standards;**
c) **Developing the training and development network for Emergency Medical Response Personnel including EMTs and paramedics;**
d) **Establishing a representative body for the Ambulance industry. E.g. An Association.**

xii. **Ambulance services should strive to be innovative and continue to develop and refine prioritisation systems.**

xiii. **In heavily populated areas it may be necessary to have medically qualified personnel present at the call centre to assist in prioritising and managing complex cases.**

xiv. Deployment systems must be adaptable to suit the growing public demand for this service as well Trinidad and Tobago's categorization as an aging population.

xv. There should be a shared database between the MOH and GMRTT to allow the Ministry, the ability to track public complaints lodged against GMRTT as part of its monitoring and evaluation procedures.

xvi. We recommend that GMRTT collaborate with the Ministry of Health and the Faculty of Medical Sciences with a view to developing a training programme for EMTs and paramedics for treating with mentally-ill patients.

INTRODUCTION

Background[3]

National Emergency Ambulance Services in Trinidad and Tobago

2.1 In the past, the ambulance service comprised the Trinidad and Tobago Red Cross and the St. John's Ambulance Brigade. Additionally, the Emergency Health Service (EHS) was established in 1999 which was managed by the South-West Regional Health Authority (SWRHA). This system was modified in 2005 when the Global Medical Response of Trinidad and Tobago (GMRTT) assumed responsibility for the national ambulance service through a contractual agreement with the Ministry of Health[4].

Funding of the Authority

2.2 According to Section 15(1) of the Act- The funds of the Authority shall consist of –

- monies identified by the Ministry of Health and appropriated by the Parliament of Trinidad and Tobago for the purposes of the Authority;
- monies collected as fees;
- contributions by the private sector clients for non-emergency services;
- monies arising from grants, covenants, donations and other receipts from persons including national and international bodies; and
- monies borrowed by the Authority.

The role of the Ministry of Health

2.3 The Ministry of Health contracted the services of Global Medical Response of Trinidad and Tobago (GMRTT). The organization is responsible for the provision of emergency ambulance services within Trinidad. As the national EMS provider for Trinidad, the GMRTT uses a combination of station-based and roving ambulance deployment strategies to ensure all persons receive safe, reliable and prompt response

[3] http://mbtt.org/index.htm
[4] Report of the Commission of Enquiry into the Operation and Delivery of Public Health Care Services in Trinidad and Tobago. Volume Two, Part One (2007)

to their medical emergency. The GMRTT's Port of Spain headquarters contain the centralised administration, dispatch and operations support units. It utilises Regional Operation Centres in the North, South and East Trinidad and numerous ambulance stations throughout the country to ensure ambulance are poised to respond to a call for help[5].

Oversight Responsibility

2.4 The MOH currently has the oversight responsibility for all ambulance service providers in Trinidad. The major ambulance provider is GMRTT.

Legal Framework

2.5 The **Emergency Ambulance Services and Emergency Medical Personnel Act Chapter 29:02,** ("the Act") was enacted in 2009 to regulate emergency ambulance services, to provide for the registration of emergency medical personnel in Trinidad and Tobago, for the establishment of a National Emergency Ambulance Authority and for other related matters. The Act provides for *inter alia*:

- An **Emergency Ambulance Regulatory Committee** which would be responsible for advising and supporting the Minister in the delivery of efficient and effective emergency medical services; (Section 4)
- The establishment of body corporate to be known as "**the National Emergency Ambulance Services Authority"** (Section 5)
- An **Emergency Ambulance Services Board** which would be responsible for governing the affairs of the Authority;

2.6 Although this Act became enforceable in 2014, several key provisions have not been operationalised including a National Emergency Ambulance Services Authority. It was envisaged that this Authority would responsible for *inter alia*:

a. the delivery of a national emergency ambulance service;

[5] http://www.health.gov.tt/sitepages/default.aspx?id=167

b. monitoring and evaluating its services.
c. The appointment of inspectors or an inspection team to visit and inspect facilities being sought to be licensed to provide ambulance services; (Section 15)
d. the licensing of Ambulance Services; (Section 21)
e. an appeals process for the hearing of appeals in relation to the refusal, suspension and revocation of licences; (Section 31)
f. the Emergency Ambulance Services Register") of all persons holding licences to provide ambulance services (Section 34);
g. A framework for the regulation of Emergency Medical Personnel (EMP), in particular the establishment of:
    i. Emergency Medical Personnel Board and Council;
h. The registration of EMP;
i. The making of regulations pertaining to this class of workers

The Tobago Regional Health Authority

2.7 In Tobago, the Emergency Ambulance services are managed by the Tobago Regional Health Authority (TRHA). The Tobago Regional Health Authority is unique, in that it is subject to the Tobago House of Assembly Act. The RHA Act #5 of 1994, Part 11, Section 5.2 states that ***"In the exercise of its powers and functions, The Board of the Tobago Regional Health Authority is subjected to the provisions of the Tobago House of Assembly Act".*** National policies developed at the Ministry of Health are/maybe subject to review at the level of the THA.

Tobago Emergency Management Agency

2.8 The Tobago Emergency Management Agency was first established as the National Emergency Management Agency, in accordance with the Tobago House of Assembly, Executive Council Minute No.64 of March 09, 1998. TEMA/TEMS share a symbiotic relationship. Additionally, they are members of the Tobago Disaster Management Committee. This committee comprises various agencies, which meet monthly to discuss, strategies for disaster responses.

Conduct of the Inquiry

2.9 Oral evidence was captured through the convening of two public hearings. The first public hearing was held with representatives of Global Medical Response of Trinidad and Tobago (GMRTT) and the Ministry of Health (MOH) on Wednesday November 28th, 2018. The persons who appeared on behalf of these entities were as follows:

Global Medical Response of Trinidad and Tobago (GMRTT)

1. Mr. John Aboud	Chairman
2. Mr. Paul Anderson	Chief Executive Officer

Ministry of Health (MOH)

1. Mr. Asif Ali	Permanent Secretary, Ministry of Health
2. Dr. Robin Sinanan	Manager, Accident and Emergency, SWRHA
3. Dr. Roshan Parasram	Chief Medical Officer
4. Ms. Bhabie Roopchand	Legal Advisor
5. Mr. Lawrence Jaisingh	Director, Health Policy Research and Planning.

2.10 Subsequent to this, a second hearing was conducted with officials of Tobago Regional Health Authority and the Division of Health, Wellness and Family Development (THA) who appeared simultaneously on Wednesday June 11, 2018. A list comprising the names of the officials who appeared is at Appendix I.

2.11 In May 2019, the Committee sought to engage the public's view on the National Ambulance Service, through the use of a survey. The survey was administered online from May 24th 2019 - June 14th 2019 where the Committee obtained 218 responses. This survey was made available to persons within Trinidad and Tobago. The questions which comprised the survey are attached as Appendix 10.

The Minutes and Verbatim Notes are attached as Appendix 8 and Appendix 9 respectively.

Summary of Evidence together with Findings and Recommendations

Objective 1: To Assess the Capacity of the National Emergency Ambulance Services in Trinidad and Tobago

3.1.1. The Committee commenced an evaluation of the National Emergency Ambulance Service by assessing the main national emergency ambulance service providers within Trinidad and Tobago namely GMRTT and the Tobago Regional Health Authority (TRHA) respectively.

Fleet Management and Capacity

Arrangements in Trinidad

3.1.2. During the public hearing, Mr. Anderson, CEO of GMRTT stated that the GMRTT is the product of the partnership between the American Medical Response and Amalgamated Security Services Limited (ASSL). The ASSL sits on the Board of Directors of the GMRTT. In 2008, GMRTT became the first EMS agency outside of North America to be accredited by the Commission on Accreditation of Ambulance Services after two years. Furthermore, GMRTT has indicated that full accreditation was obtained from the Commission on the Accreditation of Ambulance Services in 2014. The Certificate of Accreditation may be found in Appendix 12.

3.1.3. There are two levels of Life Support provided by ambulance services:

i. Basic Life Support;
ii. Advanced Life Support. (Involves paramedics administering pharmaceuticals, doing invasive procedures and having the ability to treat people with acute illness)

3.1.4. GMRTT submitted that the life support capacity of its vehicles are in accordance with the specification of the Emergency Ambulance Services and Emergency Medical Personnel Act Chap. 29:02[6]. At present, 58 ambulances are equipped to provide both Basic and Advance Life Support. Additionally, GMRTT has twenty-five (25) ambulances that are equipped and capable of offering intensive care services.

3.1.5. Based on the written submission from the MOH, during the last 5 years, there was an increase from 30 to 40 ambulances. As at November 28, 2018, 20* additional ambulances were set to be commissioned by the 2nd quarter of 2019.

3.1.6. The following table provides the breakdown of the model of each vehicle.

Table 1: Breakdown of Ambulances

# of Ambulances	Vehicle Make / Model	Year of Manufacture
9	Toyota Hiace Van with Ambulance Conversion (Ministry of Health Asset)	2013
31	Jinbei Haise passenger van with Ambulance Conversion	2016
20*	Toyota Hiace passenger van with Ambulance Conversion	2018

The procurement methodology utilized by GMRTT commences with the purchase of a panel van with basic specifics such as automatic transmission, right hand drive with engine displacement which could handle the load requirements. After which, a fabricator is sourced to complete the remodeling of the vehicle. The ambulances

[6] See Schedule 3 of the Act

used in Trinidad are manufactured in Asia and England. The cost to outfit/ equip an ambulance is $1M.

Arrangements in Tobago

3.1.7. The current fleet of ambulances operated by the Tobago Emergency Medical Services (TEMS) consist of 17 Ford E350, i.e. seven (7) Diesel and ten (10) Gasoline.

3.1.8. However, as at, January 2019, there were eight (8) operational ambulances. They are deployed as follows:

- Scarborough Health Centre – 1
- Delaford -1
- Lowlands – 2
- Parlatuvier Health Centre – 1
- Charlotteville Health Centre – 1
- Plymouth – 1

3.1.9. An additional ambulance is located at the Hospital Compound and was being used by the Patient Material and Transport (PMT) Department. All ambulances operated by the TRHA are monitored in real time via a GPS tracking system which can be viewed from the following five Units:

- Dispatch
- TEMS Manager's Office
- Operations Supervisor's Office
- Vehicle Safety Officer's office
- IT Department-THRA

Maintenance Arrangements

3.1.10. As at November 2018, only 34 GMRTT ambulances were fully operational as 15% of the fleet was taken out for routine maintenance. The CEO of the GMRTT stated that routine maintenance of a vehicle can be completed in one (1) day under

regular circumstances. Further to this, the annual cost associated with the maintenance of these vehicles is estimated at $7 Million. According to the written submission of the MOH, the maintenance of the fleet meets the standards for accreditation by the Commission on Accreditation of Ambulance Services, USA.

3.1.11. The TRHA utilizes the standards as outlined in the Vehicle manuals for Ford E-Series which was submitted to the Committee. The TRHA records mileage as a basic standard for determining when fleet maintenance should occur. 7500 miles is the minimum mileage which warrants immediate maintenance. The annual maintenance cost for the ambulances under the TRHA as at September 30th 2018 was $253,866.26. ANSA Motors and VMCOTT are responsible for the maintenance of these ambulances.

3.1.12. The following table highlights the fleet sizes of various ambulance providers in Trinidad and Tobago.

Table 2: Fleet Size of each Service Provider in Trinidad and Tobago

Service Provider	Fleet Size
Global Medical Response of Trinidad and Tobago (GMRTT)	40
Avatar Ambulance Service Ltd.	8
Eastern Divers	5
Universal Ambulance Services Ltd.	5
St. John Ambulance Association and Brigade of Trinidad and Tobago	4
Medical Associates Hospital	3
SCI EMS Ambulance Ltd.	2
Health, Emergency Rescue Occupational Safety and Environmental Services (H.E.R.O.E.S.)	2
Total	**69**

Technical Requirements for the Ambulances

3.1.13. The detailed technical requirements for ambulances are outlined in the Regulations which are appended to the Act. (See Appendix II).

3.1.14. As at November 2018, GMRTT is licensed under the Act to provide Basic Life Support, Advanced Life Support and Intensive Care Unit Ambulances. Additionally, all ambulances deployed by the GMRTT are equipped with GPS tracking devices which are monitored by the Centralised Communications Centre. GMRTT-leased vehicles are further equipped with mobile data and dual redundancy for Automatic Vehicle Location. The system of redundancy ensures maximum availability and adaptability in the event of a single component failure.

3.1.15. The ambulances within the RHA network are outfitted with basic health equipment.

Transportation of Patients

3.1.16. According to GMRTT, if the ambulance is less than 1 km away, the estimated response time is approximately 4 minutes. The response time extends to a 'maximum' of an average of 25 minutes for incidents further than 8 km.

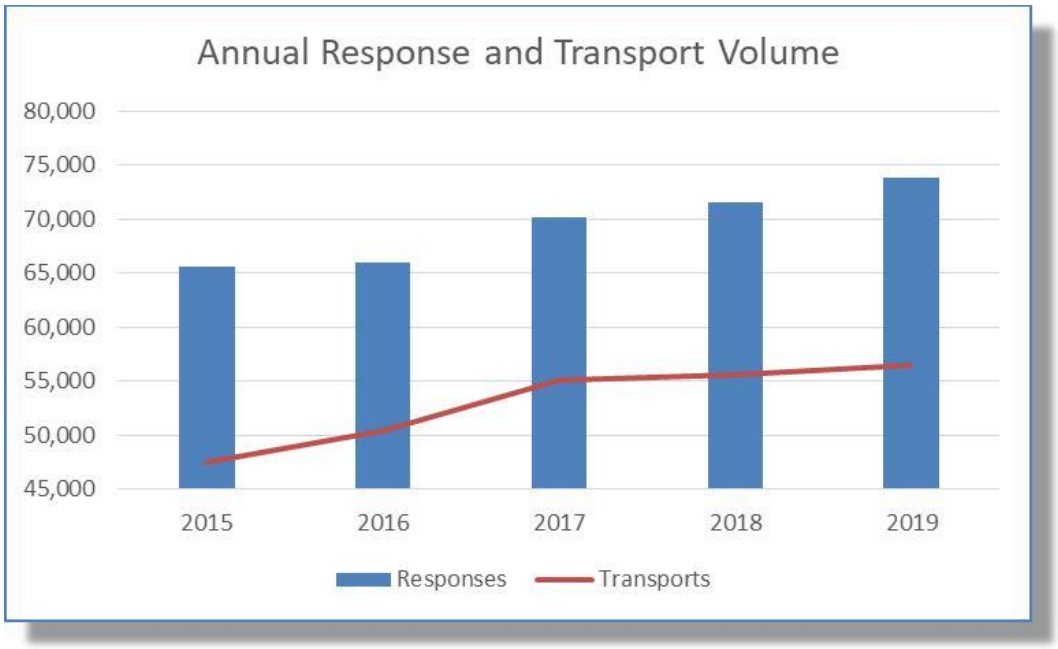
3.1.17. According to feedback received from participants in the National Ambulance Survey, the Committee noted with significance that over 72 persons, namely (33.03 %) of all respondents, indicated that the response times were greater than 20 minutes.

3.1.18. The number of patients transported by GMRTT during the period of 2017 to 2018 is as follows:

- January 2017 – December 2017 – 56,311
- January 2018 – December 2018 – 51,647

3.1.19. However, as at October 14th, 2019, GMRTT indicated that there has been an increase in its response rate as a consequence of expansion of GMRTT's fleet.

Figure 1: Annual Response vs Transport Volume



Patient Handover

3.1.20. According to GMRTT's 2017 Annual Report, "the patient handover process at the public healthcare facilities continues to be a prime contributors to impaired performance of the EMS. It was reported that the average time period associated with patient handover at public health facilities is 35 minutes. A direct intervention by the Ministry of Health in March 2016 resulted in a gradual reduction in the hand-over time experienced by GMRTT's emergency response personnel. However, the Committee noted that of the 56,000 patients transported in 2017 to various health facilities 7.5% of these patients experience a handover period in excess of 40 minutes[7]. Additionally, the cost paid to GMRTT per patient handover at a public health facility is $1200. The Ministry of Health concluded that

[7] GMRTT Annual Report: Annual Summary report on the operation and performance of the Trinidad Emergency Medical Services System – Global Medical Response of Trinidad and Tobago Limited, p9

this fee was appropriate based on the tender submission of the GMRTT as well as direct and indirect costs.

3.1.21. The average real time response times in the TEMS is approximately 15 to 25 minutes.

3.1.22. The number of patients transported by other service providers include:

Table 3: List of Service Providers

Service Provider	2017	2018
Medical Associates Hospital	553	523
SCI EMS Ambulance Ltd.	584	438
Eastern Divers	103	105
St. John Ambulance Association and Brigade of Trinidad and Tobago	63	43
Avatar Ambulance Service Ltd.	12	12
Health, Emergency Rescue Occupational Safety and Environmental Services (H.E.R.O.E.S.)	11	25
Universal Ambulance Services Ltd.	1	2

3.1.23. During the public hearing on January 9th 2019, the TRHA stated that there is a perception that arriving in an ambulance will result in a faster and more efficient service. This has led to abuse of the ambulance transportation service. Based on responses to the National Ambulance Survey, approximately 68%, 149

respondants stated that they did in fact believe that they would receive prompt medical attention if they arrived at a public health facility in an ambulance vehicle.

Emergency Dispatch System

3.1.24. Within the written submission of the MOH, it was stated that GMRTT utilizes a Centralised Command and Control Framework/Model which provides a single point of accountability and management of the dispatch system. This is facilitated by the GMRTT Communications Centre which operates on a 24 hour basis. Additionally, the GMRTT was recognized and accredited by the International Academy of Emergency Dispatch as an Accredited Centre of Excellence. It was reported that GMRTT is one of only 254 Emergency Communications Centers worldwide to ever achieve this accreditation. The date of the accreditation was not provided.

3.1.25. As at November 28, 2018 there were 24 full-time Emergency Medical Dispatchers. The dispatch system procedure is as follows:

i. Call received from citizen;
ii. Assessment of need conducted to determine priority
iii. Ambulance dispatched (if required);
iv. Medical oversight conducted with patient and Accident and Emergency Department (if required);
v. On site assessment and pick up (if required) ; and
vi. Patient handover to health facility

3.1.26. The Centre is considered the Stage 1 Public Safety Answering Point (PSAP) for the national 811 three-digit emergency access number. During the public hearing on November 28, 2018, the GMRTT stated that members of the public often contact the wrong agency for assistance which is a major hindering factor in delivering an efficient expeditious service.

3.1.27. Interestingly, the CEO of GMRTT stated that the GMRTT has deliberately minimized its marketing and promotional activities for the national ambulance number in order to curtail the misuse, abuse and overburdening of the EMTs.

3.1.28. Results from the national survey indicated that 56.88% of respondants knew the hotline telephone (811) number for the National Emergency Ambulance Service, while 36.24% were unaware and 6.88% was unsure.

3.1.29. The dispatch system in **Tobago** is guided by the established Protocols outlined by the National Academy of Emergency Dispatch. This consists of deploying the ambulance in closest proximity to the call. Prior to dispatch, a Triage system is used to prioritise calls. This is facilitated through the use of a multi-dimensional Computerised System which houses all the protocols that are required to facilitate the necessary Emergency responses and instructions for the emergency situation.

3.1.30. The main emergency line in Tobago is 639-4444, however there are 3 additional interconnected external lines: 639-1948, 639-2749, 639-2734.

3.1.31. According to the MOH, the ambulance service operates on a demand-based system. Periods of heightened and lowered demands reflect the needs of the society with significant peak periods occurring during the day.The peak hours in Tobago are between 8am to 8pm.

Human Resource Capacity of main ambulance service providers

3.1.32. The list of requirements for recruitment as an EMS personnel is listed in Appendix VIII.

3.1.33. Over the last five (5) year period, a total of eight (8) persons have been dismissed by the GMRTT. As stated in the MOH submission the annual turnover rate as determined by the US National Institutes of Health in 2010 is 10.2%. GMRTT has recorded an annual turnover rate of 9.5 %.

3.1.34. The turnover rate of the EMTs employed by the TRHA is 1.6 per annum.

3.1.35. The current staff complement of the GMRTT as at October 14th 2019 is as follows:

Table 1: Current Staff Listing at GMRTT

POSITION / FUNCTIONAL AREA	Current Staff	Current Vacancies
Accounts Coordinator	1	0
Administrative Assistant	2	0
Asst. Manager Clinical Quality Assurance	2	0
Asst. Manager Communications Centre Operations	1	0
Asst. Manager Fleet Operations	1	0
Asst. Manager Health, Safety and Environment	1	0
Chief Executive Officer	1	0
Department Head	6	0
Emergency Medical Dispatcher	27	0
Emergency Medical Technician	194	5
Human Resources Generalist	1	0
Logistics Manager	1	0
Logistics Support	3	0
Operations Scheduler	1	0
Paramedic	18	0
Quality Assurance Medic	2	0
Safety Training Officer	6	0
Stores Clerk	2	0
Supervisor: Communications	3	1
Supervisor: Field Operations	9	0
Vehicle Service Technician	18	3

Training

3.1.36. GMRTT's training and development strategy consists of the Emergency Medical Training (EMT) Training Program which involves a full module on Disaster preparation, mitigation, response and recovery and an expanded module in the Paramedic Training Program provided by the GMRTT. Additionally, the GMRTT engages staff at least once per year in a focused education program centered on disaster response. The following topics were covered:

- Mass casualty management;
- Disaster communications;
- Technology/Communication failure protocols;
- Inter-agency cooperation;
- Providing wellness during and post-disaster.

3.1.37. Clinical training programs and continuing education are medically supervised and approved by the GMRTT Medical Director. The standards for the content for these programs and the required contact hours are established by the National Training Agency of Trinidad and Tobago (NTA) and the National Highway Transportation and Safety Administration. The Ministry of Health advised that he educational programmes offered to EMTs has been reviewed and audited by the NTA for quality of content, knowledge and skill and the suitability of facilities to ensure an effective learning environment that meets the standards set forth by the NTA.

3.1.38. As such, the EMT training consists of 192 contact hours followed by 110-hour field/clinical training. The key fundamentals of the training included:

- Assessing patient needs and their necessary care;
- Assistant treatment for allergic reactions or asthma attacks;
- Bandaging patients;
- Managing patient airways;
- Medical terminology familiarity;
- Performing CPR;

- Stabilizing patients; and
- Transporting patients.

3.1.39. Annually, the employee is expected to undergo an intensive 54-hour recertification course to ensure continued competence and qualification as an EMT.

3.1.40. According to the MOH, GMRTT provides a robust and comprehensive Continuing Education (CE) Program through the following:

- Paramedics Training Program;
- Emergency Medical Dispatcher (EMD) Training Program;
- Leadership and Professional Development.

3.1.41. The training which has been provided to the staff of the Tobago Medical Emergency Service has involved the following:

- Re-certification in Basic Life Support and First Aid;
- In house training by the Emergency Room team at the Scarborough General Hospital;
- Involvement in disaster drills hosted by the Tobago Emergency Ambulance Agency (TEMA).

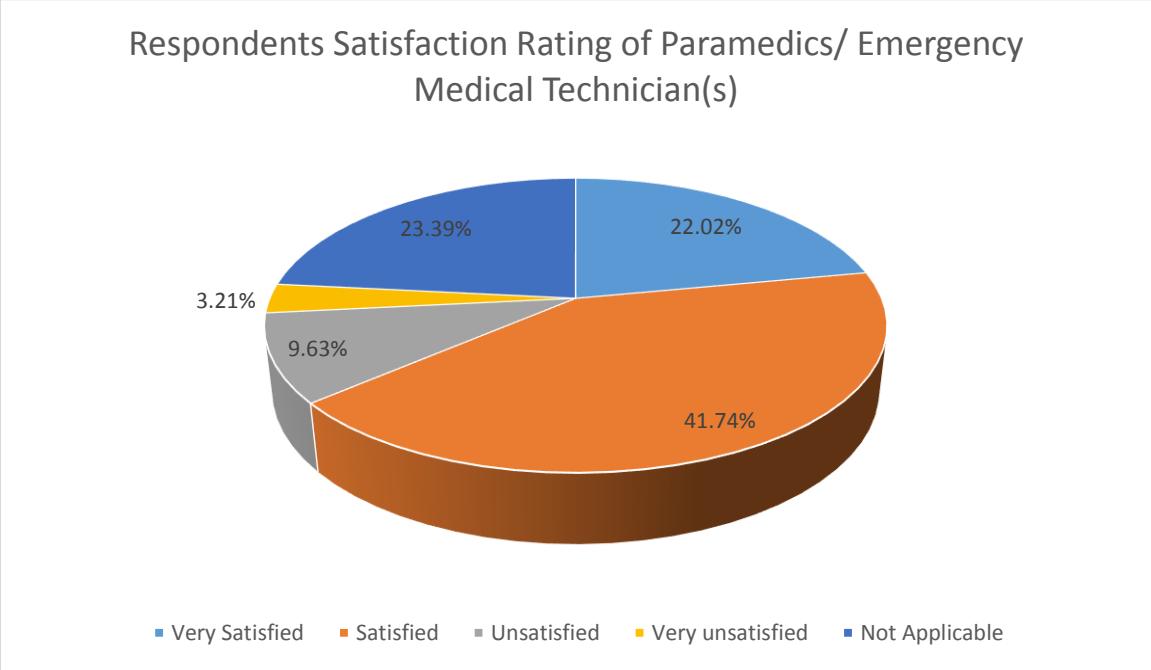
3.1.42. Newly recruited EMTs under the TRHA undergo a two-week orientation which covers:

- Defensive Driving;
- Exposure to policies and procedures;
- Track sessions;
- General Operational Procedures, Documentation and Communication;
- Orientation to the Accident and Emergency Department;
- Ride Along.

3.1.43. In terms of interacting with mentally ill patients, EMTs and paramedics are trained in behavioural emergencies which may involve both physical and chemical restraint to diffuse a situation. **Figure 1** below summaries the responses

received from the National Survey. It was notable that the majority of respondents were either 'satisfied' or 'very satisfied' with the services rendered by Emergency Medical Personnel.

Figure 2: Percentage of Persons satisfied with the quality of service provided by the paramedic(s)/ Emergency Medical Technicians



Capability to respond to Natural Disasters

3.1.44. In cases of natural disasters, the TRHA is guided by the Disaster Management Plan for the Scarborough General Hospital.

3.1.45. GMRTT is classified as a first responder agency. Therefore, it operates closely with the Office of Disaster Preparedness and Management (ODPM). The GMRTT is also an identified Emergency Support Function (ESF) with a seat at the National Emergency Operations Centre (NEOC). This has allowed for the primary involvement of the GMRTT in the National Emergency response framework.

3.1.46. Further to this, GMRTT also participates in all available multi-agency disaster drills through participation in the planning and execution of both tabletop exercises as well as full-scale live exercises. These exercises allow the GMRTT to

evaluate the effectiveness of plans, tests the preparedness of our responding staff and evaluate opportunities for improvements in response. Employees are also required to be certified in Incident Command System (ICS) 100-level.

Contingency Plans

3.1.47. The written submission of the MOH stated that the GMRTT has plans, policies, procedures, or protocols related to the following significant events:

- All-hazard internal disasters (events or situations that have the potential to be impactful to operations but do not extend beyond GMRTT);
- Earthquakes;
- Tsunami (pre- and post-event plans);
- Tropical Storm/Hurricane (scalable plans for pre-, during- and post-landfall);
- Flooding;
- Major incident plans (e.g. commercial aircraft down);
- Major epidemiological events; and
- Landslip or other geographic isolation within the service area.

GMRTT has made considerable attempts to ensure that key services may be replicated in different parts of the island. Therefore, this has led to the replication of services to a designated new deployment center in South Trinidad that has the capability to replicate the operations of the main office. This was done to ensure that there is a seamless transition of systems without downtime in the event of an interruption of capabilities at GMRTT's main location in Port of Spain.

Findings

Based on the evidence set out in this section, the Committee concluded the following:

i. The main ambulance service provider submitted that its fleet of ambulances are equipped with the necessary life support apparatuses as prescribed by the Act. This may be validated by the fact that GMRTT has attained accreditation

by the Commission on Accreditation of Ambulance Services (CAAS), USA in 2014;

ii. The GMRTT lamented the lack of a framework for the integration of non-emergency ambulance resources such as RHA-operated ambulances and private operators into the National Framework.

iii. In relation to Tobago, there has been a significant depletion in fleet of ambulances that service Tobago. Undoubtedly this has adversely impacted the performance of the service. The Eight (8) ambulances that are currently being operated may prove to be inadequate to service the island effectively. In the event of multiple emergencies occurring simultaneously, the relatively small fleet operated by TEMS may not have the capacity to respond effectively which creates a higher probability of death or serious injury.

iv. Notwithstanding that the direct intervention of the Ministry of Health in March 2016, it was detected that the patient hand-over process required further streamlining in order to further reduce the delay in the patient hand over process. Relatively long hand over periods were noted at the major public health facilities including Mt. Hope Hospital, Port of Spain General Hospital and the Sangre Grande County Hospital. There is a need for a standardised policy which outlines the clear roles and responsibilities of the stakeholders involved and the processes which govern patient handovers.

v. There should be greater collaboration between the GMRTT and the TRHA. The adoption of internationally accredited practices utilized by the GMRTT by the TRHA can only improve its current operations.

vi. As means of augmenting the fleet operated by GMRTT to more closely meet the demands for emergency medical transportation, consideration should be given to re-tendering for potential suppliers of vehicles with the aim of

sourcing additional vehicles at a lower cost. This will require careful consideration as to whether vehicles outfitted at a cheaper cost will have a significant or marginal impact on the quality of the life support apparatuses/services available to clients.

vii. The Committee was pleased to learn that GMRTT's dispatch Centre was recognized and accredited by the International Academy of Emergency Dispatch as an Accredited Centre of Excellence. As a means of holding the entity accountable for upholding the expect standards, the population should be periodically be reminded of the established standards of service they should receive from GMRTT's staff.

viii. The GMRTT should engage in more public outreach in an attempt to promote the 811 number, especially for rural communities.

Recommendations

i. The Committee strongly recommends that GMRTT collaborate with the Ministry of Health and RHAs to review or augment the advance patient arrival communication protocols observed. This may assist in reducing delays in patient handover.

ii. We recommend that the Ministry of Health foster greater collaboration between GMRTT and other ambulance operators for the purpose of inter alia:

- **a) Establishing a means/channel for supplementing the response efforts of the main provider (GMRTT) during the course of a major disaster event or major force majeure event;**
- **b) Promoting knowledge transfer and compliance with internationally recognized standards;**

c) **Developing the training and development network for Emergency Medical Response Personnel including EMTs and paramedics;**
d) **Establishing a representative body for the Ambulance industry. E.g. An Association.**

iii. **To promote more objectivity in the current procedures and processes for treating with complaints made against employees of GMRTT, a mechanism must be introduced to allow all such complaints to be shared with the Ministry of Health by way of requiring GMRTT to submit Quarterly Complaints Reports. The Committee trusts that the 2015 Contractual Agreement facilitates such reporting.**

iv. **Through its monitoring and evaluation arrangements outlined in the contractual agreement with GMRTT, the Ministry of Health must play an active role in ensuring that the standards and practices associated the accreditation obtained from the Commission on the Accreditation of Ambulance Services (CAAS) are being maintained.**

v. **As a means of curtailing the misuse and abuse of its services, GMRTT should seek to strengthen its triage system in order to prioritise critical cases.**

vi. **Given the significant cost involved in maintaining these essential vehicles, every effort should be made to ensure that the driving practices of ambulance drivers and equipment usage is managed efficiency so as to minimize accidental damages and misuse.**

vii. **The Ministerial response of the Ministry of Health advises on the components of the new deployment Centre in South and the specific services that will be replicated at this location.**

Objective 2: To Understand How the Resources associated with this service are deployed throughout the country

Deployment of GMRTT Ambulances

3.2.1 The deployment of ambulances is based on a flexible deployment model which is centered on the main Deployment Centres in both Trinidad and Tobago.

3.2.2 The Dispatch Centres managed by the primary service provider in Trinidad (GMRTT) are located are located in Arima, Port-of-Spain and La Romaine, which was earmarked and designated as a new deployment Centre in South Trinidad. Employees are sometimes redeployed based on service demand.

3.2.3 The 6 active bases in Tobago are:

i. Base 1 – Scarborough Health Centre;
ii. Base 2 – Delaford Opp. Health Centre;
iii. Base 3 – Lowlands (Dispatch Centre)
iv. Base 4 - Parlatuvier Health Centre
v. Base 5 – Charlotville Health Centre
vi. Base 6 – Plymouth opp. Health Centre

3.2.4 GMRTT's Emergency Response network also include 141 hubs. These hubs are located throughout the Island and serve as holding ports for ambulances pending an emergency response call from the relevant dispatch centres. A detailed list of the Emergency Dispatch Hubs in Trinidad can be found in Appendix V.

3.2.5 Ambulance deployment is based on an analysis of call density and call pattern in a particular areas as well as the population density. This further accounts for an analysis of population movement towards urban areas for employment.

3.2.6 Crews are assigned to one of the 141 key hubs which acts as an operational jump point. Post locations are chosen via a combination of criteria including geographical location and an analysis of call demand.

3.2.7 In especially rural areas however, the GMRTT stated that requests are "less common than the major demographics in the population intense areas around major cities". However, Mr. Anderson stated that no person should be denied based on their location. In instances where areas may be impassible, Mr. Anderson call for innovative measures such as helicopters to retrieve persons.

3.2.8 The areas of greatest demand over the last three years were Port-of-Spain Metropolitan areas inclusive of St. James extending east to San Juan, San Fernando and Arima.

3.2.9 A key technological advancement introduced to the Trinidad EMS system by GMRTT was the implementation of a comprehensive mobile data program. This introduction led to the installation of advanced Mobile Data Computers into the GMRTT fleet. This has provided the field responders with immediate access to all dispatch information related to their assigned incident and provides real-time routing and location awareness to the responder.

3.2.10 The system used in Tobago to dispatch ambulances are the established Protocols outlined by the National Academy of Emergency Medical Dispatch[8]. Ambulances are deployed based on proximity and are outfitted with GPS. A Triage system is also used to prioritize calls.

Findings and Recommendations

Based on the evidence set out in this section the Committee concluded as follows:

i. That GMRTT in particular has modernized its deployment system by introducing and incorporating information and communication technology systems. This is commendable as these modifications should translate into a more efficient response rates. However, the Committee was not convinced that the existing deployment systems used by GMRTT is configured to detect the special needs of rural areas or areas not proximate to dispatch hubs.

[8] https://www.emergencydispatch.org/TheAcademy

Recommendations

i. **Ambulance services should strive to be innovative and continue to develop and refine prioritisation systems. As observed in the United Kingdom[9], this may be facilitated through the use of alternative transport systems, such as cars or an assisted taxi service for basic patient transport which may not be at a critical level.**

ii. **In heavily populated areas it may be necessary to have medically qualified personnel present at the call centre to assist in prioritising and managing complex cases.**

iii. **The Committee is aware that with an initial cohort of 16, it will not be practical for each ambulance to have a paramedic on board, however a system should be developed where paramedics are assigned in critical areas. This will be hinged upon the development of effective prioritization and triage systems. EMTs must in every instance, however, be capable of administering the essential care to the critically injured.**

iv. **Deployment systems must be adaptable to suit the growing public demand for this service as well Trinidad and Tobago's categorization as an aging population. Therefore, the current service providers namely GMRTT and THRA should continue to adopt innovative strategies and seek to make them implementable in Trinidad and Tobago.**

[9] https://www.transportforall.org.uk/d2d/pts/

Objective 3: To Determine Areas of Inefficiency in the Service and the critical factors/conditions which are required for its success.

Legislative Review

3.3.1 The Committee learned that there were several key elements of the Emergency Ambulance Services and Emergency Medical Personnel Act Chapter 29:02 Act that have not been operationalized to date. Some of the key outstanding aspects to be constituted included

i. The establishment of an Emergency Ambulance Regulatory Committee to establish a licensure arrangement for service providers;
ii. The establishment of a National Emergency Ambulance Services Authority;
iii. Designation of Inspectors and Inspection Teams;
iv. Governing body for EMTs

3.3.2 During the inquiry there was no indication from the Ministry of Health that there was any intention in the medium to long-term to discontinue the arrangement with GMRTT. Under the circumstances, several provisions of the Act have been rendered mute or irrelevant. Notwithstanding, the MOH indicated that it was currently taking the necessary steps in the operationalization of the Emergency Ambulance Regulatory Committee as per Section 4 of the Act. To this end, the Ministry has written to the various service providers for the submission of the required documentation for the assessment and possible issuance of licenses.

Establishment of the National Emergency Ambulance Services Authority

3.3.3 According to the written submission of the MOH, the Emergency Ambulance Services Board and National Emergency Services Authority was appointed for a period of two (2) years with effect from April 10, 2018. Eight (8) persons were said to be serving on the Board and have commenced work to support the operationalization of the Authority, however, no document was provided to outline and verify the work commenced by the newly constituted Board. Additionally, the Emergency Medical

Personnel Board of Trinidad and Tobago was in the process of being appointed. The Council of the Emergency Medical Personnel Board, will be established upon the completion of the Board.

Contractual Agreement between GMRTT and the MOH.

3.3.4 The Terms of Reference associated with the contracted services of the GMRTT include the following:

(i) The transfer and provision of an active optimum fleet of ambulances to meet the needs of the service that is supplied by the service provider;

(ii) the provision of Intensive Care Unit ambulances equipped with ventilators, intravenous pumps, monitors and other medical capabilities;

(iii) the expansion of the human resources skill and competence to include not only basic life support for patients but advanced and paramedic support;

(iv) the use of advanced and updated technologies to enhance the management, operations and delivery of the service. These include computing, mobile, vehicle and patient tracking devices, online control systems and management information systems;

(v) the provision of alternative emergency support such as a doctors and nurses hotline and other facilities separate and apart from emergency rooms at public health facilities;

(vi) the use of the "patient handover" method of payment where the service provider will receive payment based on the number of patients delivered to the appropriate health facility. It is assumed that the cost for the non-delivery of patients will be absorbed with the service provider; and

(vii) the use of a comprehensive reporting tool to analyze the entire operations of the service including patient service, financial and operational efficiency.

3.3.5 From 2005 to present, the MOH has paid an annual fee of $123.3 Million.

Licenses

3.3.6 Most alarming was the revelation that none of the entities in Trinidad and Tobago that operate ambulance services were in possession of a license. The Ministry of Health cited the need for the streamlining of an Regulatory Committee for the licensing of Emergency Medical Operators as an important prerequisite for commencing a licensing system. . It was reported that nominations for the members of this Committee were submitted by the Regional Health Authorities and the Minister of Health, however the Ministry of National Security still has not submitted their nomination. It was anticipated that this committee would have been established by the end of 2018. As such, a request was made for GMRTT, to supply the relevant documents for the assessment and granting of a license. The Minister of Health is also required to recommend the service providers to be licensed.

3.3.7 During the period May to June 2019, the Ministry of Health conducted an inspection of GMRTT facilities for the assessment of an application for a licence.

3.3.8 The Internal Audit Department of the Ministry of Health will be conducting another audit of the operations and management of GMRTT inclusive of facilities during period October to December 2019.

3.3.9 Based on additional evidence received from the MOH on October 14th 2019, during the period May 2nd, 2019 to August 16th, 2019, the Ministry conducted inspections of ambulance vehicles utilizing the Medical Equipment for Land Ambulance Checklist. This Checklist outlines the minimum medical equipment requirements for licensing of private Emergency Land Ambulances in Trinidad and Tobago, according to the Emergency Ambulance Services and Emergency Medical Personnel Act, Chapter 48:50.

3.3.10 The following service providers were inspected as a means of granting licenses:

- GMRTT – a total of ten (10) ambulances;

- Universal Ambulance Services Limited- the full complement of five (5) ambulances;
- Avatar Ambulances Services Limited- a total of six (6) ambulances;
- Eastern Divers Company Limited- a total of three (3) ambulances; and
- Medical Associates Hospital- a total of three (3) ambulances.

3.3.11 According to Schedule III of the Emergency Ambulance Services Emergency Medical Personnel Act Chapter 29:02, the TRHA is licensed to provide a Basic Life Support Land Ambulance service.

Monitoring and Evaluation of GMRTT

3.3.12 The Internal Audit Unit of the MOH is responsible for conducting periodic assessments of the financial payments made to the contractor, i.e. GMRTT. The Directorate, Health Policy Research and Planning reviews the monthly, quarterly and annual reports submitted. Furthermore, the GMRTT is required to report information on operations and outcomes weekly, monthly, quarterly and annually to the MOH. The contract between the MOH and GMRTT spans five years.

3.3.13 It was reported that the current contractual period commenced on September 1st, 2015. It was submitted that this contract imposes additional obligations on GMRTT including requirement to fulfill or provide a wider range of operational metrics including the analysis of all calls, responses, on scene times and patient handover data collected, cost details, service performance, vehicle/equipment integrity and recommendations to improve the operation and management of the National Emergency Ambulance Service. As at November 28th 2018, the MOH had settled half of the fees invoiced by GMRTT.

Improvements to the Ambulance Service

3.3.14 The MOH provided the Committee with a list of enhancements and improvements that have been effected. They include:

i. The introduction of an expanding Advanced Life Support (ALS) program through the continued development and deployment of highly-trained and medically-competent Paramedics. This ALS service takes many of the previously hospital-based advanced interventions and procedures into the community to directly impact and improve on patient outcomes and experiences;

ii. the Ministry has benefited from the continued focus on quality and outcomes by GMRTT"s team of trained and certified Emergency Medical Dispatch personnel; and

iii. GMRTT is the only Emergency Communications Center in the Caribbean and Latin American region to have met the standards for accreditation by the CAAS.

3.3.15 During the public hearing on November 28, 2018, The GMRTT stated that there was a need to pursue alternative solutions to ambulance services such as helicopter and voluntary networks in cases where an ambulance may not be able to traverse the terrain.

3.3.16 Based on the written submission of the TRHA the following are improvements to the Emergency Ambulance Service in Tobago:

- The Commissioning of two (2) additional bases located in Charlotteville and Plymouth;
- The addition of ten (10) new ambulances to the fleet;
- Reopening of the base at Parlatuvier.

Shortcomings within the Current System

3.3.17 The main shortcomings within the GMRTT are as follows:

i. the issues with delayed patient turnover at the nation's public healthcare facilities. **Challenges with Hospital Drop Time (HDT)/time** to patient turnover at public healthcare institutions;

ii. GMRTT presently provides response, treatment and transport services to a volume of requests that exceeds the volume remitted by the Ministry of Health. As a consequence, a significant **deficit has grown between the fees for service invoiced by GMRTT to the Ministry of Health and the payment remitted to GMRTT by the Ministry of Health**;

a lack of proper identifiers or locators for residential or commercial property e.g. Presents a challenge to dispatchers and EMTs. GMRTT strongly advocates for, and will willingly participate in, a public awareness and information campaign to encourage the public to mark their property appropriately to facilitate emergency response;

iii. Mental health officers are not assigned to GMRTT to assist with the handling of mentally ill patients; and

iv. GMRTT has faced a significant challenge venturing into violent communities, often requiring assistance from the Trinidad and Tobago Police Service as escorts.

3.3.18 The following shortcomings were outlined by the TRHA:

- Poor preventative maintenance plans;
- Lack of cost-effective service;
- Deficiencies in resource allocation;
- Deficiencies in audit and compliance.

3.3.18 Major issues highlighted by survey respondants were :

i. Extreme delays in the response time:
ii. Inefficient service delivered by the technical staff and the need for improvements in staff equipment.

Improvement Plans

3.3.19 The following strategies were outlined by the MOH to an effort to enhance and develop the National Emergency Ambulance Service:

- Development of a Communication Strategy to inform the public on the use and relevance of the National Emergency Ambulance Service;
- Enhance the Ministry's monitoring and evaluation capabilities and/or skills to ensure compliance with contract and performance indicators; and
- Providing the required standards, regulations and oversight of all emergency ambulance providers throughout the country.

3.3.20 National Survey respondents recommended that the ambulance response rate may be improved by increasing the number of available ambulances and outfitting same with GPS technology. Notwithstanding this, the GMRTT has actively utilised GPS in its existing fleet and has reinforced the need for an increased fleet.

Inspections

3.3.21 During the public hearing on November 2018, the MOH informed the Committee that it had not been compliant with Section 15 of the Act, which empowers the MOH to appoint an inspection team to inspect the facilities of service providers, mainly, GMRTT. The Internal Audit department of the Ministry inspects the GMRTT facilities in the absence of this inspection team. The Committee was further informed that the licensing process for ambulance service providers was being conducted.

3.3.22 The assessment and inspection of new vehicles, however, are conducted by the Office of the Chief Medical Officer (CMO) and the Commissioner of Transport. The CMO further stated that each ambulance vehicle is inspected after which a recommendation is made to the Ministry of Works and Transport for it to be licensed as an ambulance.

Complaints

3.3.23 The Directors of Clinical Practice and Human Resources at GMRTT are the team leads in coordinating all of the actions related to customer complaints. As such the majority of complaints are submitted to GMRTT. If the complaint/s is/are made directly to the Ministry of Health or even within the public media, the Ministry writes to GMRTT requesting a report and if necessary, action is taken accordingly.

3.3.24 The procedure entails the following:

- Receipt of the complaint;
- Confirmation of the facts of the initial report;
- Obtain addition information or clarify information to aid in the initial stages of the investigation;
- To ensure the reporting party that the report has the immediate attention that it deserves, and that further feedback will be provided;
- The leadership team will then make a determination on the case and direct the remediation or resolution action to be executed; and
- Dependent on the circumstances and severity of the matter, potential paths to resolution may include; educational counseling, formal corrective action, retraining, remedial education, issuance of a Performance Improvement Plan (PIP), execution of a learning contract, or system redesign.

3.3.25 If the complaint/s is/are made directly to the Ministry of Health or even within the public media, The Ministry writes to GMRTT requesting a report and if necessary action is taken accordingly.

3.3.26 The type of complaints received by the MOH from the public include:

- Long waiting times;
- Alleged non-response.

3.3.27 It was submitted that the MoH engaged stakeholders to reduce the waiting period to an average of 15 minutes for patient hand overs.

3.3.28 For the period September 1, 2012 to October 25, 2018 43 complaints were submitted and categorised as stated below.

- Clinical Practice – 75%;
- Consumer Service – 21%;
- Driving/ Vehicle operations 2%;
- Communications-related – 2%

3.3.29 Resolution and feedback have been provided on the majority of these complaints. Complaints may reach a resolution within seven business days of the initial report. The outstanding complaints was not provided.

Findings and Recommendations

Based on the evidence set out in this section the Committee concluded as follows:

i. A regulatory void was created by the failure of the State to fully operationalize the Act. This is manifested in the absence of a robust and reliable oversight system of the National Emergency Ambulance Service. There appears to be some attempt by the MOH to introduce a more structured oversight arrangement via the partial commencement of the Emergency Ambulance Services Board and National Emergency Services Authority and the proposed establishment of the Regulatory Committee.

ii. The Committee was extremely alarmed to learn that there is no licensing arrangement in place for ambulance service providers in Trinidad and Tobago. A licensing system will assist the line Ministry in more effectively overseeing the operations of the emergency medical response industry by providing *inter alia*:

    a. a structured and consistent regime of standards for which all license holders will be held accountable;

b. It measures the service quality and quantity of service providers based on outlined requirements which in turn can determine whether the license will be renewed.
c. Licensing arrangements also allow the state to restrict a service provider's service in cases where a breach may occur. Licenses can further be suspended, revoked or terminated.
d. Licensing arrangements also provide insurance, safety and security to the providers and the user of the service.
e. Licenses form and strengthen partnerships among service providers within the field.
f. Licenses also set the parameters of service which can be used and provided under the Ambulance Service.

iii. The Committee found limited evidence of an active and robust system system in place by the Ministry of Health to monitor and evaluate the standards of practice observed by seven (7) other service providers. This is a serious omission of duty given the absence of key oversight bodies prescribed by the Act.

iv. The Committee noted that under the former contract the monitoring and evaluation system of the MOH utilized for GMRTT were not as effective. Thus the need to incorporate additional reporting obligations under the within 2015 Contract. The Committee intends to hold the Ministry accountable to ensuring that these reporting obligations are honoured by GMRTT in accordance with the terms and conditions of the contract.

v. The Committee also noted with concern that it was unable to clearly distinguish the output of the eight persons serving on the Emergency Ambulance Services Board.

vi. The internal and external factors hindering the further improvement in the performance of GMRTT are not insurmountable. The Committee expects that the pending Regulatory Committee, Board and other bodies will be mandated to

critical assess the National Emergency Ambulance Service and make recommendations for improvements.

vii. The financial limitations faced by the TRHA has impeded its ability to address its shortcomings.

viii. The Committee questioned whether the proposed National Emergency Ambulance Services Authority would become an added layer of bureaucracy or more importantly will act as an effective means of overseeing the operators of ambulances in Trinidad and Tobago.

ix. The evidence revealed that GMRTT's emergency response personnel have encountered significant difficulties in obtaining the assistance of the Trinidad and Tobago Police Service in responding to mentally-ill patients. The Committee is cognizant that there is a general shortfall in mental health professionals in the public sector. Improving this situation may require the up-skilling of EMTs and paramedics to equip them with the skills to effectively treat with this category of patients/clients.

Recommendations

i. The Committee recommends that the MOH seek to prioritise the establishment of the outstanding Boards and Committees stipulated by the Act in order to expedite the allocation of licenses and to provide oversight to the relevant ambulance service providers. Additionally, the Ministerial Response should contain an update on the establishing and functioning of the statutory bodies proposed in the Act, including the output (if any) of each body.

ii. The Committee strongly recommends that a status update be provided within the next month on the status of these outstanding committees and the hindering factors to their establishment.

iii. **GMRTT in collaboration with the MoH should conduct a public awareness campaign to sensitise the public about some of the challenges Emergency Medical Response Personnel experience when responding to Emergency Calls inclusive of the difficulties in locating properties at are unmarked or unidentifiable.**

iv. **There should be a shared database between the MOH and GMRTT to allow the Ministry the ability to track public complaints lodged against GMRTT as part of it monitoring and evaluation procedures.**

v. **We recommend that GMRTT collaborate with the Ministry of Health and the Faculty of Medical Sciences with a view to developing a training programme for EMTs and paramedics with the aim at equipping them with the skills and techniques for treating with mentally-ill patients. Similar to GMRTT's Paramedics Pilot Program, this programme must include a "hands on" or practical component.**

The Committee respectfully submits the foregoing for the consideration of the Parliament.

Dr. Varma Deyalsingh
Chairman

Ms. Ramona Ramdial, MP
Vice-Chairman

Dr. Lovell Francis, MP
Member

Mr. Esmond Forde, MP
Member

Mr. Darryl Smith, MP
Member

Ms. Khadijah Ameen
Member

Mr. Nigel De Freitas
Member

Mrs. Jennifer Baptiste-Primus
Member

October 1, 2019

Appendices

Appendix 1

List of Officials

The following List of Officials appeared before the Committee on January 9th 2019

The Division of Health, Wellness and Family Development

Dr. Agatha Carrington	Secretary
Mrs. Dianne Baker-Henry	Administrator

The Tobago Regional Health Authority (TRHA)

Ms. Ingrid Melville	Chairman
Mr. Michele Edwards-Benjamin	Chief Executive Officer (Ag.)
Mr. Lester Frederick	Tobago Emergency Medical Service Manager

Appendix 2

List of Technical Requirements for Ambulances.

(q) a roof top mounted coaxial cable antenna shall be installed to the cab compartment of the ambulance; and

(r) all windows, windshield and door glass shall be shatterproof.

Regulation 17(1).

SCHEDULE 4

PART A

MINIMUM MEDICAL EQUIPMENT FOR BASIC AMBULANCE—LAND AMBULANCE

The following are the minimum ambulance medical equipment required to be on board an ambulance:

(a) (i) minimum of two plastic or aluminium frame folding stretcher litters;

(ii) one multi-level, elevating, wheeled cot with elevating back with two patient restraining straps at least 5 cm wide, one on the chest and one on the thigh; and

(iii) one secondary patient transport litter with at least two patient restraining straps;

(b) Suction devices—

(i) an engine, vacuum operated or electrically powered, complete suction aspiration system with a wide bore tubing shall be installed permanently on board to provide for the primary patient;

(ii) a portable hand-operated manual suction device; and

(iii) an assortment of suction catheters (minimum of two each);

(c) Bag mask ventilation units—

(i) one adult hand-operated bag mask ventilation unit with valves which can be operated in all weathers and equipped to be capable of delivering ninety to one hundred per cent oxygen to the adult patient;

(ii) one paediatric hand-operated bag mask ventilation unit with valves which can be operated in all weathers and equipped to be capable of delivering ninety to one hundred per cent oxygen to the patient with a safety pop-off mechanism with override capability;

(iii) one infant hand-operated bag mask ventilation unit with valves which can be operated in all weathers and equipped to be capable of delivering ninety to one hundred per cent oxygen to the patient with a safety pop-off mechanism with override capability; and

(iv) sizes 1–5 masks to be used in conjunction with the ventilation units in subparagraphs (i) to (iii);

(d) Oropharyngeal airways in adult, child and infant sizes which shall be clean and individually wrapped and shall be in the following sizes:

(i) 90 mm;

(ii) 80 mm;

(iii) 43 mm;

(e) Fixed and portable oxygen equipment—

(i) portable equipment should be a minimum "D" size or 360 litres cylinder having adequate tubing and semi-rigid valveless, transparent, single use, individually wrapped non-rebreather masks and nasal cannuals in adult and paediatric sizes;

(ii) a "No Smoking" sign with minimum two point five centimetres letters shall be displayed in the patient compartment;

(iii) all oxygen cylinders shall be affixed to a wall or floor with crash stable, quick release fittings; and

(iv) litre flow gauge shall be non-gravity dependent;

(f) Bite stick shall be either commercially available or made of three tongue depressors taped together and padded;

(g) Six sterile dressings of a minimum size of 12 cm x 20 cm compactly folded and packaged;

(h) Thirty-six 10 cm x 10 cm sterile gauze pads;

(i) Four 7.5 cm x 350 cm of individually wrapped bandages, self-adhering tape;

(j) 10 cm x 10 cm sterile and wrapped aluminium foil or four 4" x 4" commercial sterile occlusive dressing;

(k) 2.5, 3 and 7.5 centimetres side hypoallergenic adhesive tape;

(l) Two sterile burn sheets;

(m) Splints—

(i) lower extremity, traction type splint; and

(ii) two 35 cm x 7.5 cm and two 90 cm x 7.5 cm padded, wooden type splints or other approved commercially available splints for arm or leg fractures;

(n) Spine boards—

a long board of at least 45 cm x 180 cm;

(o) Other equipment—

(i) cervical collars in small, medium and large sizes;

(ii) four triangular bandages;

(iii) nine foot straps;

(iv) one large bandage shears;

(v) one sterile obstetrical kit containing gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressing, towels, perinatal pad, bulb syringe and receiving blanket for delivery of infant;

(vi) poison kit, syrup of ipecac and activated charcoal;

(vii) blood pressure manometer, cuff and stethoscope;

(viii) portable non-mercurial blood pressure set;

(ix) stethoscopes;

(x) emesis basin, bedpan and urinal;

(xi) two dependable flashlights or electric lanterns;

(xii) at least one fire extinguisher;

(xiii) working gloves; and

(xiv) minimum of 1 000 cc of sterile water or normal saline for irrigation.

PART B

Regulation 17(2)(*a*).

MINIMUM MEDICAL EQUIPMENT FOR ADVANCED AMBULANCE 1—LAND AMBULANCE

In addition to the equipment set out in Part A of this Schedule, the following are the minimum medical equipment required to be on board an Advanced Ambulance 1:

1. four butterfly or scalp vein needles between 19 and 25-gauge;
2. four 14, 16, 18 and 22-gauge IV cannulae;
3. two macro drip sets;
4. two micro drip sets;
5. three 21 or 23-gauge needles and three 25-gauge needles;
6. three tourniquets;
7. adult, child and infant sizes of laryngoscope blades;
8. six disposable endotracheal tubes from 2.5 to 9.0 with at least one of each size available;
9. an intubations stylet for the neonate patient;
10. equipment for drawing blood samples;
11. two 1ml, 3 ml, 10 ml, 20 ml syringes and one 50 ml syringe;
12. twelve alcohol and iodine preps for preparing IV injection sites;
13. one roll of 1.25 centimetre wide tape;
14. five band-aids;
15. a minimum of four litres of Ringers Lactate, normal saline or a combination thereof;
16. one 14-gauge and one 18-gauge intraosseous needles;
17. a battery powered portable monitor-defribrillator unit with EKG output for ambulances providing advanced cardiac life support; and
18. such drugs as approved by the responsible medical practitioner.

Regulation 17(2)(*b*).

PART C

MINIMUM MEDICAL EQUIPMENT FOR ADVANCED AMBULANCE 2—LAND AMBULANCE

In addition to the equipment set out in Parts A and B of this Schedule, the following are the minimum medical equipment required to be on board an Advanced Ambulance 2:

1. Nasotracheal tubes
2. Cricothyroidotomy needles
3. Cricothyroidotomy surgical pack
4. Thoracostomy needles
5. Cardiac monitor capable of providing hard copy of ECG
6. External Cardiac Pacing.

Regulation 33.

SCHEDULE 5

PART A

MINIMUM MEDICAL EQUIPMENT FOR BASIC AMBULANCE—AIR AMBULANCE

The following are the minimum medical equipment required to be on board a Basic Ambulance which is used as an air ambulance:

1. Suction devices—
   - (*a*) a portable suction device, battery operated, with wide bore tubing and six ounce reservoir and a "Y" or "T" valve to control suction which can provide continuous suction for fifteen minutes;
   - (*b*) an assortment of suction catheters (minimum of two each); and
   - (*c*) rigid suction catheter.

Appendix 3

Description of the Quarterly and Annual Reports submitted by the GMRTT

Monthly Reports

1. Monthly report on the total number of calls received and the number of persons who were transported to and received by the nearest appropriate public health institution;

2. Monthly report on response times, on scene times and patient handover times of all patients accessing the service. Monthly report on the number of ambulances located at various sites across country;
3. Monthly report on the use of the Intensive Care Unit ambulances, its impact and post health condition of the patient;
4. Monthly Problem Nature Code Report indicating the distribution of incidents for emergency and non-emergency cases;
5. Monthly Complaint Registry and Resolution log report;
6. Monthly Critical Failure Report in the delivery of the service;
7. Monthly report on the customer satisfaction surveys indicating the sample size and results;
8. Monthly analytical report by the Medical Director assessing the effectiveness of the emergency ambulance service in terms of response times and patient outcomes;
9. Monthly report on the staffing hours and staff complement inclusive of core team, medical oversight and control as well as Emergency Medical Technicians as required in the delivery of the service. Adjustments should be included where necessary;
10. Monthly report on staff (EMT) training conducted during the month including a description of the program and outcome of the program(s);
11. Monthly report on the number of training sessions conducted by the operator in the management and operation of the National Emergency Ambulance Service to the local counterpart team in the Ministry of Health. The outcomes of these sessions should be clearly defined and noted;

12. Monthly community education programs on the appropriate use of services including a description of the program, date the program(s) were conducted, number of participants and its impact on the service;
13. Monthly quality improvement programmes for the administrative, technical and operational capabilities or otherwise in the delivery of the service;
14. Monthly public relations service hours including description of the services provided and its outcomes;
15. Monthly financial expenditure report including a line-by-line detail of the approved budget, expenditures for the reporting period, unexpended balance for the account and an explanation of any variances;
16. Monthly details of the cost of all inputs for the delivery of the service inclusive of all administrative, staff, medical equipment, communications, and all other costs incurred;
17. Monthly audited financial reports conducted by the Contractor;
18. Monthly reports outlining the digital recording of responses from the initial call to the delivery of the patient to the public health institution should be submitted;
19. Monthly vehicle maintenance (preventative and corrective) reports outlining all the details of maintenance required, suppliers and equipment sourced and the cost incurred;
20. Monthly medical supplies;
21. Monthly equipment and maintenance report;
22. Radio equipment maintenance report; and

23. Station maintenance report.

Quarterly Reports

1. An audited operational summary conducted by the Contractor;
2. A detailed costing report inclusive of all administrative staff, preventative and corrective vehicle maintenance, medical equipment, communications and all other cost incurred.

Annual Reports:

1. Annual Report on the total number of calls received and the number of persons who were transported to and received by the nearest appropriate public health institution;
2. Annual Report on response times, on scene times and patient handover times of all patients accessing the service;
3. Annual report on the number of ambulances located at various sites across country;
4. Annual report on the use of the Intensive Care Unit ambulances, its impact and post health condition of the patient;
5. Annual Problem Nature Code Report indicating the distribution of incidents for emergency and non emergency cases;
6. Annual Complaint Registry and Resolution log report;
7. Annual Critical Failure Report in the delivery of the service;
8. Annual Report on the customer satisfaction surveys indicating the sample size and results;
9. Annual Analytical Report by the Medical Director assessing the effectiveness of the emergency ambulance service in terms of response times and patient outcomes;
10. Annual Report on the staffing hours and staff complement inclusive of core team, medical oversight and control as well as Emergency Medical Technicians as required in the delivery of the service. Adjustments should be included where necessary;
11. Annual Report on staff (EMT) training conducted during the month including a description of the program and outcome of the program(s);
12. Annual Report on the number of training sessions conducted by the operator in the management and operation of the National Emergency Ambulance

Service to the local counterpart team in the Ministry of Health. The outcomes of these sessions should be clearly defined and noted;

13. Annual community education programs on the appropriate use of services including a description of the program, date the program(s) were conducted, number of participants and its impact on the service;
14. Annual quality improvement programmes for the administrative, technical and operational capabilities or otherwise in the delivery of the service;
15. Annual public relations service hours including description of the services provided and its outcomes;
16. Annual financial expenditure report including a line-by-line detail of the approved budget, expenditures for the reporting period, unexpended balance for the account and an explanation of any variances;
17. Annual details of the cost of all inputs for the delivery of the service inclusive of all administrative, staff, medical equipment, communications, and all other costs incurred;
18. Annual audited financial reports conducted by the Contractor;
19. Annual reports outlining the digital recording of responses from the initial call to the delivery of the patient to the public health institution should be submitted;
20. Annual vehicle maintenance (preventative and corrective) reports outlining all the details of maintenance required, suppliers and equipment

sourced and the cost incurred;

21. Annual medical supplies;
22. Annual equipment and maintenance report;
23. Radio equipment maintenance report; and
24. Station maintenance report.

Appendix 4

List of requirements for an Emergency Medical Services

The Minimum Qualifications for Entry-Level Consideration include:

- At least 21 years of age at the time application;
- Minimum of three „O" level passes (must include Mathematics and English);
- Current and valid Class 4 Driver Permit;
- Citizen of Trinidad & Tobago, or legal permanent resident;
- Effective oral and written skills;
- Pass a written examination testing Mathematics and English knowledge and skills;
- Pass an extensive physical ability screening that replicates many of the physical demands of an Emergency Medical Technician;
- Pass a medical examination;
- Pass a motor vehicle operations assessment, inclusive of manual transmission operations;
- Pass screening for drug and alcohol use; and
- Successfully pass an oral board interview process.

Upon meeting or exceeding the above requirements, and upon selection through the competitive recruitment process, the incumbent would be invited to attend the Emergency Medical Technician (EMT) training program. Upon successful completion of the EMT training program, the candidate would qualify for consideration for full-time or part-time employment.

Appendix 5

Location of Emergency Dispatch Hub

Location ID	Location Name	Physical Location	Location Type
ARB	GMRTT ARIMA DEPLOYMENT CTR	TUMPUNA RD/HENRI ST	Deployment Centre
POS	GMRTT HEADQUARTERS POST	1 ABATTOIR RD	Deployment Centre
LRB	GMRTT LA ROMAIN DEPLOYMENT	CANAAN ST - DUNCAN VILLAGE - LA ROMAIN	Deployment Centre
ARG	ARANGUEZ POST	NANAN TR/ARANGUEZ RD	Ambulance Post
AVE	ARIAPITA AVENUE POST	CARLOS ST/ADAM SMITH SQUARE	Ambulance Post
ABP	ARIMA BYPASS POST	ARIMA BYPASS/EASTERN MAIN RD	Ambulance Post
ARP	ARIMA POST	QUEEN MARY AVE/EASTERN MAIN RD	Ambulance Post
SRP	ARIMA RACING CLUB POST	OMEARA RD/CHURCHILL ROOSEVELT HWY	Ambulance Post
BAL	BALANDRA POST	TOCO MAIN RD/BALANDRA DEPOT	Ambulance Post
XBR	BARATARIA STAGING	CHURCHILL ROOSEVELT HWY/BARATARIA OVERPASS	Ambulance Post
BRK	BARRACKPORE POST	PAPOURE RD/NEW COLONIAL RD	Ambulance Post
XBT	BEETHAM STAGING	BEETHAM HWY/OVERPASS	Ambulance Post
BIC	BICHE POST	CUNAPO SOUTHER RD/BICHE ORTOIRE RD	Ambulance Post
BLA	BLANCHISSEUSE POST	PARIA MAIN RD/ARIMA BLANCHISSEUSE RD	Ambulance Post
BON	BON AIR POST	EASTERN MAIN RD/WALTER ST	Ambulance Post
BSO	BRASSO POST	CAPARO VALLEY BRASSO RD	Ambulance Post
BSC	BRASSO SECO JUNCTION	ARIMA BLANCHISSEUSE RD/MORNE BLUE RD	Ambulance Post
BRA	BRAZIL POST	TALPARO RD/SHORT ST	Ambulance Post
CAM	CAMERON HILL POST	MORNE COCO RD/CAMERON RD	Ambulance Post
CDV	CAP-DE-VILLE POST	SOUTHERN MAIN RD/ERIN RD	Ambulance Post
CAR	CARENAGE POST	CARENAGE FISHING CENTRE	Ambulance Post
SWP	CARONI POST	CARONI SAVANNAH RD/URIAH BUTLER HWY	Ambulance Post
CDR	CEDAR HILL POST	CEDAR HILL RD/SOLOMON HOCHOY HWY	Ambulance Post

Location ID	Location Name	Physical Location	Location Type
CED	CEDROS POST	ST MARIE RD/ST MARIE ST	Ambulance Post
CHG	CHAGUANAS CENTRAL POST	PERSEVERANCE RD	Ambulance Post
CHE	CHAGUANAS EAST	SOUTHERN MAIN RD/CAPARO VALLEY BRASSO RD	Ambulance Post
CHV	CHAGVILLE-CHAGUARAMAS POST	CHAGUARAMAS CONVENTION CENTRE	Ambulance Post
CHS	CHASE VILLAGE POST	THOMPSON RD/SOLOMON HOCHOY HWY	Ambulance Post
CHT	CHATAM POST	SOUTHERN MAIN RD/CHATAM RD	Ambulance Post
CHN	CHIN CHIN POST	SOUTHERN MAIN RD/CHIN CHIN RD	Ambulance Post
CLX	CLAXTON BAY POST	SOUTHERN MAIN RD/CEDAR HILL RD	Ambulance Post
CRN	CORINTH POST	CORINTH RD/NAPARIMA MAYARO RD	Ambulance Post
COU	COUVA POST	COUVA MAIN RD/SOUTHERN MAIN RD	Ambulance Post
CMA	CUMANA POST	TOCO MAIN RD/PUNCH ST	Ambulance Post
CMT	CUMUTO POST	CUMUTO RD	Ambulance Post
DBP	DEBE POST	M2 RING RD/SIPARIA ERIN RD	Ambulance Post
DBS	DEBE SOUTH POST	SIPARIA ERIN RD/SUCHIT TRCE	Ambulance Post
DMC	DIEGO MARTIN CENTRAL POST	SIERRA LEONE RD/AGUA SANTA AVE	Ambulance Post
DMN	DIEGO MARTIN NORTH POST	DIEGO MARTIN MAIN RD/WENDY FITZWILLIAM BLVD	Ambulance Post
XES	EL SOCCORO	CHURCHILL ROOSEVELT HWY/EL SECORRO RD	Ambulance Post
EPP	ELLERSLIE PARK POST	SADDLE RD/JAMAICA BLVD	Ambulance Post
ZOO	EMPEROR VALLEY ZOO POST	ZOO RD/CIRCULAR RD	Ambulance Post
ERN	ERIN POST	SAN FERNANDO SIPARIA ERIN RD/ERIN RD	Ambulance Post
5RV	FIVE RIVERS POST	FIVE RIVERS JUNCTION	Ambulance Post
FLN	FLANAGINS TOWN POST	CAPARO VALLEY BRASSO RD/MAMORAL RD	Ambulance Post
DMS	FOUR ROADS DIEGO MARTIN POST	DIEGO MARTIN MAIN RD/MORNE COCO RD	Ambulance Post
FSP	FOUR SHORE POST	AUDREY JEFFERS HIGHWAY	Ambulance Post
FPP	FREEPORT POST	FREEPORT MISSION RD/ORANGE FIELD RD	Ambulance Post
FYZ	FYZABAD POST	FYZABAD GUAPO RD/RAMLOGAN ST	Ambulance Post
GAS	GASPARILLO POST	BONNE ADVENTURE RD/CHARLES ST	Ambulance Post
GLC	GLENCO POST	WESTERN MAIN RD/HIGHLAND DR	Ambulance Post
GOL	GOLCONDA POST	GOLCONDA CONNECTOR RD/GOLCONDA RD	Ambulance Post
GGP	GOLDEN GROVE POST	GOLDEN GROVE RD/CHURCHILL ROOSEVELT HWY	Ambulance Post
GBP	GRAND BIZZARE POST	PALM DR/MARAJ DR	Ambulance Post
GRP	GRAND RIVIERE POST	PARIA MAIN RD/GRAND RIVIERE RD	Ambulance Post
XGV	GRANVILLE	SOUTHERN MAIN RD/SYFOO TRCE	Ambulance Post
GPO	GUAPO POST	SOUTH TRUNK RD/GUAPO	Ambulance Post
GUA	GUAYAGUAYARE POST	MAYARO GUAYAGUAYARE RD/AMOCO RD	Ambulance Post
GCM	GULF CITY MALL POST	GULF CITY AVE/SOUTH TRUNK RD	Ambulance Post
HYT	HYATT REGENCY POST	DOCK RD/WRIGHTSON RD	Ambulance Post
IWP	INDIAN WALK POST	NAPARIMA MAYARO RD/MORUGA RD	Ambulance Post
TAR	LA BREA PITCH LAKE POST	SOUTHERN MAIN RD/NEW JERSEY RD	Ambulance Post
LBV	LA BREA VILLAGE POST	BRIGHTON RD/LAGOON DOR ST	Ambulance Post

LFV	LA FILLETTE VILLAGE	SOMEWHERE IN LA FILLETTE	Ambulance Post
LRP	LA ROMAINE POST	SOUTHERN MAIN RD/LA PLAISANCE RD	Ambulance Post
LSV	LA SEIVA-CHACONIA POST	SADDLE RD/SAMPSON DR	Ambulance Post

Location ID	Location Name	Physical Location	Location Type
LKT	LADY YOUNG LOOKOUT POST	LADY YOUNG RD	Ambulance Post
LAS	LAS CUEVAS BEACH POST	NORTH COAST RD-LAS CUEVAS	Ambulance Post
LCM	LONG CIRCULAR MALL POST	LONG CIRCULAR RD/PATNA ST	Ambulance Post
LMV	LOWER MARAVAL POST	SADDLE RD/BERGERAC RD	Ambulance Post
MAC	MACOYA POST	MACOYA RD/CHURCHILL ROOSEVELT HWY	Ambulance Post
MAN	MANZANILLA NORTH POST	MANZANILLA MAYARO RD/PNM ALLEY	Ambulance Post
MBL	MARABELLA POST	MARABELLA ROUNDABOUT	Ambulance Post
MRB	MARACAS BEACH POST	NORTH COAST RD-MARACAS BEACH	Ambulance Post
MLO	MARACAS LOOKOUT POST	NORTH COAST RD-LOOKOUT	Ambulance Post
MTL	MATELOT POST	TOCO MAIN RD/OROSCO RD	Ambulance Post
MLD	MATILDA-MORUGA POST	MORUGA RD/MATILDA RD	Ambulance Post
MAU	MAUSICA POST	MAUSICA RD/CHURCHILL ROOSEVELT HWY	Ambulance Post
MAY	MAYARO POST	NAPARIMA MAYARO RD/MANZANILLA MAYARO RD	Ambulance Post
MDZ	MENDEZ VILLAGE POST	COORAR RD/PENAL QUINAM RD	Ambulance Post
MOK	MOKA POST	PERSEVERENCE RD/MOKA ESTATE RD	Ambulance Post
MRR	MONROE RD POST	MONROE RD/URIAH BUTLER HWY	Ambulance Post
BST	MORUGA-BASSETERRE POST	MORUGA RD/PENAL ROCK RD	Ambulance Post
MVJ	MORVANT JUNCTION POST	LADY YOUNG RD/EASTERN MAIN RD	Ambulance Post
MRV	MORVANT POST	MORVANT POLICE STATION / BUSBY ST	Ambulance Post
MTH	MOUNT HOPE HOSPITAL POST	MOUNT HOPE MEDICAL COMPLEX/URIAH BUTLER HWY	Ambulance Post
MOV	MOVIETOWNE POS POST	MOVIETOWNE EXIT ST/BHP RD	Ambulance Post
NPA	NAPA-SAVANNAH EAST POST	FREDERICK ST/DURRES DR	Ambulance Post
NMP	NELSON MANDELLA PARK POST	SERPENTINE RD/WESTERN MAIN RD	Ambulance Post
NWG	NEW GRANT POST	NAPARIMA MAYARO RD/TORRIB TABAQUITE RD	Ambulance Post
PLR	NORTH COAST PILLARS POST	SADDLE RD/NORTH COAST RD	Ambulance Post
XNS	NORTH-SOUTH INTERCHANGE	CHURCHILL ROOSEVELT HWY/URIAH BUTLER HWY	Ambulance Post
OPP	OROPOUCHE POST	SOUTH TRUNK RD/FYZABAD OROPOUCHE RD	Ambulance Post
PMS	PALMISTE-PHILLIPINES POST	SAN FERNANDO SIPARIA ERIN RD/BRASH BLVD	Ambulance Post
PLM	PALMYRA POST	NAPRAIMA MAYARO RD/TAROUBA LINK RD	Ambulance Post
PNP	PENAL POST	SIPARIA ERIN RD/RAMLAL ST	Ambulance Post
PRK	PENAL ROCK RD POST	PENAL ROCK RD/ROCHARD DOUGLAS RD	Ambulance Post
PVP	PETIT VALLEY POST	MORNE COCO RD/RAVINE RD	Ambulance Post
PIA	PIARCO AIRPORT NORTH POST	FARM RD/GOLDEN GROVE RD	Ambulance Post

PAS	PIARCO SOUTH TERMINAL POST	PIARCO RD/CARONI NORTH BANK RD	Ambulance Post
POL	POOLE JUNCTION POST	NAPARIMA MAYARO RD/SAN PEDRO RD	Ambulance Post
PGH	PORT OF SPAIN GENERAL HOSP	CHARLOTTE ST/GORDON ST	Ambulance Post
PRZ	PRESIDENTS GROUNDS POST	ST ANNS RD	Ambulance Post
PRY	PREYSAL POST	GRAN COUVA RD/FREEPORT MISSION RD	Ambulance Post
PTP	PRINCES TOWN POST	NAPARIMA MAYARO RD/MANAHAMBRE RD	Ambulance Post

Location ID	Location Name	Physical Location	Location Type
PFP	PT FORTIN POST	RICHARDSON ST/GUAPO CAP DE VILLE RD	Ambulance Post
PTL	PT LISAS POST	RIVULET ROUNDABOUT	Ambulance Post
QPS	QUEENS PARK SAVANNAH SOUTH	VICTORIA AVE/CUMMINS LN	Ambulance Post
RED	RED HOUSE POST	HART ST/ABERCROMBY ST	Ambulance Post
RCM	RICHMOND STREET POST	RICHMOND ST/PARK ST	Ambulance Post
RIO	RIO CLARO POST	NAPARIMA MAYARO RD/TABAQUITE RIO CLARO RD	Ambulance Post
SFN	SAN FERNANDO NORTH POST	NAPARIMA MAYARO RD/FRAN ST	Ambulance Post
SFP	SAN FERNANDO POST	ST JAMES ST/POINT-A-PIERRE RD	Ambulance Post
SFS	SAN FERNANDO SOUTH POST	RIEZI KIRTON RD	Ambulance Post
SFW	SAN FERNANDO WATERFRONT POST	LADY HALES AVE/QUEEN ST	Ambulance Post
CRO	SAN JUAN CROISEE POST	EASTERN MAIN RD/SADDLE RD	Ambulance Post
SUC	SAN SOUCI POST	PARIA MAIN RD/GEORGE ST	Ambulance Post
SGP	SANGRE GRANDE POST	EASTERN MAIN RD/CUNAPO SOUTHERN MAIN RD	Ambulance Post
SCZ	SANTA CRUZ POST	SADDLE RD/MONEY ST	Ambulance Post
SFL	SANTA FLORA POST	SIPARIA ERIN RD/CAYENNE TRCE	Ambulance Post
SPP	SIPARIA POST	SIPARIA ERIN RD/LALLA ST	Ambulance Post
SPH	ST AUGUSTINE NORTH POST	EASTERN MAIN RD/AUSTIN ST	Ambulance Post
SCV	ST CHARLES VILLAGE POST	ST CHARLES RD/MANAHAMBRE RD	Ambulance Post
SJP	ST JAMES WEST POST	WESTERN MAIN RD/CORONATION RD	Ambulance Post
SMP	ST MADELEINE POST	MANAHAMBRE RD/USINE RD	Ambulance Post
SMG	ST MARGARET POST	SOUTHERN MAIN RD/ST MARGARET OLD RD	Ambulance Post
MAR	ST MARY VILLAGE POST	MORUGA RD/BURTON TRCE	Ambulance Post
TAB	TABAQUITE POST	GUARACARA TABAQUITE RD/TABAQUITE RIO CLARO RD	Ambulance Post
TBL	TABLELAND POST	NAPARIMA MAYARO RD/MAIRAO VILLAGE 5TH AVE	Ambulance Post
TAL	TALPARO POST	TALPARO RD/TAMANA RD	Ambulance Post
TRB	TAROUBA POST	SAN FERNANDO BYPASS RD/TAROUBA RD	Ambulance Post
SQP	TOBAGO FERRY TERMINAL POST	WRIGHTSON RD/SOUTH QUAY	Ambulance Post
TCP	TOCO POST	PARIA MAIN RD/TOCO MAIN RD	Ambulance Post

TCV	TOCO-VALENCIA CUTOFF POST	TOCO MAIN RD/VALENCIA RD	Ambulance Post
TSP	TODDS STATION RD	FLETCHER RD/TODDS STATION RD	Ambulance Post
TCM	TRINCITY MALL POST	TRINCITY CIRCULAR RD/TINCITY MALL RD	Ambulance Post
MVP	UPPER MARAVAL POST	SADDLE RD/MORNE COCO RD	Ambulance Post
UWI	UWI ST AUGUSTINE POST	COLLEGE ST/CHURCHILL ROOSEVELT HWY	Ambulance Post
VAL	VALENCIA POST	EASTERN MAIN RD/VALENCIA RD	Ambulance Post
WAL	WALLERFIELD POST	CUMUTO RD/HAMILTON SIDING RD	Ambulance Post
WMP	WESTMOORINGS POST	GUARDIAN DR/COLUMBUS BLVD	Ambulance Post

Appendix 6

Qualifications for Emergency Medical Services Personnel

CREDENTIALS AND EXPERIENCE for an Emergency Medical Technician (EMT)

 Possession of Emergency Medical Technician's - Basic Certification from a recognised and accredited institution.
 Possession of a Heavy 'T' License.
 Must be in excellent physical condition, for which validation by a medical fitness report, no older than three (3) months, is required.
 Must be between the ages of 25-50.
 A police certificate of good character no longer than three (3) months old.
 Excellent communication skills (both written and oral)
 Defensive Driving Certificate
 Experience in the field would be an asset

SPECIAL REQUIRMENTS

- Working overtime, public holidays and weekends is compulsory
- Staff must avail themselves as far as possible for duty in the event of an emergency or disaster.
- Must possess a Heavy 'T' License.

KNOWLEDGE, SKILLS AND ABILITIES:

- Ability to establish and maintain effective working relationships with patients, medical staff, management and peers.
- Skill and physical coordination in carrying, lifting, climbing, hoisting and other similar manoeuvres in a manner not detrimental to the patient, co-worker or self.
- Strong organizational and interpersonal and Communication skills including the ability to manage stressful situations
- Highly detail and quality oriented
- Able to integrate and apply feedback in a professional manner
- Ability to work as part of a team

Emergency Medical Dispatcher

SPECIAL REQUIRMENTS

- Working overtime, public holidays and weekends is compulsory
- Staff must avail themselves as far as possible for duty in the event of an emergency or disaster.

KNOWLEDGE, SKILLS AND ABILITIES:

- Ability to establish and maintain effective working relationships with patients, medical staff, management and peers.
- Skill and physical coordination in carrying, lifting, climbing, hoisting and other similar manoeuvres in a manner not detrimental to the patient, co-worker or self.

- Interpersonal and communication skills including the ability to manage stressful situations.
- Able to integrate and apply feedback in a professional manner
- Ability to work as part of a team.
 Emergency Medical Dispatcher Certification

Five (5) G.C.E. / C.X.C. “O” Levels including English Language and Mathematics
 Police certificate of good character no longer than three (3) months.
 First Aid Certificate
 Excellent communication skills (both written and oral)
 Experience in the field would be an asset

Appendix 7

List the defects or shortcomings which were identified in Ambulance Vehicles

Table 1: shows the key defects taken during the inspections of the ambulances vehicles:.

Table 1: Deficient Items on Ambulances

Items
Basic Life Support Ambulances
• Oropharyngeal airways in adult, child and infant sizes which are clean and individually wrapped and in the following sizes: 40mm
• A "No Smoking" sign with minimum 2.5cm letters shall be displayed in the patient compartment
• Two sterile burn sheets
• Arterial tourniquet
Advanced Life Support Ambulances
• Oropharyngeal airways in adult, child and infant sizes which are clean and individually wrapped and in the following sizes: 40mm
• A "No Smoking" sign with minimum 2.5cm letters shall be displayed in the patient compartment
• Arterial tourniquet
• Length/weight based tape for paediatric sizing
• One 14-gauge and one 18-gauge intraosseus needles
• Pharmaceuticals: Salbutamol MDI

Appendix 8

Minutes

MINUTES OF THE 27TH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS, STATUTORY AUTHORITIES (INCLUDING THE THA) HELD IN THE ANR ROBINSON ROOM (EAST) LEVEL 6 AND THE J.HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, 1A WRIGHTSON ROAD, PORT OF SPAIN ON WEDNESDAY NOVEMBER 28, 2018

PRESENT

Members

Dr. Varma Deyalsingh	Chairman
Ms. Ramona Ramdial, MP	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Darryl Smith, MP	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Terriann Baker	Graduate Research Assistant

ABSENT/ EXCUSED

Mr. Esmond Forde, MP	Member (Excused)
Ms. Khadijah Ameen	Member (Excused)
Dr. Lovell Francis, MP	Member

THE FOLLOWING PERSONS WERE ALSO PRESENT:

The Ministry of Health

Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Robin Sinanan	Manager – Accident & Emergency, SWRHA
Ms. Bhabie Roopchand	Legal Advisor, MOH
Mr. Lawrence Jaisingh	Director – Health Policy Research and Planning

The Global Medical Response of Trinidad and Tobago (GMRTT)

Mr. John Aboud	Chairman
Mr. Paul Anderson	Chief Executive Officer (CEO)

CALL TO ORDER

1.1 The Vice-Chairman called the meeting to order *(in camera)* at 10:36 a.m.

1.2 The Vice-Chairman informed Members that Mr. E. Forde and Ms. K. Ameen have asked to be excused from the meeting.

ELECTION OF CHAIRMAN

2.1 The Vice-Chairman reminded the Committee that the seat of former Sen. H.R. Ian Roach was declared vacant on November 19, 2018.

2.2 The Vice-Chairman advised Members that Standing Orders 99(5) of the Senate and 109(5) of the House of Representatives mandate that an Independent Senator shall be the Chairman of a Committee established in accordance with Section 66A of the Constitution.

2.3 The Vice-Chairman then invited nominations for the post of Chairman. Mrs. J. Baptiste-Primus nominated Dr. V. Deyalsingh. The nomination was seconded by Mr. N. De Freitas.

2.4 There being no objections to his nomination, Dr. Varma Deyalsingh was declared the duly elected Chairman of the Committee.

CONSIDERATION OF THE MINUTES OF THE 26TH MEETING HELD ON NOVEMBER 28, 2018

3.1 The Chairman asked Members to examine, the Minutes page-by-page.

3.2 The Minutes were confirmed without amendment on a motion moved by Mrs. J. Baptiste-Primus and seconded by Mr. N. De Freitas.

MATTERS ARISING FROM THE MINUTES

4.1 The following matters were raised:

- With reference to Item 4: The Chairman informed the Committee that 10th Report on the Internal Control Systems and Corporate Social Responsibility Policies of the NLCB was presented in the Senate on September 18, 2018.

- With regard to Items 5.3 and 5.4: The Committee agreed that the Committee will defer its inquiry into the Pharmacy Council to focus on Financial Oversight and Financial Management at Municipal Corporations which is a current issue that should be examined.

- The Committee also agreed that two public hearings shall be convened pursuant to this inquiry and at each meeting seven (7) of the fourteen (14) Municipal Corporations will be in invited.

CONSIDERATION OF THE DRAFT 11TH REPORT ON AN INQUIRY INTO THE EFFICIENCY AND EFFECTIVENESS OF THE REGULATED INDUSTRIES COMMISSION (RIC)

5.1 The Chairman reminded Members that the Draft 11th Report was circulated on October 31, 2018 but to date no comments were received.

5.2 It was agreed that members would be given an additional 5 days to review the draft Report and submit comments and or suggestions to the Secretariat.

5.3 The Committee agreed that the Vice-Chairman will present the Report in the House of Representatives.

PRE-HEARING DISCUSSIONS

6.1 The Committee agreed that the new approach to engaging to be taken is that Members review the Issues Paper and select the questions and areas each would focus on during the public hearing.

6.2 Members then reviewed the Issues Papers selected the questions in accordance with paragraph 5.1.

OTHER BUSINESS

The Date and Agenda of the Next Meeting

7.1 The Committee reminded Members that the next meeting will be held on Wednesday January 23, 2019 to commence the inquiry into Financial Oversight and Financial Management at Municipal Corporations.

The meeting was suspended at 10:06 a.m.

PUBLIC HEARING

8.1 The Chairman reconvened the meeting *(in public)* at 10:20 a.m. and welcomed both the listening and viewing audience.

8.2 The Chairman highlighted the objectives of the inquiry and introductions were made.

8.3 The Chairman then invited the stakeholders to each make a brief opening statement:

i. Mr. Asif Ali, Permanent Secretary of the Ministry of Health stated that the Ministry reaffirm its commitment to provide an efficient and effective emergency ambulance service through its partnership with Global Medical Response-Trinidad and Tobago (GMRTT).

ii. Mr. John Aboud, Chairman of GMRTT informed the Committee that the company was formed since 2004 in response to a Government initiative to develop the national emergency ambulance service. In order to provide the quality service required in Trinidad, the company formed a

partnership with the largest ambulance provider in the United States, AMR, the local company is registered as GMRTT.

8.4 The following are the main issues highlighted during discussions with the officials of the **GMRTT** *(for further details, please see the Verbatim Notes)*:

i. The GMRTT was contracted by the Ministry of Health to provide an Emergency Ambulance Services for the island of Trinidad;
ii. In 2008, GMRTT became the first EMS agency outside of North America to be accredited by the Commission on Accreditation of Ambulance Services within two years of operations;
iii. There are two levels of Life Support provided by ambulance services:
    a. Basic Life Support;
    b. Advanced Life Support. (Involves paramedics administering pharmaceuticals, doing invasive procedures and having the ability to treat people with acute illness)
iv. There are currently 16 paramedics assigned to 40 vehicles;
v. AMR, which is the parent company of GMRTT, offered a pilot paramedic programme with a cohort of 40 persons. Within this cohort, 18 persons successfully completed the program and have been integrated into the current paramedic complement. 19 additional persons are currently undergoing training.
vi. The CEO of GMRTT stated that not all ambulances require Advanced Life Support personnel on board but in the future at least 75% of the staff will be trained in this area;
vii. The routine maintenance of an ambulance can be completed in one (1) day. In extreme cases it may require several days;
viii. The fleet of 40 ambulances have been proven to be adequate for the operations of the GMRTT;
ix. There is a need to pursue alternative solutions to ambulance services e.g. helicopters voluntary networks;
x. The current response time of ambulance to an emergency call is 4 minutes per 1 Kilometre.
xi. GMRTT stated that no patient should be refused medical care from an ambulance due to their location;
xii. The deployment of the ambulance is based on an analysis of call density and call pattern in a particular area as well as the population density. There is further analysis of population movement to account for persons who may congregate in urban areas for employment;
xiii. The GMRTT has systems which may assist in identifying and developing issues such as lay patient handover, which can be predicted based on a backlog of bed spaces and the census of facilities;
xiv. GMRTT is required to report information on operations and outcomes weekly, monthly, quarterly and annually to the Ministry of Health.
xv. Members of the public often contact the wrong agency for assistance which has contributed to a slower response time from the GMRTT;
xvi. The GMRTT has deliberately minimised its marketing and promotional activities in order to curtail the misuse, abuse or overburdening of the EMTs;

xvii. GMRTT sometimes request assistance from the Trinidad and Tobago Police Service to venture into areas with heightened criminal activity

xviii. The Emergency Medical Personnel are trained to deal with cases of unexpected violence;

xix. Dispatchers are certified by the International Academy of Emergency Dispatch. Their training/certification includes triage and prioritisation of emergencies as well as dispatch life instruction;

xx. There are 24 full-time dispatchers and if necessary, the field staff are also trained to assist as Emergency Medical Dispatchers;

xxi. The procurement methodology used by the GMRTT commences with the purchase of a panel van with basic specifications: automatic transmission, right hand drive with engine displacement that could handle the load requirements. Thereafter a fabricator is sourced to complete the remodeling of the vehicle;;

xxii. The ambulances used in Trinidad are manufactured in Asia and England;

xxiii. The estimated cost to outfit/equip an ambulance is $1M;

xxiv. Three operating centres exist, however employees are sometimes redeployed based on service demand;

xxv. GMRTT would not usually be hired for private events due to the high cost associated with procuring the service;

xxvi. Mental health officers are not assigned to GMRTT to assist with the handling of mentally-ill patients. However, the EMTs and paramedics are trained in behavioural emergencies which involves both physical and chemical restraint to diffuse a situation;

xxvii. The GMRTT indicated that an ongoing issue is the delay at the hospital regarding 'patient handovers'. In some cases, the EMTs have waited up to 30/40 minutes;

xxviii. In accordance with the contract between GMRTT and the MOH, patients are only to be taken to public health institutions and not private health facilities;

xxix. GMRTT has Language Translational technology however, it is problematic and unreliable. Alternatively, the GMRTT is seeking to hire persons who a proficient in speaking or writing spanish;

xxx. In 2019, staff will be trained in Basic Spanish;

xxxi. GMRTT does not have Automatic Line Identification to recall numbers that lose signal during an emergency call.

xxxii. The Education department of the GMRTT manages the training of staff; and

xxxiii. In the event of a national emergency, the GMRTT operates in collaboration with the ODPM. The GMRTT also re-directs staff to treat with the emergencies. An example would be the recent flooding disaster which occurred in October 2018.

8.5 The following are the main issues highlighted during discussions with the **Ministry of Health** *(for further details, please see the Verbatim Notes)*:

i. The contract with the GMRTT covers responses to emergency calls made to GMRTT over the contracted period of five years. The MOH has settled half of the fees invoiced by GMRTT;

ii. A flat fee is paid to the GMRTT, however if additional services are rendered, additional invoices are sent to the MoH;

iii. The ambulance services within the Regional Health Authorities are for inter-facility transport only;
iv. The ambulances assigned to the RHA's are outfitted with basic health equipment;
v. In response to the complaints from its stakeholders, the MOH has engaged in meetings with the aim of reducing the waiting period to 15 minutes per patient hand over at public health facilities;
vi. Based on the nature of the health complaints reported to GMRTT, the MOH is able to gain a national perspective on the reported frequency of ailments such as non-communicable diseases. The MOH is therefore able to develop outreach strategies geared towards educating the public on preventative measures in order to reduce the frequency of reports;
vii. The Internal Audit Department of the MoH inspects the facilities of the GMRTT because an Inspection Committee has not been appointed;
viii. GMRTT is not operating under a licence at this time;
ix. The MOH is in the process of licensing GMRTT and other ambulance service providers.
x. A qualified physician inspects each vehicle using a checklist and makes a recommendation to the Ministry of Works and Transport for the licensing of the vehicles;
xi. The Regulatory Committee for licensing of Emergency Medical Operators should be established before the end of the calendar year (2018);
xii. Nominations were received from the Regional Health Authorities and the Minister for the Regulatory Committee, however, the nomination from the Ministry of National Security is outstanding;
xiii. The Minister also has to recommend the service providers to be licensed;
xiv. There are approximately 8 additional ambulance service providers;
xv. The MOH may employ mental health officers who can be called out to assist EMT workers;
xvi. There is an ongoing audit of GMRTT which commenced in 2015. The audit involves the MOH receiving invoices from GMRTT, which are forwarded to the Audit Department which reviews the claims and recommends payments accordingly;
xvii. The MOH ensures that GMRTT provides value for money through assessments conducted by the technical staff of the Office of the Chief Medical Officer. The reports received from the GMRTT is collated through the Director of Health Policy and Planning and it is returned to the Chief Medical Officer's office where further examination is conducted. The information is also verified through the information stored at the Regional Health Authority; and
xviii. The patient handover period can be reduced by calling in and reporting incoming patients.

Request for Additional Information

9.1 Based on the deliberations of the hearing, the Committee requested the following information:

i. what is the actual or estimated number of patients that were transported by Global Medical Response of T&T (GMRTT) for the years 2017 and 2018:
ii. how many patients were transported by the other service providers for the years 2017 and 2018?
iii. what is the cost paid to GMRTT per patient "drop off" at a health facility?
iv. what is the average time period associated with a patient handover at public health facilities?

v. Provide a list comprising the names of all ambulance service providers in Trinidad and Tobago.

vi. Based on your response to question 2 above, please confirm:

- whether any of these service providers are paid by the state for their services?
- if so, please state the amount paid to each service provider on an annual basis for the years 2015 to 2018.
- the number of these service providers who possess a valid license in accordance with Section 21 of the Emergency Ambulance Services and Emergency Medical Personnel Act;
- the current size of the fleet of each service provider?

vii. Please provide a detailed list of the equipment installed in the ambulances operated by GMRTT?

ADJOURNMENT

10.1 The Chairman thanked all present for attending.

10.2 The meeting was adjourned at 11:04 a.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

January 07, 2019

MINUTES OF THE 28TH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS, STATUTORY AUTHORITIES (INCLUDING THE THA) HELD IN THE ANR ROBINSON ROOM (EAST) AND THE ANR ROBINSON ROOM (WEST), LEVEL 9, OFFICE OF THE PARLIAMENT, TOWER D, 1A WRIGHTSON ROAD, PORT OF SPAIN ON WEDNESDAY JANUARY 09, 2019

PRESENT

Members

Dr. Varma Deyalsingh	Chairman
Ms. Ramona Ramdial, MP	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Darryl Smith, MP	Member
Mr. Esmond Forde, MP	Member
Ms. Khadijah Ameen	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Terriann Baker	Graduate Research Assistant
Ms. Janelle Mills	Parliamentary Intern

ABSENT/ EXCUSED

Dr. Lovell Francis, MP	Member

THE FOLLOWING PERSONS WERE ALSO PRESENT:

The Division of Health, Wellness and Family Development

Dr. Agatha Carrington	Secretary
Mrs. Dianne Baker-Henry	Administrator

The Tobago Regional Health Authority (TRHA)

Ms. Ingrid Melville	Chairman
Mr. Michele Edwards-Benjamin	Chief Executive Officer (Ag.)
Mr. Lester Frederick	Tobago Emergency Medical Service Manager

CALL TO ORDER

1.3 The Chairman called the meeting to order *(in camera)* at 10:34 a.m.

CONSIDERATION OF THE MINUTES OF THE 27TH MEETING HELD ON JANUARY 09, 2019

2.1 The Chairman asked Members to examine, the Minutes page-by-page.

2.2 The Minutes were confirmed without amendment on a motion moved by Mrs. J. Baptiste-Primus and seconded by Mr. N. De Freitas.

MATTERS ARISING FROM THE MINUTES

3.1 The following matters were raised:

a. With reference to Item 4.1: The Chairman informed members that the additional information was requested from the five Corporations that appeared on January 23, 2019. The deadline for submission is February 22, 2019.

b. The request to the Ministry was received on February 12, 2019, it was circulated to all Members at the meeting.

PRE-HEARING DISCUSSIONS

4.1 The Chairman advised that officials of the Tobago Regional Health Authority and the Division of Health, Wellness and Family Development will be appearing before the Committee.

4.2 The Chairman informed Members that copies of the pre-hearing submissions were received from both entities appearing at today's meeting and the Issues Paper prepared by the Secretariat.

4.3 Members then reviewed the Issues Papers and selected the questions and the areas of interest they would pursue during the public hearing.

OTHER BUSINESS

The Date and Agenda of the Next Meeting

5.1 It was agreed that the next meeting will be held on Wednesday January 23, 2019 to convene its first public hearing pursuant to the inquiry into Financial Oversight and Financial Management at Municipal Corporations.

Proposed Site Visit

5.2 The Chairman inquired whether members would be interested in a site to the Global Medical Response T&T Headquarters at Sealots, Port of Spain, to acquire a more realistic perspective on the situation at the Dispatch Centre and to verify information presented to the committee by the GMRTT.

5.3 After some discussion the Committee agreed that a site visit would not be necessary at this time.

The meeting was suspended at 10:14 a.m.

PUBLIC HEARING

6.1 The Chairman reconvened the meeting *(in public)* at 10:25 a.m. and welcomed the officials.

6.2 The Chairman highlighted the objectives of the inquiry and introductions were made.

6.3 The Chairman then invited the stakeholders to each make a brief opening statement:

6.4 The following are the main issues highlighted during discussions with the officials of the

The following are the main issues highlighted during discussions with the **Tobago Regional Health Authority (TRHA)** *(for further details, please see the Verbatim Notes)*:

i. After an initial purchase of 10 ambulances in 2015, there are currently 8 functioning ambulances to service the 6 bases in Tobago;
ii. Two ambulances are currently being serviced and should be functional by the first quarter of 2015;
iii. Ambulances have been reserved to serve during periods of high tourist arrivals, for example for the arrival of cruise ships;
iv. The total fleet of ambulances is 18, however, 8 ambulances are currently in the process of being disposed;
v. Population density is a determining factor in the distribution of ambulances;
vi. Ambulances are deployed based on demand, however, economic constraints have reduced the TRHA's ability to procure more ambulances to service Tobago;
vii. A long-term plan of the TRHA is to procure ambulances that have the capability of traversing difficult terrain;
viii. A significant challenge posed is the difficulty associated with moving heavy persons to the ambulances in difficult terrain;
ix. The average life span of an ambulance is 5 years, however, ambulances with proper maintenance would be used for a longer time;
x. A cost-benefit analysis for the ambulances within the TRHA is still outstanding;
xi. In crucial situations in far locations, another ambulance may be deployed to assist;

xii. The Accident and Emergency Room of the Scarborough hospital had approximately 9000 visits per annum inclusive of hand-overs and walk-ins;

xiii. 14 ambulances may be ideal to service Tobago, with two ambulances per base, specifically in the North and Eastern region;

xiv. There are currently 8 Emergency Medical Technicians (EMTs) per base with 2 EMTs rostered per 12 hour shift;

xv. The monthly salary of an EMT ranges from $12000 to $15000;

xvi. Nurses are not assigned to work with EMTs on the ambulances;

xvii. The licence of the medical director within TEMA covers training for EMTs in Basic Life support;

xviii. EMTs have received training in the administration of medicine, however, intravenous (IV) injection or infusion training has not been provided;

xix. As part of its customer service responsibility, the TRHA, upon written request, provides *pro bono* ambulances services for private events;

xx. Discussions are ongoing with the Vehicle Management Company of Trinidad and Tobago (VMCOTT) to ascertain whether inspections are necessary for the current fleet of ambulances;

xxi. The process for procuring parts for to address mechanical issues affecting 2 ambulances has commenced;

xxii. The process of handing over a patient at the Scarborough General Hospital can take approximately 10 minutes. The process involves informing the Accident and Emergency Unit of the arrival time and the condition of the incoming patients. After which the patient is handed over to the Head nurse and placed on a bed;

xxiii. The THRA assumes responsibility for the medical care of a patient when the patient is placed in an ambulance;

xxiv. There is a perception in Tobago that a patient would receive faster medical attention if they arrive at a public health facility in an ambulance. This has led to abuse of the ambulance service;

xxv. No practical deterrents are currently in place to reduce the abuse of the ambulance service, although callers are subjected to triage screening;

xxvi. Public education drives are to be conducted to reduce this abuse;

xxvii. The evaluation of the performance of the Tobago Emergency Ambulance Service is being conducted through customer surveys;

xxviii. The areas of the TRHA's administrative reporting system that can be improved are in the areas of audit and compliance;

xxix. The TRHA is working towards receiving accreditation for service manuals, policies, procedures;

xxx. A preventative maintenance system does not exist with service providers and should be implemented by the first quarter of 2019. Corrective maintenance is being used currently;

xxxi. The TRHA has a close working relationship with Tobago Emergency Management Authority (TEMA). TEMA is responsible for Disaster Management in Tobago and the TRHA is a first responder;

xxxii. TEMA does not own or operate ambulances;

xxxiii. TEMS collaborated with TEMA in the implementation of an evacuation plan;

xxxiv. An 'after-action' review of the evacuation plan is conducted by TEMA; and

a. *Zello* is an app developed to contact first-responders to assist in disaster relief.

xxxv. The TRHA is improving accountability through the implementation of a Performance Management System which will be applied to all levels of staff;

xxxvi. The Audit and Compliance Committee is a sub-committee of the Board that monitors service delivery and compliance with internal controls;

xxxvii. The Audit and Compliance Committee reports to the Board, and then to the TRHA. In turn, the TRHA is accountable to the Division of Health, Wellness and Family Development;

xxxviii. Ambulances are equipped with basic equipment as outlined by the Act;

xxxix. The TRHA responds to emergencies at the airport although there is a Red Cross ambulance stationed there;

xl. There is a need for an improved relationship with the ANR Robinson Airport in Tobago;

xli. An ambulette service will add value to Tobago's public health care system. However this service is not analogous to an Emergency Ambulance Service since an ambulette vehicle is not equipped with medical equipment but is specifically utilised for transporting patients between health facilities;

xlii. Patient Material and Transport is stationed at the Scarborough General Hospital in Tobago however, one may not be adequate;

xliii. Persons who are authorised to be on the ambulance are covered under the vehicle's insurance;

xliv. Insurance coverage has been extended to the staff of the TRHA;

xlv. Helipads exist at the Scarborough General Hospital and can facilitate helicopter travel through the National Helicopter Service;

xlvi. The TRHA has an Employee Assistant Programme (EAP) system for its staff;

xlvii. Psychologists are also on staff to deal with psychological issues associated with this job;

xlviii. The TRHA has a pre-approved list of suppliers of ambulances which was updated over the last fiscal period. However, Tobago suppliers are often preferred when procuring supplies and services for the EMS;

xlix. The arrangements for the disposal of assets are in sync with the new Public Procurement legislation.

6.5 The following are the main issues highlighted during discussions with the **Division of Health, Wellness and Family Development** *(for further details, please see the Verbatim Notes)*:

i. There have been challenges in the maintenance arrangements for ambulances, however, an MOU was drafted with VMCOTT;

ii. The Division has stated that the replacement of ambulances is being conducted on a phased basis;

iii. Due to the current financial constraints facing the THA, the TRHA is unable to increase the fleet to 18 ambulances;

iv. Citizens may convey their complaints/concerns on the TRHA's website as well as the customer feedback service at the health centres and hospitals;

v. Community outreach meetings are also conducted to measure customer satisfaction with the ambulance service;

vi. Public-private partnerships are being considered as a strategy for improving Tobago's ambulance service; and

vii. In the first week of each month, releases are received from the Central Government and disbursed.

ADJOURNMENT

7.1 The Chairman thanked all present for attending.

7.2 At the conclusion of the public hearing, the Chairman announced that the Committee's report on its inquiry into the Efficiency and Effectiveness of the Regulated Industries Commission (RIC) was presented to the Houses of Parliament and is available for review on the Parliament's website.

7.3 The Chairman then highlighted some of the major issues in the Report.

7.4 The meeting was adjourned at 12:15 p.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

January 21, 2019

Appendix 9

Verbatim Notes

VERBATIM NOTES OF PUBLIC HEARING OF THE JOINT SELECT COMMITTEE APPOINTED TO ENQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS AND STATUTORY AUTHORITIES (INCLUDING THE THA), J HAMILTON MAURICE MEETING ROOM, MEZZANINE FLOOR, TOWER D, INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, NOVEMEBR 28, 2018 AT 10.20 A.M.

PRESENT

Mr. Varma Deyalsingh	Chairman
Ms. Ramona Ramdial	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Darryl Smith	Member
Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Terriann Baker	Graduate Research Assistant

ABSENT

Dr. Lovell Francis	Member
Ms. Khadijah Ameen	Member [*Excused*]
Mr. Esmond Forde	Member [*Excused*]

OFFICIALS OF MINISTRY OF HEALTH

Mr. Asif Ali	PS, Ministry of Health
Dr. Robin Sinanan	Mgr. Accident and Emergency, SWRHA
Dr. Roshan Parasram	Chief Medical Officer
Ms. Bhabie Roopchand	Legal Advisor, Ministry of Health

Mr. Lawrence Jaisingh Director, Health, Policy, Research and Planning

OFFICIALS OF GLOBAL MEDICAL RESPONSE OF TRINIDAD AND TOBAGO (GMRTT)

Mr. John Aboud Chairman, Global Medical Response of T&T

Mr. Paul Anderson Chief Executive Officer, Global Medical Response of T&T

Mr. Chairman: Good morning, members, good morning guests. I would like to call the meeting to order, this public hearing of the Joint Select Committee on Local Authorities, Service Commissions, and Statutory Authorities, including the THA. This is the Twenty-Seventh Meeting that we are having and today's committee we are meeting representatives of the Ministry of Health and the National Emergency Medical Service under the Global Medical Response of Trinidad and Tobago Limited.

Members of the listening and viewing audience are invited to post or send their comments or questions via Parliament's various social media platforms: Facebook, YouTube and Twitter, and we will consider those real-time comments, that we may consider and even ask those questions here if it is pertinent.

I would like to now invite members of the Ministry of Health to introduce themselves and following them, the members of the Global Medical Response of Trinidad and Tobago.

Introductions made.

Mr. Chairman: I would like members now, proceeding with the Vice-Chairman of our committee, to introduce yourself and go into the right and then the left.

Introductions made.

Mr. Chairman: Thank you. And I am Dr. Varma Deyalsingh. I am the Chair of the Committee and I am replacing Ian Roach who was here before, and I thank him for his service for the last three years in this committee.

The objectives of this enquiry, really, it is really to assess the capacity of the

National Emergency Ambulance Services in Trinidad and Tobago. It is to understand how the resources associated with this service are deployed throughout the country and to determine the areas of inefficiency in this service and the critical factors, conditions, which are required for its success. As we know, we have the ambulance service and as a medical practitioner for 30 years I have heard complaints from way back. I have seen the improvements. So I have seen improvements and I am thankful for those improvements. But we also have instances where there are little pockets of discontent, little pockets that we need to work at. And this Committee, as well as, you know, members from the Ministry of Health and your company, together with other stakeholders, I think our objective is to see if we can get, somehow, some other relief, some other—you know, if there are little gaps in the system, if we could look and work at those gaps. And part of the discussions today—I would probably introduce three recent complaints that I got personally and we can see if we can solve it and see if somehow we can get things in place to see if we could put a cap on those. orgin

So I would now want to invite Mr. Asif Ali, the PS of the Ministry of Health, to make some opening statements.

Mr. Ali: Thank you, Chair. Good morning again, Chair, members of the committee, officials from the GMRTT and my colleagues from the Ministry of Health. The Ministry of Health takes this opportunity to reaffirm its commitment to the provision of an effective and efficient national emergency ambulance service. As in many cases, this is the first time a person will encounter the public health system and it allows for immediate care and subsequent transport to a public hospital.

In this regard, the Ministry continues to partner with GMRTT in the provision of this service. It is envisaged that today's proceedings will be insightful towards promoting a greater monitoring and evaluation and improvement of the service as we seek to continue to provide a quality service to our population.

Thank you, Chair.

10.25 a.m.

Mr. Chairman: Thank you, Mr. Asif Ali. Would Mr. John Aboud, the Chairman of Global Medical Response of T&T, please give us some opening statements?

Mr. Aboud: Good morning again, Chair, and Committee members. GMRTT wishes to thank you for the opportunity to provide whatever information or clarification you seek in carrying out your mandate. GMRTT is a joint venture company between Amalgamated Security Services Limited and AMR, the largest ambulance service provider in the United States. This joint venture company was formed in order to respond to an initiative from the Government in 2004 to provide accelerated development of the National Emergency Ambulance Service which was then run by the South-West Regional Health Authority. As part of the pre-qualification for the tender, bidders must have had at least 10 years' experience in providing the service.

Since no one in Trinidad and Tobago had these qualifications, it was clear that the bid was forcing interested parties to pursue joint venture relationships with foreign partners. Amalgamated was extremely fortunate to attract AMR, the biggest ambulance provider in the United States to partner with us. This decision in hindsight was a very critical and important one as over the years the joint venture company has been able to draw an international best practice, where today, notwithstanding challenges, Trinidad and Tobago can boast, without fear of contradiction, of having the finest national emergency system in the Caribbean. The joint venture, GMR and ASSL working together, have accomplished results that are far above what was foreseen and what either party could have done on their own.

We have received positive feedback on the performance of GMRTT from prominent members of the local medical community. GMRTT has gone about its business quietly but with undeterred focus to bring world-class ambulance service to Trinidad. The patient transport volume has grown, not through promotion, but through building citizen confidence in the service. Nearly daily, GMRTT receives praise from the citizens we

serve. GMRTT is a company predominantly comprising—in fact, 99.9 per cent comprising of hardworking Trinbagonians who are devoted to the profession and proud of the service they provide.

We work closely with our employer, the Ministry of Health, on a daily basis as we strive to achieve excellence daily. As one example of where we came from, when we took over this service there were approximately 20,000 calls annually. Today, we respond to in excess of 70,000 calls well within our contracted mandate utilizing state of the art technology. Once again, we thank you and look forward to answering any question or clarifications you may have.

Mr. Chairman: Thank you, Mr. John Aboud. Now what we would like now is to have a period of questioning at the stage and I am asking members please divert your questions through the Chair, and I would like to start with the Vice-Chair to please start the level of questioning.

Ms. Ramdial: Good morning everyone. This question, Chair, through you, Mr. Aboud, can you tell me what level of service is given on your ambulance?

Mr. Aboud: Ma'am, could I refer that question to my CEO?

Ms. Ramdial: Sure.

Mr. Anderson: We have two levels of service which is commonly known as Basic Life Support which is provided by emergency medical technicians, and Advanced Life Support which is provided by paramedics. The Advanced Live Support is substantially more clinically sophisticated. They will administer pharmaceuticals, do invasive procedures and have the ability to treat people with acute illness much more severely.

Ms. Ramdial: So, Mr. Anderson, do you have paramedics on all of your vehicles—ambulances—on all of them?

Mr. Anderson: No, and we do not contemplate ever needing to have 100 per cent paramedics.

Ms. Ramdial: Can you tell me how many? On how many ambulances you have

paramedics?

Mr. Anderson: Sixteen.

Ms. Ramdial: Sixteen? Out of a fleet of how many?

Mr. Anderson: Forty.

Mr. Smith: Thank you, Mr. Chair, through you. First of all, when we do these type of joint selects we tend to know as members of the Committee to have some form of interaction with the committees and the teams that we interview, and I must say the interaction that I personally would have had with this organization personally with my family, with workers and neighbours have been—overall I have been very pleased and positive with regard to the service that I have gotten, but of course, you hear things out there. People may not the same experience that I may have had. One of the things we talked about is with regard to the maintenance of the vehicles. In your submission you stated that the ambulances are fully operational as 50 per cent is taken out for routine maintenance. What is the average time frame for undertaking routine maintenance of these ambulances? That is one. And how many intensive care ambulances are there in the GMRTT fleet?

Mr. Anderson: Generally, routine maintenance requires a one day service. There may be jobs that are more extensive as the vehicle gets older and those would perhaps be out of service for multiple days. Very rarely is the situation where an ambulance is out of service for protracted period of time because we do stay on top of the maintenance. With respect to the intensive care, those are ALS ambulances. Their dual purpose is both ALS emergency response and intensive care non-emergency transfers, and that is the 16.

Mr. Smith: All right. And what is procedure for the commissioning of these ambulances; and how are decommission in terms of the vehicles disposal over a period of time?

Mr. Anderson: Commissioning of the ambulances, it starts with a specification that we collaborate with staff and experts within our parent organization on the American side. We then seek a converter or builder that is either done locally or abroad, and then when

they arrive in the country they have to be stocked fully. Any equipment that is not new with the vehicle is then transferred, and then retired vehicles are currently in a yard basically. To this point, we have only retired vehicles that are the Government's assets and so would hope that one day the Government will take control of those so I would not have to house them any further. In the future, the ambulances are our assets under our current agreement. When we retire those we would figure out an appropriate disposal arrangement.

Mr. Chairman: I recognize Mr. De Freitas.

Mr. De Freitas: Good morning, again. My apologies. I had to step out to come back. So I heard that you have paramedics on 16 of the 40 ambulances. Is there a particular reason for that ratio, why 16 of the 40?

Mr. Anderson: The paramedic programme is relatively new. It is a very extensive training process. When we started that, we started with an initial pilot group of four people and then created a curriculum. The American parent company of GMRTT operates the largest paramedic training college in the world, in the English speaking world and we have stood up a campus of that college. It is a bona fide college in the United States within our facility of GMRTT, and so we internally trained the first cohort. That started with 40 of our current staff. That eventually, in terms of people who completed the programme, got us to our current complement of paramedics which is 18. And so, we have a current cohort in training now, which is I believe is 19 persons. So gradually we will get to a point, I think, where roughly 50 per cent of the staff is trained to the paramedic level because there still is a need for Basic Life Support ambulances. Not every case requires an ALS ambulance.

Mr. De Freitas: So is it safe to say at some point all of the ambulances will have—as much as it may not be needed, but at some point you will have a lot more ambulances with paramedics on it. Are you aiming to get to that level in the future? Because you are constantly training individuals, which is great.

Mr. Paul Anderson: I foresee probably a deployment where roughly 75 per cent of

employment is the ALS ambulance. We could potentially go to 100 per cent, and that is a little bit excessive because not every case requires a paramedic.

Mr. De Freitas: The only other thing is we know that with doctors, specifically in the hospitals, they do training in different places. So, for example, if you have done medical school in England then you can transfer quite specifically to Trinidad. If you have to do an exam or whatnot that is fine, but if you are trained in the States then it is not that you can transfer that knowledge strictly to Trinidad and Tobago. You spoke to a paramedic training programme coming out of the US, is there any, in your opinion thus far, extra training that is needed or more specific training for dealing with medical issues to Trinidad and Tobago much like the doctors have to go through a specific training for here?

Mr. Anderson: You know the nature of the cases that paramedics in Trinidad versus paramedics in the United States are probably a little different, but EMS, the types of cases that a paramedic deals with anywhere in the world is pretty close to the same. There may be different intensities like an emergency childbirth which is more common here than it is in most places. The United States is an example. I guess there are very extreme cases of reptile bites or something like that that are very specific to Trinidad, but with that exception it is pretty standard globally. We have worked as a company with the National Training Agency to create the local credential for EMS professionals in this country, and that is aligned to—which is pretty common—the United States Department of Transportation which is the regulatory agency in United States that creates the standards of credentialing, and a person receiving training through an American institution would be very aligned to the requirements in Trinidad without question.

Mr. Chairman: I would like to recognize Ms. Ramdial.

Ms. Ramdial: Thank you. To the Ministry of Health: From Mr. Anderson's testimony there are 40 ambulances, is this adequate enough for Trinidad and Tobago; or do you think there should be more vehicles?

Dr. Parasram: Based on the response that they have been able to provide, we think it is

adequate at this point. There may be some gaps in the service, for instance, in certain territories, for example, Toco. When we had the flooding recently the vehicles would have not been able to traverse the flooding. I think we have to think beyond ambulances for those kinds of things. We have to think about the use of helicopters for reaching out, the use of voluntary networks like they do have in parts of the UK where actually regular citizens are trained in certain levels of life support and they are activated through an app network. So we have to think beyond the ambulances alone. But I think the numbers that they have in terms of their response in their reports have been adequate thus far.

Mr. Chairman: Could I ask, what is the normal response time to most of—the average response time?

Mr. Anderson: Our requirements have different response standards based upon the proximity of the ambulance to the case. So, for example, if the ambulance is less than with one kilometre, the response time requirement is an average of five minutes. Currently, that is just about four minutes for that particular category, and as these sort of bands go out the response time extends up to a maximum of an average of 25 minutes for incidents that are more than eight kilometres from the ambulance. And so, we have met every one of those for the entirety of our operation of this service.

Mr. Chairman: I would like to recognize member Baptiste-Primus at this moment.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Through you, Mr. Chairman, I would want to follow up on the question that was just asked, but before I do so, Mr. Aboud I just have one or two questions for you. You indicated in your opening statement that the Global Medical Response presents a world-class ambulance service for Trinidad and Tobago. For the purposes of even our listening public how long has Global Medical Response been operating in Trinidad and Tobago?

Mr. Aboud: About 13 years.

Mrs. Baptiste-Primus: And you would have been the Chairman of this company—

Mr. Aboud: Yes, Ma'am.

Mrs. Baptiste-Primus:—for how many years?

Mr. Aboud: From inception.

Mrs. Baptiste-Primus: From inception. I also noted that this company—and based on what you said and from my own knowledge in the past, the operations of this company, fairly pretty competent in terms of delivery of service, how many foreigners operate within the company?

Mr. Aboud: Two.

Mrs. Baptiste-Primus: I gather Mr. Anderson would be one?

Mr. Aboud: Yes, Ma'am.

Mrs. Baptiste-Primus: And who would be the other one?

Mr. Aboud: A colleague from AMR, but you really cannot check Mr. Anderson as a foreigner any more. [*Laughter*] He is married locally and I think he is a citizen.

Mrs. Baptiste-Primus: I understand and I understand where you are coming from.

Mr. Aboud: But two.

Mrs. Baptiste-Primus: I would have interfaced with Mr. Anderson many, many years ago in another capacity. But just a follow-up on the question that was asked earlier: In your response to this Committee you were asked whether there are any areas that are not serviced by GMRTT, and your response suggested that all areas have access to the service. One, can you confirm whether all rural areas, and areas with mountainous terrain, are serviced by GMRTT? I gather you would pass that on to Mr. Anderson.

Mr. Anderson: Yes, we have responsibility for all of Trinidad. We do not operate in Tobago. It is not part of our contracted scope. But a citizen making a request for an ambulance anywhere in Trinidad, we do have the responsibility to respond and we do respond. Obviously in the more distant rural and almost wilderness areas are less common than the major demographics in the population intense areas around major cities. We did have a case recently where the ODPM requested us and we sent a paramedic to Cumuto. We boarded a helicopter and there was a—I do not want to get too much into the details

given confidentiality—person with medical problem on the north coast that was not accessible by roads. So we do get sort of innovative and creative working with local partners to be able to do some pretty incredible responses.

Mrs. Baptiste-Primus: And secondly, are you confirming that under no circumstances a client should be refused an ambulance service due to his or her location?

Mr. Anderson: Not on my watch.

Mrs. Baptiste-Primus: How is the geographic spread of the ambulances? You have to cover Trinidad and Tobago, how is that spread? Trinidad, yes. Tobago is the THA. In Trinidad what is your geographic spread of your ambulances?

Mr. Anderson: There is systemic concentrate in the population dense areas. So along the East-West Corridor, along the north-south highway, and the point is it will thin out is the population thins out. One thing about EMS is that people move around, and so the call intensity and the call pattern is actually somewhat predictable because people's movement were regular. So you just have to drive on the roads in this country in the morning to know a lot of people come from, if you will, bedroom communities into Port of Spain and into San Fernando. And so, at night they are certainly more disbursed because people are more disbursed. During the day they more concentrated in the urban centres because that is where the people are.

Mrs. Baptiste-Primus: In your submission you stated that GMRTT has systems, knowledge and ability to identify developing issues before they occur and that is reflected on page 16 of your response. Could you share with us what issues GMRTT would usually attempt to anticipate?

Mr. Anderson: Probably the most common issue is to lay patient handover at the receiving facilities. We can predict that based upon prior days and the census of the facilities and available bed space things tend to back up in the casualty, and when it backs up in the casualty it backs up into the EMS system. We monitor 40 operating metrics continuously and there are hourly reporting to operational leaders on those things. So if

we see patterns start to develop with respect to unexpected call density in a particular area, we are able to react to that and adjust the deployment plan so that additional ambulances are allocated to that particular area.

We looked at both from a predictive basis call volume and call severity, and then our retrospective basis, we look at what is the care provided and is that consistent to the standard of care and protocol. We will then modify the continuing education programme from the feedback from that QA system to make sure that we have the professional competency and the clinical competency necessary. What happens in EMS is that there some things that the EMTs and paramedics do that are not very frequent, and so they do not get sort of in-practice experience. And so, those skills need to be honed and sharpened sort of offline in the continuing education programme.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman.

Mr. Chairman: I would like to recognize Mr. De Freitas.

Mr. De Freitas: Thank you, Mr. Chair. Just to ask a question because I am liking what I am hearing coming out of the statements that you are making by way of checks and balances, and the measuring that is taking place in the metrics and everything. What I want to ask, is there any kind of data sharing between your company and the Ministry? So, for example, you may notice that a particular incident is recurring a lot in a particular area, and by sharing that information with the Ministry they can then implement a programme to help reduce the incident of that particular thing. Is any data sharing going on between the Ministries? Because you guys seem to be collecting a large amount of data that helps you to efficiently run your institution.

Mr. Anderson: The short answer is yes, we have an obligation to report weekly, monthly, quarterly and annually various information on operations and outcomes to the Ministry of Health.

Mr. De Freitas: To the Ministry: What programmes are you implementing based on the great data that you are getting from the company to help reduce some of the more frequent

incidences that may be occurring that require ambulances? Do you all have any programmes that you can point to that you are developing, or have been developed to help reduce some of these mishaps that would require an ambulance service?

Dr. Parasram: So what we have—I mean I can speak to two different levels. There is what he described in terms of the handover. So when he picks up—one of the major issues he had sent over to us is there is a handover issue at the A&Es. So we actually met with all the RHAs, the directors of Health to let them know what the issue was. There was a lengthy time in terms of turnover. So going from the ambulance trolley to the Ministry of Health trolley, the RHA's trolley, there was a delay, sometimes as much as I think going into 30/40 minutes at times. So we actually set about to try to turn that around. That would have been earlier on in this year, and we actually were able to in most RHAs to get it down to as little as between 10 and 15 minutes for trolley turnover, and impacting on their end being able—because then ambulances cannot leave until we take the patient over. So it impacts on their service delivery as well. So that is one answer in terms of the actual direct way in which we interact from the reports.

Another way in terms of policy is we look at the nature of the complaints that they get. So, for instance, you would see people complaining of uncontrolled diabetes, uncontrolled hypertension, and they responding to those kinds of emergencies. So from a national perspective in terms of the policies that we develop, we can utilize their data to form polices related to NCDs, which is non-communicable diseases so that we try to limit the amount of patients that actually have those events. In the North Central Regional Health Authority they have actually started an outreach programme based on the type of cases that are seen in the populations. So they would have seen a cluster of diseases, uncontrolled diabetes, uncontrolled hypertension, based on the reports from GMRTT as well, they would now send doctors and nurses to the community to try to pick up those cases and get better control at that level so that is less cases coming back to the ENA. So those kinds are our approaches.

Mr. Chairman: I must commend you for the reports you give. I saw the detailed report that was given by the company and I am sure as you mentioned it, it does definite—it will definitely help the Ministry of Health in their policies. So we gather that one of the gaps we had was the waiting period that occurred in handing over, and this has now been somehow looked into. And so, we should get an improvement in that.

I think another gap we had was the adjunct services, like when you are going into an area to let the police services come on board also. I think I saw that in your report. So since you are going into an area and your team may have a difficult situation to manage, and having that difficulty you may need the officers there on board to help you probably apprehend, get that person into that situation because we may be dealing with a patient who may be somehow delirious for any reason, hypoglycaemic—low sugar—getting on erratic. You may a person who had a psychotic break. There was a complaint I actually had—and we would probably look at this—where a mentally ill person, his relative called the hospital for an ambulance and it was not forthcoming. They actually did not get an ambulance to come and they had to actually hold that person, tie up that person, bring that person into St. Ann's, and again the police service did not come on time.

So how are we going to improve that system where there is a dangerous situation, somebody is pelting articles at your staff, your staff is at risk and you would need that support from the police service? Are there any suggestions that you all have—

Mr. Aboud: Chair, I just want—you have put two or three things into that statement. As Chairman of GMRTT, perhaps my only function is to hear complaints and deal with them, or to see if these complaints are genuine and what went wrong? That is my job. In that comment that you were making that you got a complaint, you said the relative called the hospital. Now—

Mr. Chairman: So it was not under your—

Mr. Aboud: I want to just make a point that on many occasions when there is a national or someone from the community is dissatisfied with perhaps the response of the ambulance

service and I hear about it, we check to see what the chain of information was, the transfer of information; and everything at GMRTT is recorded and logged. This is US standards. So on many occasions you find that people are calling the wrong place.

They call the fire services. Well we call for the ambulance, but that that is not GMRTT. They call the hospital, but that is not the right place because that is not the national ambulance service. They call E99 and part of their function is to relay the information to us, but regrettably many times there is no sense of urgency. So we would get the call, but when we check the time that we get the call in our log, and the time that the person says they called for ambulance service, it is sometimes an half an hour, 45 minutes. But we cannot know that someone—I mean we are not that good yet. We cannot know that there is a problem, a national outside there is in distress and needs an ambulance service unless we get the call. And so, a lot of the information is not transmitted to us and we have deliberately not—we have had this discussion with almost every board meeting. We have deliberately—forgive me—not promoted ourselves to the national community in any big way because success brings success.

As I told you, 13 years ago South-West was transporting maximum 20,000 patients a year. Today, we are over 70,000 and sometimes the Ministry of Health will say, "Aye, what going on? What you all giving away?" The reality is that as people get more comfortable with the ambulance service and they realise it is a good service and they can use it, they call, and it our job to respond. We cannot play God. Somebody calls, we respond. So we are not going outside there—because if you go out on the road and you ask 10 people what is the national ambulance service telephone number, I do not know if five could answer you properly.

Mr. Smith: Mr. Chair, "just rell quick". It is stemming out what you said. In terms of the emergencies that come in to the hospital service, people coming in, what percentage of that comes in from the ambulance? Because people may drop or drive "dey own self". What percentage is that? I have a few follow-up questions to that.

Mr. Ali: Through you, Chair, Member I do not have that data offhand. We probably going to have to get that for you.

Mr. Smith: That is a key—because I know a lot of people drive themselves. Secondly, does it occur—and is there a percentage that when the ambulance arrives at a location and they deal with the person, is it mandatory that they have to take them to a hospital, or is it that it could be settled there and the person could go back to their home? Is there any data in terms of the paramedics and the people in the ambulance being able to service the people right there that they do not have to clutter the hospital?

Mr. Anderson: Approximately 10 to 15 per cent of the cases the incidence is not found. So somebody called, maybe it was a malicious call or something like that, and the EMTs and the paramedics respond, they check the area, they ask around, patient not found. Sometimes it is a good intended citizen who thinks that somebody is having a problem, when in fact maybe they are just taking a rest and that patient does not want to go. So that is maybe another 10 per cent of the cases where a person who is mentally competent, refuses care and transport and we obtain a refusal, maybe against medical advice and we leave that person where they are because they are of their own free will.

10.55 a.m.

The future is to resolve cases that can be resolved in the pre-hospital setting and not transport those cases. Where there is a real problem that can be resolved by us and not transport those cases to the A&E.

Mr. Smith: Okay. You spoke about something before with the time. You know, time is life in terms of some of these things. I have seen in North America where they have actually had campaigns about "get out de way", about when an ambulance is coming, what to do and so on. Will that assist you all with cutting out that time if that was done? Mr. Aboud just mentioned that people may not even know the number. Is it that we need a national campaign to educate the public that will help in these two fronts?

Mr. Anderson: I do not know if that is a decision for me. There is benefit and also counter

benefit from promoting the ambulance service and its use. The immediate reaction is you tend to get a lot of misuse when you do that. The people that are having a crisis tend to reach out, either via 811 directly to us or 999 or they ring 911 and then it goes to 999, and those cases are eventually transferred to us. So, in terms of a Trinidadian national having a real problem and being oblivious to how to reach out, I think those cases are pretty rare.

Mr. Smith: There is in the local government, because I consider and we all consider you all part of the services, there are special services. In local government, there is a meeting that they have monthly, that they are supposed to have, called co-ordinating meeting where all the services in the region come together. WASA, T&TEC, Health, PURE and so on are invited to let everybody know what is going on. Before they used to have these meetings, you would see "they paving the roads and WASA park up" waiting to dig it up right after. That is to help with the coordination. Have you all ever been invited, Ministry of Health, to those meetings with the ambulance service and is it something that will assist? Because I know sometimes in the hotspots where there are issues going on with criminals, I do not know if you all have had issues going into those areas because I know a lot of these services have issues going into those areas sometimes. Have you all ever encountered any issues in those areas?

Mr. Chairman: Excuse me, one minute. This brings the term the cooperation with the police officers in apprehending difficult patients as well as going into the hotspot areas. Another question I would like to ask, Mr. Smith, you mentioned the corporations, do they have ambulance services also? I know they are attached to them. There may be certain doctors involved but I do not know if it comes under the City Hall or—? Would anybody be able to clarify that there? Ambulance services attached to City Hall or San Fernando Borough Corporation.

Mr. Smith: No, no.

Mr. Chairman: There is a medical team there. Not your ambulance necessarily but others from their—no?

Mr. Ali: Not that I am aware of, Chair.

Mr. Chairman: Okay, sure.

Mr. Smith: But in terms of the question with the hotspots, do you all get any issues going into—?

Mr. Anderson: Yes, we do. I mean we do not have any areas, hotspots, if you will, that are off-limits. Obviously, we have heightened sensitivity about certain locations in this country. Everybody knows that. If it is a violent case and we have evidence of some type of violent situation, the job of an EMT or paramedic is dangerous enough and so we will stage in the area, in a safe area and wait for TTPS to go in and secure the area and advise us that it is safe for us to proceed. That happens with varying success in all candour. The incident of unexpected violence where we did not have any prior indication, that does happen as well and our people are trained to escape those scenes and there certainly have been times in our tenure where that has happening and people have been really at significant risk.

Mr. Chairman: So I guess—well, there is a need to have some better cooperation with the police officers. We have already established that fact. I am looking at, is there a need to have public awareness to raise awareness of the numbers. You know, probably Ministry of Health may need to do that. I know there may be some fallbacks as you say, something is so good, people may access it. But then you have a—when someone makes a call, you have a two-tier system where you can actually judge what is happening, if it is an emergency that you have to be on the scene with your acute life support team or just the basic health team, so you already have that in place when a call is in place. So what I am saying, if we are thinking about persons may abuse the system, I think that judgement could be left to your team when that call comes in. Is it an acute case that needs that acute life support system with your high-tech team or is it something that, you know, it can take a little more time?

Mr. Anderson: We do prioritize. We use an international standard. In fact, our despatch

centre was just internationally accredited to that process. It is not precise, it is based on the information that you obtain and Trinidadians are very clever people and they know what to say to get an ambulance.

Mr. Chairman: I would like to recognize Ms. Ramdial.

Ms. Ramdial: Yes, thank you. Just going back to a previous topic with respect to paramedics on your fleet to the Ministry of Health, Dr. Parasram. Are you satisfied with 75 per cent of the fleet being equipped or having paramedics on them or would it be better with 100 per cent?

Dr. Parasram: Well, I think we always have to look at the outliers when we look at the percentages. If we have 100 per cent and it depends on the availability of the ambulances, as he said, there is the likelihood that if you have 75 per cent, 25 per cent of the ambulances possibly could be in a situation where they may not be able to adequately respond because of the way they are distributed. So I mean, of course, 100 per cent would be our goal but again, you have to look at the cost benefit and you have to look at the actual occurrences of the events and make a decision based on that. So, of course, based on historic trends, he would probably place 75 per cent of them where you would have seen the events occurring, so it would have decreased that window, but there is still always a window of chance that, you know, the capabilities should be higher.

Mr. Chairman: I would like to recognize Mr. De Freitas.

Mr. De Freitas: Thanks again, Mr. Chairman. So I am just trying to envision the logistics, more specifically at the beginning period where you get the call. So, so far I have heard that there are two ways to contact or get an ambulance through direct call which is the 811 or the emergency service. Now, I know you have said that with a direct call, it is up to international standards, everything is recorded. I am not sure what the standard is for the emergency service and I guess this is to the Ministry. Do you not think it is better to have one that is put out to the population? So for example, if we are going with 811 so that people can call them directly so that the recordings are there and you can get that data and

you leave the emergency numbers alone for now or they use that as a secondary emergency number, do you not think it is better that way? Because in the States, it is 911 and that is it. All right, I guess they could call an ambulance directly but everybody knows 911. In Trinidad, we know it as the emergency numbers that we have. We are now hearing there is an 811 but it seems that with the 811, they can assess better the need for an ambulance at that point.

Because look what is happening now. We are hearing that we as Trinidadians are clever and we know what to say to get an ambulance but that is wasted time. That ambulance could have gone to somebody who truly needs it and that really starts off with the point of, you have two numbers that you are working with. So if we have one number that everybody knows and subscribes to and that standard is set to the same international standards that the direct service is using, then we can properly treat with missed calls—I would call them mishaps or missed calls—where time is wasted in terms of ambulances going to situations that they did not really need to. So what do you think, Ministry of Health?

Mr. Chairman: Before Ministry responds, I want to agree with Mr. De Freitas that you know, sometimes you are reaching out for an ambulance, they may call the hospital and they may get one response and you know, sometimes they may call outside St. John's and people go down that list and they do not know which ambulance service to call and I will give a scenario that happened recently. But before I go to that, we actually would need one number that people can call and that could be despatched to, you know, so this is something, I think, we have to look forward and maybe in our report, that we may want to recommend. Yeah, good.

Mr. Ali: Thank you, Chair. Member, we do advertise the 811 number. I take the point of the Committee, maybe it needs to be improved upon, maybe more widely disseminated but it is available and we do have it advertised. But yes, there is definitely a need to consider having the population more aware of the 811 number. Just to say that just to come

back to Mr. Anderson's point, even though they have the 811 number, that does not necessarily reduce the likelihood that those who do not need the ambulance service will not still access it.

Mr. De Freitas: No, no, no, they will, you know. You cannot stop them, you cannot change their behaviour. What I am saying is that based on the standards at the despatch, they will be able to pick up on trends and be able to put things in place to properly deal or reduce those types of calls. I do not know what the standards are for, let us say, the 999 service but we are hearing that there are international standards for the 811 service so every call is recorded and you can go back and audit those calls over a time period and say, well listen, people are getting smart, this is what they saying, this is what they doing, and you can change the types of questions that the despatcher would ask that individual, to sort of decipher out exactly what is happening at that point in time. In other words, there is a potential to make that particular service better and that is why it is important to ensure just like—and to use the 911 example, everybody knows 911, even outside of the country. So much so, I think, you said earlier that people call 911 and it goes to the 999. So it is that level of widespread knowledge of the number that is required and then the checks and balances and the measuring and the backend that is needed to reduce the incidences where you waste ambulances' time.

Mr. Chairman: May I ask the members of the GMRTT, the certified emergency medical despatchers, how many despatchers are currently employed at your company?—and please outline the training that was undertaken by these despatchers.

Mr. Anderson: All right. The certified emergency medical despatcher is a credential from the International Academy of Emergency Dispatch and they have standards. It is a certification, it is a telecommunications professional. So we have 24 full-time and then there are some of the field staff that are cross trained as EMDs in addition to being an EMT, and some of the EMDs started as EMTs and that is to provide relief for, you know, when full-timers are on leave and that sort of thing. We do have a few part-time but that

is pretty rare.

That training is—they go through a—we bring a person from the academy to Trinidad to conduct the certification training. There is an examination at the end of that. They have to perform on that examination to a passable level and they are issued their certificate. They then go through an on-the-job training programme with our systems because that is not part of that certification. So we have a very, very sophisticated computer ID despatch system that they will go through a period of training with a senior member of staff and then they are monitored in the despatch centre so that they are sitting side by side with an experienced person until they develop their own workflow, and then they are released to function independently as a despatcher.

It is a globally recognized standard and it includes the process for triaging and prioritizing incident priority based upon the presumptive level of severity from the interrogation of the caller. And so, it is a fairly elaborate process but it is all computer-driven and so there is not a lot of freelancing that goes on. So when the despatcher hears, you know, the first person, the first question they ask is: "Is the person breathing?", and if not, it stops there and they start giving what is called despatch life instruction. And so they will walk somebody through mouth to mouth resuscitation, CPR, emergency child birth and it is all scripted for them so they do not have to make up anything. And so a layperson can be trained to be an emergency medical despatcher and we have brought people in with no medical experience whatsoever and they have gone through the training and they function very competently as an emergency medical despatcher.

Mr. Chairman: I commend your company for introducing the despatchers and that level of competence here, and I know the gold standard, you have set the gold standard into this and this is very commendable. I have seen some of your services offered and it is first class, it is world class, you have that standard there. I am saying if I collapsed, I would rather one of your paramedics see me than an intern now graduating because the level of training they get—and I am sure Dr. Parasram would realize, we will forget some of those

basic trainings. And I have actually seen one of your persons who had that level of training give magnesium sulphate to a child with asthma and this is something I would hesitate to do as a physician, so I commend you for that.

Now, one thing I need to ask the Ministry of Health officials: Are there any despatchers trained? Like, if persons call the health services in Port of Spain hospital or whichever hospital, do they have that level of training and if not, would you be willing to somehow train those officers or direct them to the relevant 811 number?

Dr. Parasram: Well, I do not think at the hospital there are despatchers trained, we are really—we have operators, more telephone operators so they are telecommunications background. They would be aware of the requisite numbers to send persons on to, but the function at the hospital is completely different from the function of an ambulance service. So we have to, again, look at the calls that we have been receiving, look at the frequency, and we can review it and see if there is a need in particular areas. But as of now, the RHAs have not indicated to the Ministry that there is a need in that particular area. But of course, seeing that there is a programme in place with GMRTT, if there is a need, we can liaise with them to actually fill that gap.

Mr. Chairman: Because I still see people calling a hospital first to get that input, eh, so if in that timeline, somebody could guide them, you know, somebody has an emergency, what to do in that situation, it may be very beneficial.

Dr. Parasram: And I mean, in a hospital setting, there is always the ability to transfer to a department where there is a physician or a nurse that can assist in terms of calling, if there is that level of emergency as well.

Mr. Chairman: But you may have to put that in place, eh.

Dr. Parasram: Yes.

Mr. Chairman: I would like to recognize Mrs. Jennifer Baptiste-Primus.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Staying with the Ministry of Health, this question is directed to the Permanent Secretary, Mr. Ali. If you feel you do

not possess the information, I guess you will pass it on to a member of your team. The questions that were sent, the responses that this Committee got with particular reference to section 15 of the Act where the Minister of Health has the authority to appoint inspectors or an inspection team to visit and inspect the facilities of GMRTT, the response was that the inspection team has not been appointed to date. Could you share with this Committee what may be the reason or reasons for the non-appointment of inspectors or the inspection team? I refer to page 35 of your response.

Mr. Ali: Thank you. Chair, through you, member, so we have not invoked the licensing process at this point. We are in the process of licensing the providers. What we do have in place at this point would be our Internal Audit Department. They do visit the facilities of GMRTT and they do provide some level of audit at the provider's facility.

Mrs. Baptiste-Primus: While one appreciates that, Mr. Ali, you would agree with me that the framers of the law would have put in that specific requirement for a reason. So that, what is the time frame the Ministry is working with to ensure that section 15 of the Act is implemented?

Mr. Ali: Chair, through you, again, member, we are looking at the first quarter of next year.

Mrs. Baptiste-Primus: Okay. Mr. Chairman, I would like to direct these two questions to GMRTT. On page 2 of your response, with regard to the las procedures, in terms of increasing or decreasing the fleet, you indicated that you intend to increase the fleet by 20, by the second quarter of fiscal 2019. Could you, in that context, provide the Committee with an overview of the procurement methodology employed by GMRTT?

Mr. Anderson: Sure. Purchasing ambulances starts with the purchase of the panel van, the chassis, and so we have requirements for that. Our preference is an automatic transmission right-hand drive with sufficient engine displacement to handle the load. That whittles it down pretty severely. We will then choose a fabricator. In the past, we have locally converted vehicles that we have sourced through a local auto-dealer and that was

successful. Our most recent procurement, I attended, as I do every year, a conference called Arab Health which happens to have the largest medical—

Mrs. Baptiste-Primus: Sorry, the conference is termed?

Mr. Anderson: Arab Health, it is in Dubai every January. The reason why I go, in addition to heading one or two sessions, is that it is the largest trade exposition for health care in the world and so every supplier from every corner of the world is represented there and there are probably 20 ambulance builders. And so I met with some that had a product that sort of met my sniff test, if you will, and then we went through a process of negotiating with them, a builder, it happens to be, in this instance, a fabricator in Dubai that has the Toyota Hiace chassis and a very, very high standard of fabrication. I actually have a person in Dubai right now that has completed the inspection on the completion of the build. I think, perhaps, even as we speak, those ambulances are about to be shipped by sea to us and then we will receive them here, clear them from the normal importation controls and then finish the outfitting and put them in service. So our procurement is, as a private agency, we negotiate with our suppliers and then our goal is to have a longstanding relationship with a builder, with a fabricator so that we could continue to perfect that.

Unfortunate in that our American parent operates 7,000 ambulances and buys 2,000 ambulances a year, and so, they have a full-time staff. We actually have a fabrication facility in Texas, and so our future might be to create a specialty vehicle. We are under obligation under our contract now, to purchase another 24 ambulances that we will do some time in 2019, and to deal with some of these issues that are special. I would like to think that a portion of those 24, perhaps 12 of them might be a different type of vehicle that we can fabricate at our facility in Texas where it is a high-wheel base, something that can ford flood waters and things like that. A more rugged, perhaps more rough ride but something that can deal with sort of the terrain, extreme circumstances. It would be nice to have that in the fleet and I think we have an opportunity to do that.

Mrs. Baptiste-Primus: Based on the information that you have just shared, are those

vehicles going to be new vehicles or pre-owned vehicles?

Mr. Anderson: They are all new.

Mrs. Baptiste-Primus: So your company has never engaged in purchasing pre-owned vehicles?

Mr. Anderson: We did once. Out of desperation, I happened to find somebody that was selling three used panel vans and so I snapped them up and had them converted locally to ambulances. They served us for a good four years.

Mrs. Baptiste-Primus: From which country do you all purchase vehicles, ambulances?

Mr. Anderson: They are mostly Asian built. We have had not good success with South American built. I will not mention the brand because that is not fair, all right, but it was a South American fabrication of a European brand. We did not have really good success with that. We did, through the Ministry, when they were purchasing the ambulances, we did acquire an English brand and they have served us well. The Asian chassis I think performed better to the terrain of Trinidad because the power-to-weight is a more generous ratio because we do not have cold weather here, we do not have snow and so our roads tend to have a steeper pitch than you will find in Europe, and so having better power-to-weight ratio allows those ambulances to transverse the steeper inclines in which a lot of our patients reside.

Mrs. Baptiste-Primus: And just shifting the focus a little, with respect to the licensing of GMRTT in providing the national ambulance service, is GMRTT in possession of a physical licence to operate and if yes, how often is this licence renewed?

Mr. Ali: Maybe I can answer. GMRTT is not in possession of a licence, member, through the Chair. As I mentioned earlier, we are in the process of licensing providers. So what currently exists, GMRTT is managed through the contractual arrangement, that is what governs the relationship between the Ministry and GMRTT at this point.

Mrs. Baptiste-Primus: Through you, Mr. Chairman, and Chairman of GMRTT, from where I sit, that is a gap in the operation of this company. I mean the company is well-run,

delivers a good service but this issue is one I want to strongly recommend that urgent attention be paid and that the necessary licence be granted to GMRTT. They are providing a national service, the law requires it and therefore, Ministry of Health, you all need to step up to the plate.

Mr. Anderson: I want to make it clear, as a company, we will apply for the licence as soon as there is a process to do so. We do not have any qualms or reservations about that.

Mrs. Baptiste-Primus: That is why it is not directed to you, Mr. Anderson.

Mr. Anderson: Thank you.

Dr. Parasram: Just to add, in terms of licence, we are in the process of doing the licensing of the authorities but in terms of the individual vehicles, we do inspect every single one of them and make a recommendation to the Ministry of Works that they can licence in terms of ambulances inspected by a physician that is trained in the field and there is a checklist that is available to ensure that the ambulances are sound so there is that monitoring that occurs already.

Mrs. Baptiste-Primus: That is a secondary—

Dr. Parasram: It is a secondary. Yes, that is right.

Mrs. Baptiste-Primus:—mechanism that the Ministry has put in place and I understand, but after GMRTT being in this country for 13 years, I think the point has been made?

Dr. Parasram: Yes.

Mrs. Baptiste-Primus: Okay. Thank you, Mr. Chairman.

Ms. Ramdial: Just to follow up on member Baptiste's question, how soon before this regulatory committee is formed under section 4 of the Act?

Mr. Ali: We will have that done before the end of the calendar year.

Mr. Chairman: So am I to understand that we are operating outside the law with our ambulance service? Because if since 2009, we were mandated to have licence, if someone takes legal action, would that have any sort of consequences?

Ms. Roopchand: Chair, we recognize that we have not been licensing the service

providers and we do take your point and we have started the process. We needed to put the regulatory committee in place, we have gotten nominations from the RHAs and the Minister has his reps, we are only waiting on one which is National Security, and as soon as we get that, the committee has do to the recommendation with respect to the provider licence. So we expect at least during December. We have also written to all providers indicating that they are to make an application to the Ministry if they are in the business of providing emergency ambulance services.

Ms. Ramdial: So how many providers in addition to GMRTT exist, who you have written to?

Ms. Roopchand: At this time, it is about eight.

Ms. Ramdial: Eight?

Ms. Roopchand: Yes.

Mrs. Baptiste-Primus: Chairman, permit me, that is a lot. I did not think there were so many providers. Who are they besides GMRTT?

Ms. Roopchand: We have small providers like Archangel, St. John's.

Mr. Chairman: Red Cross also would—

Ms. Roopchand: Red Cross, Eastern Divers. So we do have a few at a much lower scale.

Mr. Chairman: Yeah, Petrotrin has a fleet of five also, and then there is the private hospitals would also have their cadre. But one thing I want to ask though, just back-tracking a bit, could you tell me the cost of outfitting, Mr. Anderson, one of your ambulances, fully equipped with all your equipment?

Mr. Anderson: A million dollars.

Mr. Chairman: With medical equipment and everything, a million dollars. Right?

Mr. Anderson: Yeah.

Mr. De Freitas: TT?

Mr. Anderson: TT.

Mr. Chairman: Well, I would hate if some patients, you know, who may get in there,

aggressive and violent, and gets loose there, so I mean, you have to have some way of restraining and protecting. Yes, question?

Mr. Smith: Yes, Mr. Chair, through you, you know we also stream online so we also try to give the people who are listening and watching online the benefit to get some of the questions in, so I was just handed one. One of the questions that came from the web is, you mentioned that there were 16 paramedics involved, somebody asked where exactly are these 16 paramedics assigned to, if it is a specific area? And then I will come to my question.

Mr. Anderson: They are split between our north operating-base in Port of Spain and our south operating base in La Romaine.

Mr. Smith: In terms of where your head office is in terms of the starting point, because Trinidad is a spread-out area, I do not know if you all are in Port of Spain, is it that these vehicles start at one point or do you have offices throughout the area that you will have an advantage moving out? That is the first question. If you could answer that.

Mr. Anderson: We have three operating centres in north, south and east.

11.25 a.m.

Mr. Anderson: But that is just where the employer reports to work. When they go available from that, at the start of the shift, they could be sent on a call or sent to cover an area almost anywhere in Trinidad. We try to minimize that, but things happen and it is not uncommon for someone to start a shift, say out of La Romaine, and end up six hours later on a call in Arima. That certainly does happen. They do not start to Arima from La Romaine, no.

Mr. Smith: I know the public would have wanted to know where you all start from and move up, but it is a moving momentum.

Mr. Anderson: It is called a fluid deployment system.

Mr. Smith: Yeah, yeah, yeah. In terms of, you mentioned the competition, do you all do other private events as well or is it specifically just to the Government?

Mr. Anderson: Very rarely somebody would make an enquiry and ask for—I cannot think of a single case where we have done a private transport. Sometimes somebody has an event.

Mr. Smith: Like a sports day or those kind of things.

Mr. Anderson: A lot of those we do free of charge. We have to be very discriminating with those. Most of the time, when somebody calls and wants to hire us, our rate is much, much higher than the other providers, and so they tend to price- shop and use somebody else.

Mr. Chairman: So, part of the gap I mentioned was the accessibility of mentally ill patients trying to get to the hospital. Is there any level of having mental health officers or persons trained in mental health? I think part of our challenge now, we know mental illness is increasing in the country. One in four persons may have it and you may have more calls to apprehend certain persons—persons who may be on drugs, persons who are having a meltdown out there, psychotic patients. What sort of training would your staff have in apprehending those persons? And again, that is one question. And the other question is the Ministry. Is there anything you could suggest that we can help that situation, in terms of joint effort with mental health officers in the area to apprehend those persons?

Mr. Anderson: The EMTs and the paramedics are trained in what we call behavioural emergencies, and part of that includes restraint of the patient, appropriate and safe. One of the benefits of the paramedic level advanced life support is they can use physical restraint and chemical restraint. And chemical restraint is, I am sure you are aware, the preferred methodology. Because it is safer for the patient and for the care providers and downstream when we hand that patient over to the receiving facility.

Mental health emergencies and behavioural emergencies are a challenge for every EMS system in the world. I know of a few projects that our company in the United States is involved with, of specialty ambulances, that are staffed with a mental health professional that handle those cases. That is very costly. But it is probably something to think about. In

Trinidad, there are half dozen or so of those. One of the big challenges we have with mental health cases is when they occur after hours, and they tend to occur after hours.

Mr. Chairman: For the officials in the Ministry, we may have to have a roster with mental health officers in each area that could be deployed. If they are called out, some level of payment could be given to the mental health officers—because each area—we have about 27 psychiatric health centres scattered throughout the country and there are mental health officers assigned to each of those areas, probably three or four. So, what I am suggesting, we may have to make a system where we put them on a roster, where they could be called out, and probably paid when they are called out, to assist your services, in case they are called out.

Dr. Parasram: Yeah, I think that is a reasonable suggestion because after hours, one, it is difficult to access the mental health officers who really act under the Mental Health Act to actually, in collaboration with the police, so one gap is definitely accessibility of the mental health officers to get to the cases. So we have to put something in place. If it requires overtime, we have to consider it as well. I think the increase in number of mental health officers may need to be looked at as well. But collaboration with the police is an essential thing that we have been trying to work on, through the mental health unit at the Ministry of Health, through mhGAP training as well, to see if we can actually get them a little more amenable to these kinds of illnesses and emergencies.

Mr. Chairman: Our duty is to solve some of these problems that have suggestions. Yes? So all those ideas together, we would have to put something in place.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. This question is directed to the Ministry of Health. Perhaps the Director, Health Policy Research and Planning, may be useful in this regard. The Committee was informed that the Internal Audit Department conducts periodic assessment of the financial payments made to the contractor and claims. Can you confirm when the last assessment and reconciliation of services provided by GMRTT was conducted by the Ministry of Health?

Mr. Jaisingh: Thank you, member, for the question. The audit is ongoing, since the commencement of the contract since 2015. It is an ongoing process of auditing because the submission of reports is, as GMRTT indicated, every month and every quarter. So the audit is ongoing as the process continues.

Mrs. Baptiste-Primus: Mr. Director of policy planning, I do not understand what you just told me. What does it mean? The audit is ongoing. That is public service language that I am very familiar with. What does that mean? Is it that the audit is 50 per cent completed, 60 per cent, 25 per cent? So the Committee can get a feel.

Mr. Ali: Chair, through you, maybe I can just explain a bit. We have two aspects at the Ministry. You have the financial aspect when we are invoiced by GMRTT. Our audit department, as I have said, they would review those claims and recommend payments accordingly. That is part of the audit function.

The other part of it—and Mr. Anderson mentioned it, the monthly reports. When we get those reports, we do not just use them because of the data. We will also validate the information in there. That is not done by the Audit Department. That is done out of the Office of the CMO, with his technical staff. So that is the other part of the audit function. Maybe the word "auditors" may be misleading. But let us say the review function. I am not sure if that helps.

Mrs. Baptiste-Primus: Okay, I am pretty satisfied with the addendum that you gave there, but who at the Ministry verifies that the Ministry is getting value for money? We know that the company, GMRTT, has been around. We know the perception is, in the minds of people and even those of us who sit here, that GMRTT delivers an efficient professional service. But that is not the issue here, the issue is from the Ministry's point of view, who is responsible for verifying or ensuring that the Ministry is getting value for money?

Mr. Ali: The Chief Medical Officer.

Mrs. Baptiste-Primus: Yes.

Mr. Ali: I am saying, the answer being the Office of the Chief Medical Officer, so the

certification—

Mrs. Baptiste-Primus: Right, could you share with this Committee, how do you go about, you and your team, how do you all go about measuring value for money?

Dr. Parasram: We get the reports. The reports are actually normally collated through the directorate of health policy and planning. So it comes to me. It goes down to health policy and planning. They actually look at the reports, analyze them to some extent, send them up back and we look at the trends. We look at the number. Basically, the outputs we look at and the number of cases they would have seen, the types of cases over the period, which is usually a three-month period at a time. So we certify, based on a three-month period of reporting. So that is verified, using the RHA framework as well. So if I have any concerns, in terms of transfers, we can verify it.

Because the forms that are normally given by GMRTT at handover is also stored at the RHAs. So there are triplicates of the form. So I think GMRTT stores one and there is one at the RHA as well and there is another form that goes back. So we can verify through that mechanism that has been going back to the RHAs to ask them, from time to time, to do spot checks to see if they match back in terms of the patients that are sent to us. So there is that verification mechanism that we have been using on a quarterly basis.

Mrs. Baptiste-Primus: Okay, thank you. And finally, has the Ministry, are you all in a position to calculate the dollar value for each emergency ambulance response? If you are not in position to forward the information now, you can forward it to us subsequently.

Dr. Parasram: Yes, so we have the total number of cases that were responded to. We have the total contractual sum. So we can calculate it and get it to the Committee.

Mrs. Baptiste-Primus: Thank you, Mr. Chairman.

Mr. Chairman: So, I think we have clarified a bit that we may have the greater collaboration for the Ministry of Health, in terms of when they enter the hospital setting, the handover time, as well as the collaboration with the police. We will have to look at the police officers and mental health officers.

There was an instance, I just want to raise, that a member of the public raised with me. I was actually attending a function at Medulla Art Gallery on the 27th of October, with a former Sen. Rahul. Someone had a seizure and this was their response—a little synopsis of what happened.

> It took over one hour from the time we called the ambulance, 811, to the time she received medical attention from the emergency services, 15 seizures later.

Now, she was there and I came in close to the end. She actually, 15 seizures later, the young lady received some attention. It is also to be noted that, at the time, we called 1558. I do not know which provider service that is.

> There was one ambulance available to respond, which was coming from Arima. We called a total of four times and were told on two occasions that the only available ambulance was in the east. This means that for the entire period of one hour, there was no emergency response ambulance available to service the entire stretch from west to Arima.

Why I brought this point in, you may have, I mean, you have excellent services, you have excellent ambulances, good service. I mean, we have come a long way, but we still have little instances like this that we may have to now see what is happening there. So, do you have any response about this scenario?

Mr. Anderson: I mean, it is hard for me to comment on a specific case like that. I could certainly look it up and find it. But it is oftentimes misleading. This sounds critical and I do not intend it to be—is that when you are there at an emergency, I mean, seconds become minutes, minutes become hours. If we had a one-hour response in Port of Spain, I would have heard about it.

Mr. Chairman: The thing is, I was at that function. I did not know what time they called.

Mr. Anderson: Right.

Mr. Chairman: But when I reached to the end there, I would say it is about half hour. I was there at that function and she was there. Now, two numbers they called there, right?

So what I am looking at, if they are not getting through to you, is there any backup services that they could have called? I mean, there are the other ambulance services. Because there is another number there. So we have to have, in my opinion, a backup service, a second line. You know, if you are not getting through to you, there is an emergency. I would hate if there is an emergency and they are making various calls and not getting a response. So I can, you know, any sort of comments?

Mr. Anderson: What is happening now is we are experiencing substantial delays in turnover at the institutions and it does happen where every ambulance in Port of Spain is at Port of Spain General Hospital waiting to offload and that puts a stress on us and the Ministry is very well aware of it. The RHAs are very well aware of it. It is a capacity issue. And when it happens it tends to extrapolate, right? I mean, one delay becomes now two, three, four and then suddenly you do not have anywhere to take a patient and offload. And so, and until the entire system can surge, is that that causes an imposition on our ability to respond. Resolving that is effectively like going out and buying million-dollar ambulances and putting them on the road.

Mr. Chairman: For the officials on the Ministry, is there a system where if their ambulance calls the Casualty Department, there is a prep team waiting, a response team waiting, to receive someone from an ambulance setting? Because, I mean, you guys do a tremendous effort of resuscitating the equipment you have. And you bring them up to a point to Casualty. We are seeing a delay there. So the cost that we are putting out to your company, I think it is like $123.3 million, I think Ministry of Health pays you.

So, let us say you have provided such an excellent service, you have brought somebody up to the hospital level but there is a delay now of 20/30 minutes to get them just on another trolley to go to that Casualty setting where there may be another delay. So I think somehow there is a little gap there we need to know. Is there a call-in system that, you know, you now identify the emergency, you have actually implemented the correct standard of care, but when you reach to the hospital setting now, you may have that care

not being up to standard or that level of care not being fast enough, the haste in it? Comment?

Mr. Ali: We could defer it to Dr. Sinanan, in his capacity as head of department for San Fernando A&E?

Mr. Chairman: Yes.

Mr. Ali: And he would have been one of the heads of department that would have worked when we had the issue with the trolleys and tried to resolve the issue. So maybe he could let you know what happened at San Fernando.

Mr. Chairman: Sure. But it is not just the trolleys. There is the issue of having your team ready to take somebody. So somebody has a heart attack or a stroke, you have a team willing and ready to take the second-line management very quickly.

Mr. Sinanan: Morning, Chair.

Mr. Chairman: Morning.

Mr. Sinanan: And yes, the short answer to your question is yes. Once they call in, we do take over those patients immediately. Care is not delayed. So even though the turnaround time for their equipment might be 20 minutes/25 minutes, that does not affect the patient care. It just means sometimes we may not be able to transfer from their trolley to ours, but we will initiate care on that trolley if necessary.

But in terms of the critical care, we worked with GMRTT over the last year or so to set up something called ESChat, which is one of their systems that they work with us to put on to our computers in the emergency department. So there is a method then that they can communicate, "I have a level one transfer", et cetera, "with an ETA", estimated time of arrival, and then we will get ourselves ready.

Mr. Chairman: And is this available in other hospitals like Port of Spain or Mount Hope also?

Dr. Parasram: Yes, the call-in system does apply to all hospitals, to varying degrees in different areas.

Mr. De Freitas: Just to ask a question: So if one of the public hospitals is not available, in terms of a turnaround time to transfer, do you all take them to only private hospitals, or is that a no-no? You do not go to private hospitals at all, you only deal with the public hospitals?

Mr. Anderson: There has been some vacillation of that. The prior administration instituted a policy to allow us, on patient request, to go to a private institution. That was never memorialized into formal policy and that since has been redacted.

Mr. Smith: Through you, Chairman, I know we are reaching the end, almost to wind-up. You all started off stating how you all are affiliated to the number organization, in terms of ambulance, in the US—how do they rank worldwide? And, two, we like to calibrate and benchmark with the other islands, which we are a part of—are you all, or maybe not you all, or the parent company doing the same facility in other Caribbean islands, and if so, which islands?

Mr. Anderson: In the Caribbean, we only operate in Trinidad and Tobago.

Mr. Smith: In terms of number one in the US, how is that calibrated and what is the competition like, and how does it calibrate worldwide, in terms of where you all rank?

Mr. Anderson: Our two accreditations really speak. I mean, in 2008, we were the first EMS agency outside of North America, so certainly the first in the developing world and in this region to be accredited by the Commission on Accreditation of Ambulance Services. It is the gold standard. In fact, it is a point of pressure with me and that agency, because the map they use on the website is only North America. So we did not make a map, and I am threatening to pull the accreditation until they get a global map, so we could at least appear on the map.

That speaks volumes, and I did that as CEO in 2008, in building this company and leading to that. It took us two years. So we started in 2006. That forced us to fully develop the organization. So things that were not on the front pressure cooker, it required us to go into the corners of the organization and build capacity and formalize policy. So it is a good

blueprint to create a world-class agency.

With respect to the other Caribbean islands, we have surpassed all that I am familiar with. Aruba probably comes closest, but they do not deal with anywhere close to the volume and severity of the cases that we deal with.

Compared to the United States, all the way back in 2006, we retrained all the staff that came across from SWRHA and a point of pride for me is that when they took the US National Registry exam, they out-performed the average in the United States for that year. And so, you know, those two things, in addition to the accreditation and dispatch, to me give validation that when we say we are a world-class agency, we are. I know just anecdotally from being in this industry for 30 years, is that GMRTT in Trinidad is a very, very close sibling to an AMR operation in a mixed urban/suburban/rural and wilderness operating area anywhere in the United States. We stand up very, very competently to the best that our company does.

Mr. Chairman: Speaking about training, the Medical Director of Clinical Quality Assurance, do you have somebody in that post presently?

Mr. Anderson: Yes, we have a Medical Director.

Mr. Chairman: Would you mind naming that member?

Mr. Anderson: It is Dr. Simone Aboud. She is new.

Mr. Chairman: —because I know the other doctor, Dr. Singh had left.

Mr. Anderson: Yeah, he migrated for personal reasons.

Mr. Chairman: Good, so you have somebody in that place to do that training, because I was very impressed with the training that was given by your previous Clinical Assurance Director.

I need to ask one question: With our input of nationals from Latin America, do you have any sort of—you know, there are the phones now where the apps, if there is a language problem, Spanish or even Chinese. We had a Chinese national who recently collapsed and the doctors could not make head or tails what was the language, what was

being transmitted, how to ascertain what was the problem. Do you have any apps that those officers would have to have that language barrier somehow dealt with?

Mr. Anderson: We do have that piece of technology. It is very clumsy because it is hard to detect what language you are trying to translate. The automatic translation technology is not advanced, I think, to the point of it being reliable in an emergency setting.

One of the recently added enquiries we do at hiring now is check for Spanish speaking and Spanish language skills. And we have it on our training plan for 2019, for a rudimentary Spanish medical language course. So the paramedics can ask simple questions like: Point to where it hurts. Are you having trouble breathing? That sort of thing. There is no way we will ever get to a point of being able to handle, in an emergency setting, any language that there is. And again, you may recognize it is an Asian dialect but you do not know which one. And so it is very difficult. And so the paramedic just responds to other cues about patient condition.

Mr. Chairman: But I mentioned there is a simple WhatsApp on your phone you can get now and you get some translation. So, this may be something to consider for your personnel to have.

Another question I would like: Let us say somebody calls your ambulance and they collapse, is there any sort of link with the Bmobile/Digicel, that if that call is not completed, you can now trace where that location is?

Mr. Anderson: We do not have—it is called ANI/ALI. It is automatic number identification and automatic line identification. The telecommunications in this country has not advanced to that point. For example, in the United States, the cellular providers have been legislatively required to achieve the same number identification location on a mobile phone as on a fixed line. Because all that technology was created when everybody used landline telephones, and so it was very easy to triangulate on spot where the phone was. They have been mandated, in terms of their licensing, service operators in the United States, to create that same capacity. We do not have that yet. We do use GPS technology,

but the minute that capacity is created in the telecommunications industry, our systems are capable of taking that in.

Mr. Chairman: So probably the Legal Advisor, Ms. Bhabie Roopchand, may look into somehow if we could put that into legislation—telecommunications link-up— because I think that is vital if a patient collapses, you have no way of knowing where that patient is located. So I suggest that.

I must commend you for thinking ahead about the flooding issues and trying to equip ambulances that may be able to go into flood areas. But you have stated that your staff is engaged once per year in focused education programmes, centred on disaster response. Please confirm who provides this training and when was the last training exercise conducted. And also, could you explain how you modified your operation in the immediate aftermath of the national flooding disaster of October 2018?

And in cases of mass casualties, like vehicular accidents, what action plan is to be implemented? So three questions, I will repeat it as well. The first thing, let us go. Who provides this training for any sort of disaster response? When was the training exercise conducted?

Mr. Anderson: It is annual training, so it would have been done sometime in 2018. I do not have the specific date. The training is provided by our education department; it is through that college that we stood up a campus.

As it relates to the floods, that is always a challenge because it is a challenge of access. Our efforts are coordinated with ODPM to bring other assets that can bring the patient to us. It gets pretty creative and there is a lot of ingenuity.

During the floods, probably the biggest problem that we faced was when the north/south highway was closed and the country was bifurcated. We actually had to hire a boat to bring staff from San Fernando to relieve the dispatchers. And then we had to put that dispatch team in a hotel overnight so that they could report to work the next day after adequate rest. I was really worried if that was a prolonged problem because—we were

fortunate that by happenstance we had the right number of ambulances on both sides of that divide. But if I started to have vehicle problems or something south, I would not have any way to redeploy ambulances from north. And so, it is good that we have things dispersed around the country to begin with, but that circumstance stressed this entire country, including the ambulance service, without question.

Mr. Chairman: So, after the flooding, is there any way you have modified your operations? I mean, you have planned to get the new ambulance services, but any way you have modified your operations?

Mr. Anderson: It is not really necessary for us to modify because the medical emergencies are going to occur. Certainly during a national disaster, we call out additional staff and that sort of thing and we scale up to our maximum capacity but most often mass-casualty incidents do not give any warning, and so it is just an adaptability of being able to redeploy resources for something that maybe requires five ambulances. Those happen with some frequency, and so all of our personnel are trained in their role in the incident command system, and I would say the coordination on the ground between agencies of national security, us, ODPM, when they get involved. On the ground it works pretty well, I would say.

Mr. Chairman: You also indicated that a significant deficit has grown between the fees for service invoice by GMRTT to the Ministry of Health and the payment remitted to the GMRTT by the Ministry of Health. What was the size of this deficit for the years 2017 and 2018?

Mr. Ali: Chair, what that speaks to, the contract speaks to any responses made over—the contracted monthly sum is invoiced to the Ministry separately. We do have an audit process to verify those invoices. That has been ongoing. We have settled two quarters of that. In terms of the quantum, I do not have the quantum available.

Mr. Chairman: So then there is a flat monthly fee paid out, but if there are any additional, for a certain amount of services offered. But beyond that, if there are additional

numbers, you pay by invoice. Is that the way things run?

Mr. Ali: Correct, yes.

Mr. Chairman: Okay. Have you ever considered other services, other provider services? Would people say that there might be a monopoly in this system? I mean, could you give us an input, because I think there are other ambulance services like Red Cross, St. John's? They may not be up to mark, but is there any way that we could look at cases of other services being available also?

11.55 a.m.

Mr. Ali: Chair, yes we can look at that. We can look at that when we are reviewing the current contract, because we do have a contract with GMRTT at this point in time. That is something that we can definitely look at, at the Ministry. Yes.

Mrs. Baptiste-Primus: How long the contract is for?

Mr. Chairman: When would your contract be—how long is your contract for? Was it from 2015?

Mr. Ali: Yes, five years, to 2020.

Mr. Chairman: Okay.

Mrs. Baptiste-Primus: So, just permit me, Mr. Chairman. So the contract is in five-year cycles?

Mr. Ali: The current contract is a five-year contract.

Mrs. Baptiste-Primus: Okay.

Mr. Chairman: Now, we looked at the operation of the GMRTT and the Ministry of Health. Now, Ministry of Health, do you have your ambulance services up and running? Because there are ambulances, I know, with the Regional Health Authorities. Are they functional? Are they well equipped? Can you give me a feedback on how many ambulance services there are available?

Mr. Ali: Chair, so I can start the answer and the CMO will take it from there. In terms of the ambulance service, the service provided by the RHAs is not an emergency ambulance

service. All right, those are really for inter-facility transport—

Mr. Chairman: Sorry.

Mr. Ali:—inter-facility transports between hospitals, health centres, what have you. They do not respond to calls from the public. All right. In terms of the numbers, we currently have 47 ambulances in total across the four RHAs.

Mr. Chairman: And could you give me—are they equipped, because according to the Act, right, the minimal medical equipment for basic land ambulance— you know, I want to know, these ambulances that you have an inter-hospital services, are they equipped according to this Act with the basic requirements?

Mr. Ali: Yes, they are.

Mr. Chairman: I mean we can put that request in writing if you do not have—

Mr. Ali: If you want the information. As I said, the requirements for the basic life support.

Mr. Chairman: Basic life support, equipment, defibrillator, everything is in it, right?

Mr. Ali: Yes.

Mr. Chairman: There was an incident, I got another complaint about an individual—now this does not have to do with the Ministry of Health or probably with your company, but it is something that it is there, it occurs. It happened in the airport actually where someone was travelling, he got a heart attack, they called out the ambulance service from the Airports Authority, I think it was, and the complaint was there was no sort of equipment in the ambulance. They mentioned Red Cross, I did not verify if that is attached there.

They also mentioned that the training—the nurse, the ambulance driver they did not have any sort of basic training. This guy collapsed there, a heart patient, when they were trying to—they said the resuscitation efforts were minimal. Nothing was really done and when they tried to say, listen, we want to go to Mt. Hope Hospital where there are the facilities, they were told by that ambulance service no, we can only take you to Arima.

So, two things come up there. One, the service provider there was probably not up to mark. Two, the other thing is, when you are now having to make a decision which is

the best hospital to go to—now I do not know if that person would have lived if they had gone to Mt. Hope which offers excellent services in cardiac resuscitation. And it brings up a third point, if there is an international person here traveling and collapses at the airport that will be a major embarrassment for our country. So could you give an input into that?

Dr. Parasram: Sure. So, the Ministry of Health has a public health department which acts almost like to ensure that no communicable disease comes off a flight. So, it is not a true health bay in the way it was meant to be and it was never structurally designed as such. So, basically we have health control officers and we have a line to the County Medical Officer of Health.

Red Cross, I believe, operates out of the airport at present and they are contracted by the Airports Authority. So the service that is run there is contracted by the Airports Authority. So it is not a Ministry of Health service or an RHA service at this point in time, and we have recognized the gap that you have showed to us as well. And there is need to actually have either GMRTT have an ambulance placed there or one of the Regional Health Authorities—the North Central Health Authority, we have already begun discussions with them to see how they can actually equip the Port Health Unit better. And we have spoken at least a public health trained nurse to be on staff 24 hours a day, as a first initial placement, and then even a medical officer being on staff with the requisite equipment as well there is some equipment in the Port Health Unit which resembles a crash cart but it is not complete.

So in terms of going forward, I think we already have plans, physical plans for infrastructural upgrade of the Port Health Unit, which is with the Airports Authority right now for validation and just in terms of there, because they have to do they have to do the upgrade for us. So, they are validating that. Once we get it back we are pushing forward towards upgrade of the facility and then to do the staffing through the Regional Health Authorities to make sure that we have 24-hour presence at the airport.

So, we have recognized the gap as well.

Mr. Chairman: I thank you for being able to recognize the gap and working towards it. But I think we all need to push something on our part, I do not know if the Airports Authority, is it under our portfolio? So, we may need to push that, because if I am saying it could be an international embarrassment for us if something happens here. So, thank you for trying to address it and push it.

So, coming to an end of this hearing are here any questions any Members—?

Mrs. Baptiste-Primus: Not for me, Mr. Chairman. I am satisfied that at this point in time that the country is getting a reliable service from GMRTT and I commend them for that and also the Ministry of Health. But, I want to commend the Ministry of Health greater the next time around when they come that they would have addressed the issue of the licence.

Mr. Chairman: So in closing, I would like to invite the following persons to make closing remarks: Mr. Asif Ali.

Mr. Ali: Thank you, Chair and Members. Thank you Committee for the rich discussion. We have taken on board at the Ministry of Health some of the recommendations with regard to the greater public awareness of the 811 number. I think what came out definitely, and we have recognized that, is a greater collaboration between the agencies. You mentioned the police, the medical officers, Airports Authority. We have recognized that and we have started to work on that. There is always room for improvement and we will be working on those and just to reassure the Member that the licensing will be sorted out before we meet again. Thank you.

Mr. Chairman: Mr. John Aboud.

Mr. Aboud: Thank you, Chair and Members of the Committee. We were very happy to come before you this morning because over the years we have had to bite our lips and take the pressure because it was not our place to make any public comments as our employer, the Ministry of Health, is the one that we report to and only them.

So, we were very happy to have the opportunity this morning to clarify and clear

the air on some issues. We take—I as a Trinidadian take great pride in what GMRTT has evolved into. It is—in fact at some point in the future we want to invite the Committee to visit the facility and see for yourself the kind of technology, the kind of training, the aptitude and the attitude of Trinidadians who are working there. So we are very proud of that.

I get many, many, many more compliments about the service than I do about the bad service and so. But we will strive and we are not there yet and everything you have asked for Chair, is doable. I mean, it is not my place to say, but everything has a cost. So, you want a rocket, you can get it, it is going to cost money. And therefore I guess the Ministry and Government policy have to decide, have to draw a line, a scale, as to how much we can spend and what we can get for how much we could spend. And, I think we are doing a good job at that.

So, as I close I want to wish everyone a happy holiday season and hopefully we will see you all again sometime in the future. Thank you.

Mr. Smith: Not in the ambulance.

Mr. Chairman: I, thank you, Mr. John Aboud. [*Laughter*] So, we hope we do not have to go in your ambulance. I thank you all for coming here. I thank the Members, it was a very productive meeting. We will follow the gaps, we know the gaps and we are going to work at it and hopefully, if we need to call again we would call in future and I invite members of the public who are listening to please, if they have any sort of comments, they can probably send it to us, any areas that we left out. So, I thank you all and please have a good afternoon.

12.04 p.m.: *Meeting adjourned.*

VERBATIM NOTES OF THE TWENTY-EIGHTH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO ENQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS AND STATUTORY AUTHORITIES (INCLUDING THE THA) HELD IN THE A.N.R. ROBINSON (EAST) MEETING ROOM, TOWER D, INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, JANUARY 09, 2019 AT 10.30 A.M.

PRESENT

Dr. Varma Deyalsingh	Chairman
Ms. Ramona Ramdial	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Nigel De Freitas	Member
Mr. Darryl Smith	Member
Ms. Khadijah Ameen	Member
Mr. Esmond Forde	Member
Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Terriann Baker	Graduate Research Assistant

ABSENT

Dr. Lovell Francis	Member

OFFICIALS - TOBAGO REGIONAL HEALTH AUTHORITY

Ms. Ingrid Melville	Chairman, Board of Directors
Ms. Michelle Edwards-Benjamin	Chief Executive Officer (Ag.)
Mr. Lester Frederick	TEMS Manager

OFFICIALS - DIVISION OF HEALTH, WELLNESS AND FAMILY DEVELOPMENT

Dr. Agatha Carrington	Secretary
Mrs. Dianne Baker-Henry	Administrator

Mr. Chairman: Good morning, ladies and gentlemen. Good morning, members. Thank you for being here with us from Tobago, and the meeting is the Joint Select Committee on the Local Authorities, Service Commissions and Statutory Authorities (including the THA). So I welcome you all to the 28th meeting of the Joint Select Committee. Today, the Committee is convening its second public hearing pursuant to the enquiry into the efficiency and effectiveness of the national emergency services. And on this occasion, I have the pleasure of welcoming the representatives of the Division of Health, Wellness and Family Development and the Tobago Regional Health Authority. At this stage, I would like the members to start to, if you can, please introduce yourselves starting with the Division of Health, Wellness and Family Development.

Introductions made.

Mr. Chairman: Will the members of Tobago Regional Health Authority introduce themselves?

Introductions made.

Mr. Chairman: It is a pleasure to meet you all and welcome. I am Dr. Varma Deyalsingh, I am the Chair of this Committee and I would like my members to introduce themselves starting with the Vice-Chair.

Introductions made.

Mr. Chairman: Thank you all. I would like to remind you that the concerned objective of this meeting today, this enquiry, is to really assess the capacity of the national emergency ambulance services in Trinidad and Tobago, to understand how the resources associated with this service are deployed throughout the country and to determine areas of inefficiency in the service and the critical factors, conditions which are required for its success. I would now invite the chief officials to make brief opening remarks which hopefully should not exceed two minutes. Could we start with Dr. Carrington?

Dr. Carrington: Thank you very much. Consistent with the objectives that have been placed before us, we recognize our responsibility in terms of the execution of these functions, we recognize the importance of our stewardship to the Tobago population and visitors and with respect to that, the THA had a relationship with the TRHA to the extent that the TRHA provides services on behalf of the THA. The particular issue that we are going to discuss with you is that of our ambulance services and our stewardship in that regard would be placed on the table so that persons would be aware of what we have been doing. We have had some challenges and those would be identified and discussed, but more importantly is the commitment of our team, our dedicated team in terms of responding to the needs of our population and ensuring that our stewardship is brought to bear with respect to that. I thank you very much.

Mr. Chairman: Thank you. And would Ms. Melville, please, proceed.

Ms. Melville: Thank you, Chairman. We are grateful for this opportunity to provide accountability of the stewardship of the Tobago Regional Health Authority. Our mission is to be the premiere health service deliverer within Trinidad and Tobago. In so doing, we provide a seamless health care service. We seek consistently to improve and to make sure that our services are world class. This initiative and this opportunity will be another opportunity to enhance the service which we offer. We are cognizant of our duty as duty-bearers and so, we are available for the scrutiny of the Committee.

Mr. Chairman: Thank you. And we welcome you guys, you know, to the opportunity to discuss with us, you know, to give recommendations and hopefully, at the end of the session, we would be able to come up with some ideas, you know, what are the shortcomings, how we could improve the system. And just to give you a little reminder, we actually met with the providers in Trinidad, our last meeting, and we met with the GMRHA and we actually had some discussions with them, how they run their services. And we would be looking into the shortcomings that we saw at that meeting and some of the shortcomings were staff training, some of the shortcomings we had were the delivery

time spent when they went to the hospitals to transfer the patients there, the waiting time that they would have had. The other shortcoming we would have had was the training of the staff. So those were features we saw: response time, training of staff. And you know, we got some suggestions, we got some recommendations and we now would like to look at the Tobago issue, how well are you managing yourselves, how could we, this Committee, help in such a way to give recommendation to improve the services.

So, at this time, I would like to invite any of the members to, you know, start with any sort of questions that you may want to put forward. I recognize member Forde.

Mr. Forde: Thank you. Morning again, and welcome. We would have received the reports submitted by you all, right, and it has been identified that you all have eight working ambulances according to the report. Is that amount feasible? Is it workable in terms of ensuring that efficiency, in terms of ensuring as you would have mentioned in your opening statement, Ms. Melville, premium health deliverables in Tobago? What can we say with regard to the eight ambulances and being operational in Tobago as we go along?

Ms. Edwards-Benjamin: We have eight ambulances at present. Ideally, we would have purchased 10 at that point in time so we were expecting to operate with 10. However, we have six bases situated throughout the island and therefore, we are able to furnish each base with a functioning ambulance and we also have one ambulance that is in reserve in case we have a breakdown. We also use that ambulance in times where we have cruise ships on the island or where we have heightened tourist activities so that we can station that one at specific activities. So yes, we would say, at this point in time, we can manage.

Mr. Forde: Okay. In terms of the demographic of Tobago in terms of the population size, is there a recommended standard in that, based on your size, your demographic, the population base, that there is supposed to be a stipulated amount of ambulances per capita? Is there any documentation to that effect internationally?

Ms. Edwards-Benjamin: No, we are not aware of that.

Mr. Forde: Not necessarily, but you all are satisfied with the amount to work with in Tobago at present?

Ms. Edwards-Benjamin: At present, yes.

Mr. Chairman: Is it divided according to a population density or do you just go with the six parishes that may exist?

Ms. Edwards-Benjamin: No, population density in terms of—we are not saying that the divisions are perfect or ideal, but in terms of the population density, we have one ambulance on the north coast at Parlatuvier that is centrally located. We have one at Charlotteville which is our furthest point. We have one at Delaford which is roughly midway closer to Scarborough from the countryside. We also have one at Lowlands, Plymouth and Scarborough. So because the western end of Tobago is the area where we get the highest number of calls, we do have a higher number of ambulances in that area.

Mr. Chairman: Is it that that area has a higher amount of probably—is it more densely populated and this is why you get the calls?

Ms. Edwards-Benjamin: It is more densely populated, yes, and there are also more social and tourist activities in those areas.

Ms. Ramdial: How many ambulances make up your total fleet?

Ms. Edwards-Benjamin: Our total fleet is 18 ambulances. However, there are eight ambulances which are at the point of board of survey so they are no longer functional and the TRHA is moving to do away with them. The 10 new ones which were purchased in 2015, those are the ones that we rely on to provide the service.

Ms. Ramdial: Okay.

Ms. Ameen: Chairman, just coming off that, you indicated that 10 new ambulances were purchased in 2015, early 2015, so of those, two are not functional at the moment?

Ms. Edwards-Benjamin: Of those, two, we have issues with specific parts and we are in the process of sourcing those parts from overseas to repair them.

Ms. Ameen: So how soon do you expect those?

Ms. Edwards-Benjamin: We expect that within the first quarter of 2019, those ambulances will be back up and running.

Ms. Ameen: And you indicated that the seven diesel ambulances which are more than 10 years old, you are taking steps to dispose of it by recommended procedures.

Ms. Edwards-Benjamin: Yes.

Ms. Ameen: Do you intend to replace those with any new vehicles?

Ms. Edwards-Benjamin: Well, bearing in mind that the life of an ambulance is roughly five years, we will have to be purchasing new ambulances sometime in the near future because even those that we purchased in 2015, by 2020, those would have outlived their normal life. So yes, the TRHA, in our long-term plans, we do intend to purchase more ambulances in the near future.

Mr. De Freitas: Morning. Just a question based on the first set of responses that were given. What was the criteria used for the location of the bases in Tobago? Why were they put in those specific locations?

Ms. Melville: Okay. The criteria used was population density but also geographic—the nature of the terrain. That is why we have two ambulances in the far north-east end of Tobago, Charlotteville and Parlatuvier respectively. We also have one in Delaford. At one point in time, we had one midway along the eastern coast between Delaford and Scarborough. However, due to issues raised by the union that we did not have a physical base, we had to discontinue that because in order to maximize our efficiency, we had ambulances roving on the eastern coast so that the response time would be more rapid. We are still reviewing that. However, due to economic constraints at present, we maintain the six bases which exist.

Mr. De Freitas: As we are talking about response time, in the eastern side of Tobago, the terrain is very different and a lot of the houses would be difficult to access by ambulance given the size of the vehicle and whatnot. Is there an attempt to have a management plan or to put into your management plan as it relates to ambulances, something specific for

that side of the island versus the western side of the island which is more flat, to assist in that response time? Because the response time on that side of the island has nothing to do with where the bases are located but more so the ability to access people on that side. So is there any plan to help with that?

Ms. Melville: Yes, we have looked at different classifications of ambulances and another issue we have also is sometimes the wait of patients with that difficult terrain. So that you might have a track leading up to a house and you have to negotiate with someone who is not of average size, who is of above average size. So we have looked at the bariatric ambulances and it is in our long-term plan to have ambulances that can more easily access terrain that is outside of the normal roadway where cars can drive.

Mr. De Freitas: Chair, and based on the data that you have been getting back in relation to the numbers of calls that you would get, five years, to me, seems like a pretty short time for the lifespan of an ambulance. Is the data that you are getting sort of match up with that in the sense that there are so many uses of ambulances, based on the data in terms of calls, that five years is what it should be or can you have it that you have the ambulances for a little longer, maybe seven to 10 years because the usage is not that great?

Ms. Edwards-Benjamin: Five years really is a ballpark figure, an average figure based on the quality of the ambulance and they sometimes—usually would outlast the five-year period. But we work with the five-year period as a standard. If we get extra time out of the ambulance, yes, that is welcome, but we work towards replacing them after the five-year period.

Mr. De Freitas: How has that been working out? Because, for example, in 2015, 10 new ambulances arrived, you already had eight down but they were far exceeding the expiry date if we could call it that. It means that by the time you get rid of those eight, the 10 new ones that you bought in 2015 would have long since been expired because that five years would have gone. When I am looking at some of the reports that you had in the papers, for example, the ambulances would have been brought in in 2015 and two years

later, you only had two ambulances working out of the 10 new ones. When I take into account the lifespan that you are talking about, then that seems just about correct in terms of maintenance. Have you done a cost-benefit analysis or an assessment in relation to that? Because it is hard for me to understand a five-year lifespan on an ambulance. It means that you are going to have some serious economic constraints in maintaining an 18-ambulance fleet in Tobago. What plans do you all have in place to address that?

Dr. Carrington: So the issue raised with having two ambulances actively in use had to do with the fact that we were challenged in terms of our maintenance arrangements for these ambulances. Further to that, there were arrangements in place, an MOU with VMCOTT to ensure that we put some structure allowing for us to maintain these vehicles so that they would be available for use. We have come a long way since then. Notwithstanding the five-year minimum, we know that we have to work them longer than that. What is going to assist us is that arrangement with which we will actively pursue the maintenance arrangement allowing for them to be available for use. So no longer would you see two out of 10, you will see eight out of 10, nine out of 10 and we will, on a phased basis, replace the ambulances when they are not as serviceable as they ought to be.

Mr. De Freitas: So this is my last question. So do you have a ballpark year in mind as to when we can get back to 18 or a certain number out of 18 operational on the island?

Ms. Melville: It is not anticipated that we will get back to 18 having regard to our financial situation nor would it be required to have 18. What we would do is to ensure that the minimum number that is necessary to cover our bases and to replace as and when required, that that is available to the population, so that is what we will work with.

Mr. Smith: Thank you, Mr. Chairman. Through you, I think the first question was asked by Mr. Forde but I think last year when we hosted the other ambulance team here, and you were out of the country—but I remember reading that, and that was a specific question that was asked with regard to the industry standard and the former people that were here last year, I do not have it in front of me now, but they actually had that information. So if

you need to get what is the industry standard, you could probably liaise with the local Trinidad arm of it, but I remember them mentioning that.

A second part of it is a question and this is the second part of this aspect with this Committee and I asked the Trinidad arm about this whole thing and they did not have the answer. And the reason why I am asking it is, Mr. Forde as well, coming from local government with regard to disaster management in the different Tunapuna, Diego Martin—I was the former chairman there, we would have done a number of exercises with CERT and so on, with the residents of the areas, and what shocked me—at least in Diego Martin, and I do not know how it works in Tobago—was when we were asking the residents in terms of if they have an emergency, if they have a plan, which is an earthquake, if you have a plan, if somebody gets a heart attack, if there is a tsunami plan for each home, and with all the different scenarios, the majority of the people said that they would not wait on an ambulance because they did not trust it or they were not comfortable; they will put the person in the car and take them.

And I asked the question the last time and I am going to ask you all now. Do you all have data with regard to your health facilities? How many people do that, come in on their own with an emergency and how many people come in with the ambulance, and if they do, why? If it was the fact that they did not bother to call, they just brought them based on lack of trust or they called and they did not come? Do you all have statistics like that?

Mr. Frederick: Thank you for the question. Some of the information in the question would have to come from the hospital in terms of those that come into the hospital by private car, but we do have our information here as to how many persons come in via ambulance.

Mr. Smith: All right, well, if we could get copies of that—but what you all should do, this year as it is a new calendar year, is to compare it to how many people come in so you would have to work with the various health agencies and then see why. Probably ask a

question—why?—is it that people do not trust or they do not think it is reliable or the wait of time. So, after waiting X amount of time, "they jump in the car", because that would help you all, and again, with regard to the first part, if you could get those details and information with the industry standard from them.

Mr. Chairman: Mr. Frederick, excuse me, would you mind voicing the figures for us for the benefit of the public that will be listening?

Mr. Frederick: The information is here, I am just looking for the page, but I do not want to keep you back, I will indicate when I find it. Is that okay?

Ms. Melville: While Mr. Frederick is looking for the data, Minister, the TRHA is also responsible for the hospital and health centre services. Regarding the hospital services, our Accident and Emergency room is inundated with clients who are not emergency or accident cases and so they will drive themselves to the hospital, and we do have the data which we can provide regarding the actual number of visits which we had over the last calendar year or the last fiscal period. On average, it is about 9,000 visits per annum and—however, the number of persons who actually arrive via the Tobago Emergency Medical Services, TEMS, would be much less because as I have indicated, many of them are not emergency cases and that can account for the lessened use of the ambulance. Of course, I am not denying that we will have challenges in terms of persons who might not want to use the ambulance service but sometimes they do not need to.

Ms. Ameen: Chairman, through you, do you have any method of feedback to measure citizens' satisfaction with the ambulance service? Do you ask questions, do you do general surveys or any method at all, whether it is the people who are in the hospitals or the man on the street, to gauge and to identify issues that they see as a challenge, why they would not or have not used the service when they were in need of it and therefore, you have specific concrete things to improve on to make your service more accessible?

Ms. Edwards-Benjamin: The TRHA does have the facilities for the public to comment or to voice complaints on our website. We also have a customer feedback service which

is based at the health centres or at the hospital. However, in terms of the ambulance service, a lot of the feedback we get comes from our meetings that we host. We host meetings at various community meetings, community outreach meetings, and that is where you find that persons are most inclined to voice issues concerning the ambulance and the ambulance service.

Mr. Chairman: Yes, from purviewing of the newspaper articles, I saw you have the community meetings and Dr. Carrington was very vocal in coming up with suggestions to improve the services and even admitting there were some deficiencies in the past. But we had some old newspaper articles but I think we have come a long way since then. I need to find out this though. The amount of ambulances that you need in Tobago, is it 10 or is it the six or is it the eight? What is your level of functioning you think you could mention? Because your fleet of 18 is no longer there. You bought 10. What do you think is a good level that you could actually work with? And this is what I need feedback on.

Ms. Melville: Ideally, Chairman, if we had 14 ambulances, I think we would be better able to service the population. If each base were to have at least two ambulances, particularly in the north and eastern areas, because if you look at the geography, between the base at Delaford and the base at Scarborough, it is a long stretch of road, it is almost the length of the island. And so ideally, we would like an ambulance to be stationed, for example, at Roxborough Health Centre, because at the Roxborough Health Centre, we have a walk-in service as well as the normal clinic service and quite often, patients would need to be moved from the Roxborough Health Centre to the hospital, and so usually that health centre would have to call and the base would respond. So ideally, if we had more ambulances to be placed, we would be able to respond quicker and there could be greater satisfaction with our service.

In addition, the downtime of the units would be less because the preventive maintenance schedule would be kept and adhered to, because there would always be at least one ambulance at the base. So, at the moment, out of the 10, we try to keep three

units in that way so that they are not always in full use and so even the replacement strategy which the CEO spoke to, we are looking at a phased replacement strategy. So that we are not looking at replacing all 10 ambulances but due to usage and the reduced usage of some units, we would be better able to manage even that.

11.00 a.m.

Ms. Ramdial: Chairman, I just want to go back, through you, to Dr. Carrington. You mentioned earlier financial constraints. But, in the last budget, if I am not mistaken, the THA and every secretariat across the board got increases for fiscal 2018/2019. Am I to interpret by that statement that there are some problems or challenges accessing the funding from Central Bank?

Dr. Carrington: Let just say that the issue with respect to availability of resources is a common one, it is not just associated with Tobago. And when I mention that, these resources are to be distributed, or to be allocated between our human resources and our other support services. So my saying that, is that we must ensure that in allocating these resources that we do so appropriately. It is no secret that much of our resources across the island goes towards human resources, and that we have to ensure that we do the allocation such that goods and services can be provided. So it is in that context I mentioned the issue of resources.

Mr. De Freitas: Thank you, Mr. Chairman. In light of the economic constraints, has any thought been given to utilizing a model similar to what is in Trinidad by way of a public-private partnership? So, in Trinidad you have several entities that would provide an ambulance service, and then the Government pays them to do that and then they take on all the responsibilities in relation to providing a service to a particular international standard.

I am not saying that you have to follow that specific model, but you might be able to work out something where you allow private entities into the space, just to bolster the service and the number of ambulances. So, as much as you may indicate 14 is good for

what we have now, by allowing private entities to enter the space, you may end up with 10 more on top of that, 24, and obviously to the benefit of all Tobagonians. So has any thought been given to sort of like a public-private partnership.

Dr. Carrington: Thank you for that question, the issue with respect to public-private partnerships that is a focus in our Assembly and so our public-private partnership unit is up and functioning. This particular issues has not been raised as a priority project, but that is one we will be willing to look at such that we can explore a more appropriate option.

Ms. Ramdial: Through you Chair. Now, in your submissions you stated that your annual allocation is approximately $14 million for TEMS. Out of that 8.1 million is allocated for personnel expenses. With just eight ambulances in operation, what is ratio of ambulances to EMTs, and what is the gross salary of an EMT under the TRHA?

Ms. Edwards-Benjamin: So presently, we have 48 EMTs on staff and we have eight ambulances. So that will give us roughly six EMTs per ambulance and at this moment that is, sufficient to run the service effectively and to allow for—

Ms. Ramdial: Six EMTs per ambulance?

Ms. Edwards-Benjamin: Per base.

Ms. Ramdial: Per base? Okay. So, you have six—?

Ms. Edwards-Benjamin: So, we have eight EMTs per base, correction. Of the eight ambulances, we need to bear in mind, we have one at the hospital that does not count. So we have one at the hospital, so there are seven in the district or allocated to TEMS at this point in time. There is one at the hospital for inter-facility transport. So, yes, roughly we have eight EMTs per base.

Ms. Ramdial: How do they operate, though? Is it a shift system? What about their gross salary? What is their gross salary?

Ms. Edwards-Benjamin: So the salary is between 12,000 and15,000 per month.

Mr. De Freitas: How many EMTs are on the vehicle itself? When the vehicle—?

Ms. Edwards-Benjamin: Pardon me? Two.

Mr. De Freitas: So then eight EMTs at the base and two are assigned to the vehicle? So when the go out on a call like—?

Mr. Frederick: Thank you for the opportunity to give a brief explanation. We have six bases. Six ambulances working at any one time, it does not mean that the seventh one is down. Right. There are two EMTs per shift. We run a 24/7 service of 12 hours per shift. So it is two EMTs per ambulance, per shift.

Mr. Chairman: Do you have nurses also available on those ambulances?

Mr. Frederick: No, we do not.

Mr. Chairman: Okay. Could you give me an idea of the training of the EMTs, what level of training we have? Because you may have different levels in terms of basic life support training, and the advance life support training. So, could you give us an idea of the training of the EMTs? Because I understood Tobago was actually up front in Trinidad in the sense that you all were the ones that started training in 1999, I think I am right. The first set of trainees, and I think you, Mr. Frederick, was among the first trainees in Tobago. So you have actually, you know, lifted that barrier in 1999. So, I congratulate you and I also congratulate from your background in mental health which I will follow up with a question later on.

So, from the basic training from 1999, what I understood it was the training of EMTs to a certain level, then a Canadian company came in and did some further training. Have we moved beyond that EMT training from basic life support to advance life support? Because you see what I am looking at is if I get a heart attack in Trinidad and the GNRHA takes me up and carries me to the hospital, but I get a heart attack in Tobago and there is not that training that is now what we will call geographical discrimination in terms of health. So is it that your health in Tobago, your first responders, are they equipped as some of our first responders here and if there is a deficiency, how could we now help you in your training of your responders there?

Mr. Frederick: Okay. In Tobago—thanks for the commendation. Yes, I was one of the

19 EMTs that were trained in the inception in 1999 and have worked my way up to where I now.

We were trained in basic life support. There is not really a "paid"—and I would explain what I mean by that—person in our system beyond basic life support. The legislation only allows and then we are covered under the "licenceship" of our medical director. So that only allows for us to function as basic life support. However, every ambulance is equipped with an AED, an Automated External Defibrillator. So, yes, if you are having a heart attack in Tobago, God forbid though, we are trained and we are quipped to take care of you on the ambulance.

There is what you call "EMT intermediate" and that is the reason why I mentioned the word "paid" earlier on. You are employed by the TRHA as an EMT basic. We do not have any "licenceship" legal, you know, band widths to go beyond that. Some of us have gotten some other training before and that is when we were in the 19. That would not fit into basic life support.

Mr. Chairman: So, in terms of let us say somebody collapses in Tobago. The EMT personnel can come out, they can start to give oxygen, bag and mask, defibrillate, but in terms of giving IV access, to keep an access open to give drips, those essential services that may be necessary. Somebody, who you know, hypoglycemic, sugar runs low, you could test that. But in terms of starting some sort of medication, do you have any sort of training in that?

Mr. Frederick: Yes. Not the IV though. In the hospital you will give IV bolus and, you know, glucose and that kind of thing. However, on the ambulance we have Glucophage, it is like sugar in a tube. We have that on the ambulance and we give that to persons who are hypoglycemic.

Mr. Chairman: I am looking at an accident victim bleeding, you need to have an IV, you need to have drips running. Is there any way that the EMTs could be trained to a level further to step up their training, like in different modalities that you can offer them training

where you put on an IV access you have that access open? You start some drips because that is life saving and I am saying if it is in Trinidad. Why have somebody in Tobago not getting that same sort of services? What can we do to help that training this is what I would like some suggestions.

Mr. Frederick: I love that, and it makes me a bit more comfortable, in that yes, it is added training and anything for the benefit of the patient and to improve our service deliveries I would openly welcome. So, the only challenge there is a matter of getting the legal framework cleared and being able to have a medical director to cover us in that regard.

Mr. Chairman: You see, we have the same emergency Act that is covered in Trinidad. So, we will have to figure out why in Trinidad we have that service afforded and in Tobago it is not. So this is something we will look into because it is a lifesaving event. So we are looking at probably training the EMTs to go a step further. Also the possibility of—let us say access to the hospital. Let us say, you pick up an accident victim, somebody with a heart attack. Do you have, you know the training—you know, there are devices now, like a portable ECG, you place it on the patient's chest. Through the Web you can send a message straight to the hospital, the cardiologist can read it to see this person has fibrillation or some sort of heart problem, and they can stand ready and waiting. So again, if the EMTs are not trained in looking at the ECGs, there are those devices available that you can probably purchase that may be able to send that ECG to the hospital so that they can be ready and waiting.

Mr. Smith: Thank you, Mr. Chair. I know very topical now—Mrs. Baptiste-Primus, go ahead, sorry, I know ladies before gents. Go ahead.

Mrs. Baptiste-Primus: You are already on your—[*Laughter*]

Mr. Smith: I apologize. I know it is very topical now, with regard to the inspection of the vehicles, I am assuming if not, you will answer that is being taken care of; that is part one.

Ms. Ameen: Do not assume.

Mr. Smith: And part two. Do you all do—do the ambulances do private events, like sports days and other events as well or are there any other services on the island privately that does that?

Ms. Edwards-Benjamin: Yes, persons who are having private events can actually write to the TRHA to request the presence of an ambulance at their facility or in the vicinity of the activity.

Mr. Smith: What is the rate for that?

Ms. Melville: At the moment it is part of our CSR, our Corporate Social Responsibility. So, in Tobago there is a lot of synergy, this is our contribution to developing that. So there is no cost at present for that service but as we are looking more and more into revenue generation, it is probably one of the areas that we need to look closer into.

And just to go back previously, yes Chairman, we have considered offering a more advanced service. We have looked at offering services where we have paramedics on the ambulances or zoned, so that they can quickly maybe intercept the ambulance and it is something that we will look into more closely in this fiscal period.

Mr. Smith: Part one of the question, the inspection.

Ms. Melville: I will let Mr. Frederick answer. Our ambulances have not been on the road for five years, the addition to the fleet.

Mr. Smith: So it is not due for that, is what you are saying?

Mr. Frederick: Yes, we are not due, however, to ensure—we are due as yet, but to ensure because we know of other entities that have, you know, some kind of teething issues where that is concerned. So to be on the safer side of town, we have begun having discussions with VMCOTT which is our service provider and is also, you know, the provider that does the inspection. So that we could make sure that we cross our t's and dot our i's where that is concerned.

Ms. Ameen: Chairman, I have a little concern. Private vehicles, private cars under five years old do not have to be inspected, but it is different for the vehicles that fall in different

weight categories, for instance, people who have pick-ups will know that even if the vehicle is less than five years, they have to be inspected. So that there are different rules for different categories of vehicles, and I want to ask you to double check with VMCOTT.

And you have 10 ambulances that were purchased in 2014 but you do have others that you own, that are older than that. I want to ask for the sake of the security and safety of the public that you double check whether those ambulances ought to be inspected and let us not presume that because they are under five years old that they do not have to be inspected.

Mr. Chairman: I would like even remind members that in the past in Trinidad we had a GMRTT ambulance which actually exploded. There was an article found in Trinidad *Newsday* by Cecil Arson and he said that, on carrying a patient to the hospital, there was an explosion where the ambulance actually exploded and fire, ensued and it was, you know, something that is a disaster because the patient was further traumatized. So looking into the effects of, you know, maintenance is a suggestion that, you know, that is one of the things that we have to look at something because things are happening.

But I would like to find out why are there—the two that are down, could you tell why, what is the problem with those two?

Mr. Frederick: One developed some engine problems and the other developed the differential problems. Both have differential problems but one has engine problems. We have already begun processing to get the parts.

Mr. Chairman: I would like to recognize, Mrs. Baptiste-Primus, who has been waiting patiently.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. My patience levels are very high. I have sat here, Mr. Chairman and I have listened to the questions and the responses given and clearly we can identify the tremendous effort that the TRHA is placing on the delivery of health care in Tobago, despite the multitudinous challenges. I just need to clarify a couple of things. As an addendum to the questions that were being asked about

the ambulance services, what is the monthly fee paid to the VMCOTT? I perused the Memorandum of Understanding, but I have not been able to extract that information. I saw where the agreement is the payment of $300 an hour. So what is the monthly fee paid to VMCOTT?

Ms. Edwards-Benjamin: Okay. So our MOU does have a standard monthly fee paid to VMCOTT. Instead, we pay them according to work that is done within the period.

Mrs. Baptiste-Primus: So what are the parameters that we are working with? What is the average paid to VMCOTT then, monthly?

Ms. Edwards-Benjamin: I do not have that data at this point in time.

Mrs. Baptiste-Primus: So, you can all provide that, Mr. Chairman, through you, of course, provide that information to the committee.

In terms of handing over of patients at public health facilities by the emergency ambulance personnel, what is the average length of time taken to hand over a patient at the Scarborough General Hospital? That is one. Two, is the THRA satisfied with the current hand over arrangements? Three, if not, what are some of the solutions that you would like to propose?

So that is definitely—the first question is definitely either you, Madam Chair or you Madam CEO. We are dealing with the hand over—handing over of patients at public health facilities or Mr. Frederick perhaps, I would leave that up to you all.

Mr. Frederick: I will attempt the handing over period. Of course, you understand that different patients would impact—

Mrs. Baptiste-Primus: Well, give us an average.

Mr. Frederick: Roughly five/10 minutes.

Mrs. Baptiste-Primus: What does it involve? What does the handover involve?

Mr. Frederick: The handover involves, of course, depending on the condition of the patient we would pre-inform A&E as to the unit is coming with XYZ patient and our estimated time of arrival. So that is one thing that allows them to be prepared. Once that

happens, when we get there we hand over to a nurse and we give the nurse the basic information—

Mrs. Baptiste-Primus: Any nurse or the nurse in charge?

Mr. Frederick: The nurse in charge of the A&E department. And they take over the patient, and they point us to a bed that is available and we would put over the patient. Of course, very often with the assistance of the health attendants at the A&E department.

Mr. Chairman: Do you have to wait for any beds available? Because I think this was one of the—delay was mentioned in our last meeting. When the ambulance arrived to the hospital, they have to wait for like a stretcher to take the patient to there. Is there any delay in terms of that?

Ms. Edwards-Benjamin: Hardly likely. We do not have much of a wait time at the A&E in Scarborough. For the EHS as Mr. Frederick would have highlighted that, usually they forewarn the department of an incoming patient and therefore, arrangements would be made to receive that patient so as not to keep the EHS or the EMTs waiting. When they arrive at the hospital, the EMTs do wheel the patient directly into the A&E department into the critical care area. So that, they are not ignored or they are not behind person's back, they are right there and therefore every effort is made to relieve them at the quickest possible time. So, we usually do not have ambulances waiting 15/20 minutes outside of our A&E.

Mrs. Baptiste-Primus: So at what point in time does that person become a patient of Scarborough General Hospital? At what point in time in that process? Is it upon arrival at the hospital? Is it upon arrival into A&E? Is it upon the conclusion of the handing over? At what point in time during that process?

Ms. Edwards-Benjamin: From the time the patient enters our facility they become our patient. From the time the ambulance pulls up and the patient is wheeled off the ambulance, that patient becomes the patient of the Scarborough General Hospital.

Mrs. Baptiste-Primus: So the patient must be wheeled out of the ambulance to be

deemed to be a patient of the hospital?

Ms. Edwards-Benjamin: There is usually, that specific topic is not really a bone of contention, because I have known of times where the emergency, or emergency room staff would have had to attend to patients even while they were still in the ambulance.

Mrs. Baptiste-Primus: I am just trying to determine the medico-legal responsibility. Because members of the public, particularly when you read about certain medical situations developing in Tobago, may not aware of when a citizen who requires medical attention and would have been picked up by the ambulance, when that person is deemed to be a patient of the hospital. So, it is necessary to clarify for a greater national understanding. So if an ambulance picks up someone from someone's home, they are in transit, when that person reaches the hospital, when is that person a patient of the hospital? From the time the ambulance enters the compound?

Ms. Melville: Member of the committee, the ambulance as well as the hospital is under the jurisdiction of the Tobago Regional Health Authority.

Mrs. Baptiste-Primus: So from the time that person is picked up and placed on the ambulance—

Ms. Melville: So from the time that person is picked up and placed in the ambulance, they are under the jurisdiction and the TRHA is responsible for that patient.

Added to which, you would have mentioned the issue of the handover arrangement and recently a survey was done and while I am not saying everyone is entirely comfortable with the service that we are providing, there is a recognition within Tobago that if you arrive on an ambulance, you are attended to quicker. So that that survey found that there were clients who would be in A&E and they would find that their wait time is quite long and they would go back home, drive themselves back home and call an ambulance. And then, the ambulance would pick them up because now they know that their care would be expedited. We found that on a recent survey. So that there is a level of abuse of the system in that these clearly would not be accident or emergency cases but they are seeking medical

attention at A&E.

Mr. De Freitas: Okay so, I just want ask the question. So that begs the question, what level of screening is taking place between the call, dispatch of the ambulance and then at the Accident and Emergency, I guess the walk-ins. Is there screening where somebody in dispatch assesses whether it is an emergency, whether it is not an emergency?

Ms. Edwards-Benjamin: Yes, patients are screened and interrogated. However, persons do know the correct answers to give and they do know the correct conditions to complain of, in order to get an ambulance service.

Mr. De Freitas: So then what happens? So, for example, let me just create a scenario. So, I—my leg is hurting me, right, it may not be deemed an emergency, so I tell the dispatch on the phone, I am having chest pains which causes a response and then you get to the hospital and you realize that there are no chest pains but it is really the leg that is hurting you. At that point in time, what does the hospital do? Because you are getting that feedback realizing that the system being abused but there is a cost associated with that, there is a delay in time and in terms of quality of service with people who actually need it. What mechanisms can you then put in place to treat with the abuse of the system by people?

Ms. Edwards-Benjamin: So even when the patients come in on the ambulance, they are still subject to the triage system that exists at the Accident and Emergency department. So, at that point in time, when the medical staff would examine the patient and realize that the patient is not necessarily in the category that they complained of on the phone, then the person would be reassigned to the correct category and manage according to the departmental policy.

Mr. De Freitas: That is correct in terms of providing the proper health care. What I am talking about is the abuse. So the individual has no deterrent for abusing the system, because you just basically indicated they got expedited by way of their health care. But you have to treat with the abuse of system, because you have limited number of

ambulances and a scenario can occur where somebody is having a heart attack, but because another person is abusing the system, that person cannot receive the quality of care.

So what is the repercussion to the person that abuses the system, because you can complain of chest pains, but as you say, when you go through the triage system and you realize that is not the case, there must be some level of repercussions so that that person does not abuse the system. For example, in other countries, they have to pay. You have to pay for that ambulance ride and that puts a stop to the abuse of the system. You are not calling the ambulance unless it is a real emergency because you have to pay an exorbitant amount of money for that ambulance ride. I am not saying that you want people to pay in Trinidad and Tobago but you understand where the feedback prevents an abuse of the system.

Ms. Melville: At present, there are no sanctions such as you would have suggested. However, the TRHA tries to conduct ongoing public education and information. So that people are aware that, you know, that sort of practice is negative and it should not persist. And we do that sort of education also to prevent the misuse of the A&E service because like I mentioned Roxborough Health Centre is one example, but we have three health centres which offer an enhanced service. So that if your case is not an accident or an emergency, we recommend that you visit one of the three health centres at Canaan, Roxborough or Scarborough to seek medical attention and in fact, you might be dealt with more quickly than going to wait behind the people who are real accidents and emergencies because as the CEO acting mentioned, we do a triage and in the triage you would be put at the end of the cue if your situation is not accident or an emergency. So it might be worth your while to visit one of the health centres which are open Monday to Friday, 8.00 a.m. to 8.00 p.m.

11.30 a.m.

Mr. Chairman: I would like to recognize Mrs. Baptiste-Primus again.

Mrs. Baptiste-Primus: Thank you, Mr. Chairman. I just want to shift the focus a little,

in your submissions, on page 16, with regard to the shortcomings of the emergency ambulance service in Tobago, can you indicate what projects or initiatives are currently being implemented with a view to enhancing the efficiency of Tobago emergency ambulance services? On page 16 of your response you talk about shortcomings, so I am enquiring whether or not you can indicate what projects or initiatives are currently being implemented with a view to enhancing the efficiencies of Tobago's emergency ambulance services.

Ms. Edwards-Benjamin: Well, presently, we are looking at the way we measure the service that we are providing in terms of our response times, et cetera. So we are putting in place measures to better monitor our response times to better measure the actual performance of the fleet and the departments. In terms of—we also intend to implement additional training for staff to improve the outcomes of our patients, and, yes, our customer satisfaction, our customer feedback systems. We also want to improve our customer surveys, et cetera, so that we could get a feedback from the public as to how well we are performing.

Mrs. Baptiste-Primus: And my last question in this regard, Mr. Chairman, what deficiencies exist in the audit and compliance within the TRHA?

Ms. Edwards-Benjamin: Well, we have realized that, in terms of measurement of our performance, we do not measure enough. We do not measure—some measurements are such as—I do not have one off the top of my head, but we realize in going through our reports that there are things that we still need to measure more closely. And, therefore, in terms of our reporting systems, we do not report adequately to satisfy the needs of the organization in terms of planning, et cetera. So we intend to improve those, that area of audit and compliance, and then of course we intend to work towards—we are working towards the accreditation of the service. So, yes, accreditation for in terms of our policies, procedures, updating of our manuals, et cetera.

Mrs. Baptiste-Primus: I will pause for now, Mr. Chairman.

Ms. Ameen: I have a follow-up to that, Mr. Chairman. I do not know if Ms. Edwards-Benjamin has the report in front of her where on page 16 there were four specific items identified as the main shortcomings at present. One is poor preventative maintenance plan and one is lack of cost-effective service; one is deficiencies in resource allocation and one is deficiencies in audit and compliance. So I thought perhaps we could get a specific response to Minister Primus' question on each one of these. What are your plans to improve on the poor preventative maintenance plan?

Ms. Edwards-Benjamin: In terms of the preventative maintenance, we do have maintenance for our ambulances, however, we do not have a preventative maintenance system in place at the moment. So most of what we are doing, we do a lot of corrective maintenance, but in terms of a preventative maintenance system with our service providers, we do not have that this at this point in time, and that is something that we intend to implement.

Ms. Ameen: Do you have a time frame for implementing that preventative maintenance plan?

Ms. Edwards-Benjamin: I think I would have mentioned before that we are aiming to accomplish that by the first quarter of 2019.

Ms. Ameen: You indicated the lack of cost-effective service as one of the shortcomings.

Ms. Edwards-Benjamin: Generally, we believe that we can be more cost effective because of—we are all well aware of the economic climate in which we operate and therefore we have to examine our service and try to improve our efficiency in all areas. So we generally believe that we need to be more cost effective in the service that we provide.

Ms. Ameen: And you also identified deficiency in resource allocation. Can you indicate some areas where you have had challenges with the resources allocated and how it may affect your service to the public?

Ms. Edwards-Benjamin: Well, as the Secretary would have indicated, that the majority

of our resources, our financial resources, go towards human resources. And in terms of our maintenance of our equipment, et cetera, that we sometimes fall down in that area, and therefore you would find that if we continue to allocate resources in this manner, you would find that even though we would have the staff on hand to run the service that our ambulances and our equipment will suffer as a result. Therefore, we intend to look at the allocation of those resources in terms of ensuring that all aspects of the service is well financed and equitably financed.

Mr. Forde: Thank you, Mr. Chairman. In all the discussion so far, the acronym, TEMA, which is Tobago Emergency Management Agency, has not been mentioned. It is an agency within the THA, the Tobago House of Assembly. What role can they play in this same emergency and ambulances that we are speaking about with regard to assist your particular department, as the case may be? Where can TEMA fit in, in terms of roles and responsibilities, in terms of duplication, in terms of assessment, and enhancing the whole, you know, efficiency of emergency operations in Tobago?

Ms. Melville: We have a very close working relationship with TEMA because the TEMS is a member of the disaster management committee in Tobago. In fact, the entire TRHA, we are first responders, added to which, we have explored whether maybe, while not a PPP arrangement, but whether maybe TEMA can assist us with managing, servicing, operating the fleet; discussions are still ongoing. That review is still ongoing. We have not actually done any pilot, however, that is one proposal that is on the table. Earlier Mr. De Freitas mentioned the issue of PPP, and we have had situations where in the past we had the private sector donating an ambulance, however, the maintenance and all other services fell to the TRHA. So we are not adverse to that. We, as the CEO has indicated, we are looking at ways to improve in a cost-effective manner, and these proposals are all issues which the board, in strategizing, will look at, because accountability is a very critical issue. We are looking at putting in place a performance management system which would make sure that, from the highest to the lowest level, there is greater accountability and

measurability of the deliverables. And if there is measurability then the performance appraisal system, which we operate with right now, will become a thing of the past, as we know that we are accountable to the community we serve.

Mr. Forde: TEMA, they have their own ambulances?

Ms. Melville: No, they do not, they depend on us. So that is why I am saying there is synergy. So if an ambulance—sometimes TEMA has an event, or TEMA is called upon to manage an event, they will call on the TRHA to provide the ambulance component. So say, for example, there is the Cycling Classic in Tobago, TEMA is called upon to oversee that. TEMA will contact the TRHA and TEMS, and all the preparatory meetings which are called, the TRHA would work side by side with TEMA in that regard. In terms of drills, in the event that there is a national disaster or a disaster in Tobago, the TRHA and TEMS, we are critical components of those drills.

Mr. Forde: Thank you, Chair.

Ms. Ramona: Through you, Chair. Ms. Melville, you spoke about accountability. Have you been reporting monthly to the audit and compliance committee?

Ms. Melville: The audit and compliance committee is a subcommittee of the board—

Ms. Ramona: Right.

Ms. Melville:—and that committee receives and requests reports from the various service areas to ensure that we are delivering as we should. Mr. Frederick knows he is called upon to answer if what we has written is not adequate. It is a way that we are doing quality control, because in the past the quality function was centralized within the THRA. Now we are working more towards the integration of quality across all service areas.

Ms. Ramona: And the audit and compliance committee, to whom do they report?

Ms. Melville: They would report to the full board, and then the whole TRHA would then escalate reporting up to the Division, because we receive our subvention through the Division of Health, Wellness and Family Development.

Ms. Ramona: Thank you.

Mr. Chairman: It was alarming that the meeting we had, the last meeting on this same discussion, that the Ministry of Health, you know, has not appointed the licensing committee. There is a licensing committee; there are the ambulances, you know, according to the Emergency Ambulance Services and Emergency Medical Personnel Act. So in a sense, you know, they have to expedite the licensing of the ambulance service, also the providers, the public and the private. Do you have any sort of licensing authority in Tobago via the Tobago, you know, regional authority?

Ms. Melville: No, we do not, but we ensure, in terms of procurement, that even the physical, the vehicles which we procure, that they adhere to the legislation. We ensure that the weight, the width, the body, all those measures, we ensure that we are compliant in that regard, but we do not have a body that is established, because under the legislation there was no decentralization of that function.

Mr. Chairman: Because what was forthcoming also is the ambulance services that were available at our international airport was really a Red Cross ambulance, and, you know, certain deficiencies came about where, you know, it was lacking in any sort of, you know, emergency, major emergency equipment. So your services and your ambulance are all equipped with the basic equipment that is mandated under the Act, right? So that is a fact.

Ms. Melville: Yes, they are.

Mr. Chairman: Yeah. And what about Crown Point airport, looking, you know, for, you know, is there a—somebody could elaborate on the situation there?

Mr. Frederick: I love that question because it was one of the departmental recommendations that we would have had in terms of our service delivery, and though we do not have a fixed service at the airport, we do respond to emergency calls at the airport, mainly from our base that is closest located, which is Low Lands. But we would like to have that kind of symbiotic relationship with the Crown Point Airport Authority, and we could have had, you know, small discussions with them in the past, but it has not grown to where we would like it to be as yet.

Mr. Chairman: So this is something we have to probably look at providing, you know—

Mr. Frederick: Yes.

Mr. Chairman:—because with the international travellers, you know, the situation that occurred here, with a businessman collapsing at Piarco Airport recently.

Mr. Frederick: Yes, I know of that situation.

Mr. Chairman: Yeah. So you are aware of the situation, and give us a take on that information, because I think you were a part of development of the ambulance services. Do you have any ideas about the—you know, there may be an ambulance service that may not be fully functional; I think there is a term for it—

Mr. Frederick: Ambulette.

Mr. Chairman: Ambulette. Is there a need for an ambulette service in Trinidad and Tobago? Because you have the ambulance services that could provide the emergency state of the line, what about the ambulette services. Do you think there is a need for that?

Mr. Frederick: Yes, I would think so. It would supplement what Chairman would have indicated earlier on in terms of the need for additional ambulances. So, yes, we would be able to, once we get that ambulette service, although it must be understood that an ambulette does not carry medication, it is almost a transport service, almost. So there are those calls from our dispatch centre, but, you know, a patient could change their situation in a matter of minutes. So while you would have initially assessed the patient to the dispatch centre, because that is communication, by the time the ambulance is on the way things could change. So you might have dispatched an ambulette based on our assessment and then when they get to the scene or when they are almost there things could change. But notwithstanding that, I would not say, no, that we do not need to expand our services where we could have ambulettes involved.

Mr. Chairman: It reminds me of some time ago when a former founding member of the People's National Movement, a former Government Minister, acting Prime Minister, the Minister of Health, Kamaluddin Mohammed, who most of us would be aware of, whilst

he was at our Mount Hope hospital, and the family actually made a request for an ambulance to drop him home, that was denied. And it pained me to see that a man who had served in that capacity would have had to, you know, actually voice, you know, his family voiced that opinion in the newspaper about that lack of service. So I think the ambulette services are something we have to factor in. There are patients who may have to leave Barrackpore and attend to a cancer treatment in St. James. Those patients, you know, they may need that service that somebody can pick them up, carry them for their radiotherapy, chemotherapy, and drop them back home. So there is a need for that. There are persons who may be, you know, elderly persons, wheelchair bound and not able to afford private ambulance to carry them for physiotherapy. These are the people there that are in public crying out for help for suffering. And I look at even, you know, the fact that if we could treat our former, you know, deputy Prime Minister like that, a Minister of Health like that, what will happen to the normal persons out there, the ordinary citizen? So the ambulette system, you have that available in Tobago, and I think probably, members, this is something we may have to look in Trinidad setting to have that services running for people who, you know, they may not be able to afford an ambulance to drop their relatives to come to the hospital. And we may need that service to develop in Trinidad as, you know, an augment to the service. Any comments you would want to make, Sir.

Mr. Frederick: Yes. We actually have that service at the hospital, not in its full entirety, it is called, Patient Materials and Transport. That is one of our—

Mrs. Baptiste-Primus: Sorry?

Mr. Frederick: It is called Patient Materials and Transport, PMT. You would see outlined in one of our responses where in terms of how we allocate the ambulances, one is currently at the hospital and it is for that purpose, but of course one for 65,000 people, you know, is obviously not sufficient. That ambulance transports patients from hospital for dialysis and those things. Yes, now and again, we may have to take home someone

which is not part of emergency medical service, it falls under the PMT, but, you know, one for 65,000, or even sometimes you have patients from hospital, two, three, four, five, who have to do dialysis on the same day, you know, you have that issue. And then you have persons on the outside, external patients, who have to go to the same dialysis centre, and, of course, after dialyzing them, you know, they are very weak and unable to actually sit in a car. So, you know, I am all up in arms with the recommendations for that ambulette service which would be able to, you know, do that particular service.

Mr. Chairman: So there is a need to expand the ambulette services, and probably Trinidad needs to probably see if we can follow you guys and at least have something, you know, running properly in terms of the ambulette services. A question I wanted to ask though, I think Ms. Baptiste brought up the legalities of, you know, someone entering the ambulance, when would they belong to the hospital or the Tobago House of Assembly, you know, THRA? In terms of the staff, if there is an accident and the members of staff get damaged, the EMTs, are they covered?

Ms. Melville: Yes, Chairman, we have—[*Interruption*]

Mr. Chairman: And why I asked that because certain of our nurses here voiced that concern also, that the driver may be covered but not the nurses who may have to go on escort.

Member: Correct. Yeah.

Mr. Chairman: So this is something—

Mr. Frederick: Yes, we have had that situation, exact same situation in Tobago where nurses would have voiced that. It eventually boils down to education, because once anybody is on our vehicle, once you are authorized to be in the vehicle, you are covered by the vehicle insurance. In addition—I do not know if it is called Workmen's Compensation Act, or something to that effect, where once you are on duty and you are providing the services for which you are paid, you are covered as well.

Ms. Melville: And in addition to that, over the last six months or so, we have instituted

insurance coverage for our staff, because in addition to the staff transporting persons and ambulances, we have staff who travel with patients to Trinidad and who have to also negotiate the highways and byways in Trinidad with patients, or after delivering patients, and so we have instituted insurance coverage for those staff members. In terms of the ambulance service which you spoke to, Chairman, in addition to what Mr. Frederick would have outlined, we also have a palliative care service mainly to deal with oncology patients, and we provide transport which would allow our staff to also reach patients where they are and to support patients in terms of accessing their care at the oncology unit.

Mr. Chairman: I commend you for that service. As you mentioned transport, could you tell us about the transport in terms of somebody coming from Tobago to Trinidad via helicopter services, is it up? Is it functioning? Is there a need for improvement there?

Ms. Edwards-Benjamin: Yes, the helicopter service is very much up and functioning and very efficient. We do have a helipad at our hospital, so we no longer have to deal with the issues of getting the patient to Crown Point. Once we have a helicopter transfer, the National Helicopter Service provides that service for us, and they would land at our helipad there at the hospital. Our in-house ambulance will take the patient to the point and patients are taken to Trinidad, to whichever facility in Trinidad that they are transferred to.

Mr. Chairman: As we have mentioned that we are looking in at the personnel, you know, the coverage given to the personnel, but first responders, sometimes after the—and Mr.—you know, I am sure you are aware of that in your knowledge of the mental health, because you first started in mental health, you know, Mr. Frederick. First responders, do you have any way of helping those first responders deal with all the, you know, the situations where they reached there and they are seeing people ailing, and the research has shown first responders need some sort of therapy to prevent trauma and post-trauma. Do you offer such services?

Ms. Edwards-Benjamin: Yes, the TRHA does have an EAP system for our staff, and it

is available to them. They can access that service privately or individually, but there are times following events that we would have to call in EAP and we do group sessions with them. So, yes, that service is available where our employees can have that facility to have counselling, or if it is just to explain or to express their—to deal with their psychological issues. We also have our psychologists on staff who also, if the situation escalates, that deal with our employees.

Mr. Chairman: Ms. Ameen.

Ms. Ameen: Yes, thank you, Chairman. Mr. Chairman, I want to go into tendering a bit.

Mr. Chairman: Sure.

Ms. Ameen: In the report in your submission you indicated that a selective tendering process is used to procure vehicles, and while I want to get some details in terms of which companies comprised that list of prospective bidders, I also want to ask if you—well, I want to ask you to provide the Committee with a list of the prospective bidders that you have approved to provide ambulances. But I also want to ask, in terms of preparation for the new procurement legislation, what preparations you have to change your tendering procedure? Well, procurement is the acquisition but also the disposal of assets. So you have seven diesel ambulances which you say are more than 10 years old which you would want to dispose of. Will you be utilizing the principles in the new legislation to dispose of those new ambulances, for example?

Ms. Melville: We do have a pre-approved list of suppliers which was reconstituted over the last fiscal period. At the moment I am not sure that there are service providers who supply ambulances on that list, because we generated a new list over the last fiscal period, but that list can be made available to you of all suppliers, potential suppliers, pre-approved to supply the TRHA. Regarding the new procurement legislation, we have been providing training at different levels to our existing purchasing department, as well as to managers. However, we recognize that in terms of what is coming out of the Procurement Regulator, based on the procurement handbook, that we need to reassess and redesign our

procurement function within the TRHA. That is ongoing and very soon, within the next quarter or so, we should be fully compliant in terms of what is required now under the new procurement legislation. But, yes, in all the procurement which we do and all procurement functions, we have taken on board the principles of value for money, equity, also all the principles, and also considering that Tobago is an island with various suppliers who form a private sector which must be related to.

Ms. Ameen: At present, do you give preference to suppliers in Tobago as opposed to Trinidad and Tobago?

Ms. Melville: As I said, we try as far as possible to maintain that, our responsibility in terms of even working with the private sector in Tobago. So once the item is available from the private sector in Tobago, and the disparity in pricing, if any, is not outside of the range, then, yes, preference would be given to the Tobago suppliers.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. With regard to your submission that both the Tobago Emergency Management Services and TEMA are members of the Tobago disaster management committee, which you said meet and discuss, the report was submitted, the Disaster Management Plan, could you explain to this Committee how Tobago Emergency Medical Services, how you all have collaborated with TEMA in a real life situation?

12.00 noon

Mr. Frederick: Yes. We are members of the Tobago disaster management committee. Actually, I am the representative for TEMS on the committee, and then we have another person representing the TRHA on a whole on that committee.

One situation in that we would have literally worked out with was the last—flood?—storm. Right. I wanted to make sure that I got it correct. And we would have worked very closely with TEMA; in fact, all the entities worked together because we had to do—moving people. There is a word which just eluded me. We had to move people—evacuation—we had to implement our evacuation plan, and actually operationalize it, and

that was between TEMA and TEMS and all the other entities, the other first-responding agencies. So, we actually—we do not only just sit around the table and say what we will do, we actually roll up our shirt sleeves, take off our tie and hit the road.

Mrs. Baptiste-Primus: Well, that does not help—I do not know about the other members of the Committee—it does not really help me to understand how did you all collaborate, the ways and means in which you all collaborated and worked as a team in that real-life situation.

Mr. Chairman: And how do you evaluate it?—to evaluate it after, to see how well it worked.

Mr. Frederick: Yes. We have the after-action review which is hosted by TEMA; so it is a call-out system. We also have it on Zello, which is a feature on the phone, it is an app where all the first-responding agencies can hear it once your phone is on, and you have the app on your phone and you have Internet you would hear it. It very often would be sent out by TEMA, and the EOC, Emergency Operation Centre, would be operationalized so different levels of management would go there, the heads would go there and we would operationalize it out.

We would also be in the field, side by side working together with firemen, with CERT technicians, with soldiers, coast guard, everybody would be working together, literally working together in those situations, even on the scene of an accident if it is that, you know, it is that extensive we would all be out there working together. But most of the time the call would come from TEMA except it is an accident, we would then send the call to TEMA, you know, but if it is a natural disaster, TEMA would send the information out via Zello, phone call, email, everything.

Mr. Chairman: In terms of a disaster, so you collaborate with the fire services. Now, I understand in Trinidad and Tobago, I think there are 62 fire officers trained in paramedics and I think there are about 24 ambulance services provided by the fire services. In case of there is a failure in terms of they cannot locate one of your ambulances on time, would

you be able to get the fire service ambulance to come on board and help in that situation? And I am not talking about a natural disaster where, you know, you have storms and whatnot, but are there needs sometimes to somehow source the fire service ambulance with their paramedics?

Mr. Frederick: Yes. There are.

Mr. Chairman: One other question. Now, if there is a storm—again, there is blockage of the road, in Trinidad I think it was in Toco, there was, I think, the Japanese government had given us a 32-foot boat. Right? Thirty-two foot boat and that is available as a sea ambulance, I think they call it Angela. Is there a need for an Angela in Tobago where blockage of the road, you may be able to come up, yeah, to circumvent that aspect?

Ms. Melville: Certainly, Chairman, if you can use your good office to motivate [*Laughter*] it would be ideal because we would appreciate that with open arms.

Member: If we can get an Angela.

Mrs. Baptiste-Primus: Perhaps we can get—

Mr. Chairman: Or a Jennifer. [*Laughter*] Yes. Yes. All right. So, as we try to wrap up here, I would like to ask, are there any other questions that members would like to ask?

Ms. Ameen: Mr. Chairman, from the reporting of the members here, it sounds like Tobago has their business much more intact than Trinidad when it comes to ambulance service delivery. And very often when entities come before joint select committees in Parliament they give a good account of themselves even if, you know, when if they exaggerate a little in some areas, but the truth is that it does not appear that Tobago has any, well any major issues with being strapped for allocations, financial allocations that is, and I see the Secretary smiling. At least, we did not get the impression from your testimony today that you have had to tighten your belt, that you have had difficulty in allocation. Many entities have had delays in releases from the Ministry of Finance.

You have allocations, you have sufficient allocations in the budget, but there are delays in the moneys actually being released. Does the THA, and by the extension the

regional health authority and the ambulance service, suffer from a delay in releases from central government? [*Crosstalk*]

Mr. Chairman: Well, you know, we are all reaching an ageing population and in Trinidad and Tobago. We have an ageing population, 13 per cent of us are over 60 years old, and you define an ageing population as if you are more than 10 per cent. So, more and more you would find the elderly would be succumbing to heart attacks, strokes. You would have the occasional, you know, accidents happening, and the need for an ambulance service is really, you know, we have to look ahead to get it up and running because of our ageing population also.

I think you have your act together, and I think we have identified certain things, you know, to get the ambulettes to get, as they say, you know, certain, you know, better training actually to reach that level of training so we would not have a disparity for what is offered in Trinidad and Tobago.

We have also seen the need to get, as I am saying, the Angela on board, and overall I think I am pleased with what we are hearing, and we have learned from you guys, and we have also, again, you are the first set to start the training in 1999, so it is something, a benchmark that you listed and I would like to thank you for your—

Ms. Ameen: Chairman—

Mr. Chairman: Yes. Sure.

Ms. Ameen:—my apologies for interrupting you.

Mr. Chairman: No. I am sorry.

Ms. Ameen: It sounds as though you are wrapping up.

Mr. Chairman: Well, I was about, but I did not realize you—

Ms. Ameen: But I want to get. I know we started a few minutes late, but I wanted to get the answer for my last question—

Mr. Chairman: Sure. Go ahead.

Ms. Ameen:—which is whether they are having delays with releases?

Mrs. Baker-Henry: Good afternoon, again. As the Division, we are responsible for releasing allocation to the TRHA. What is happening, it is no secret that the Tobago House of Assembly receive their money from the central government on a monthly basis. At the divisional level we receive our releases from the Division of Finance. And so what we, as soon as we receive our releases, normally the first week within a month, and as soon as we get our releases we will seek to attempt to disburse the funding allocated to the TRHA as quickly as possible.

It is not about the sufficient allocation, but what we attempt to do, and I am trusting and I know what the TRHA attempts to do is prioritize their expenditure so as to maximize the use of the resources that are allocated/released to them. So it is about structuring their expenditure to maximize the usage.

TRHA would need more money, yes, but they utilize the fundings that they are given in the best and most efficient—at least, they attempt, let me say that, to utilize their resources as best as they can, given their priority areas. So, certainly if you were to ask them, they may say they may need more money, but they tend—

Ms. Ameen: No. No. No. Chairman, I just want to guide you, I do not want you to misunderstand my question in terms of whether the allocation is sufficient. All agencies have to prioritize.

Mrs. Baker-Henry: Okay. Great.

Ms. Ameen: There are many state agencies that have been allocated an amount in the budget—regional corporations, for example—and you apply to the Ministry of Finance for the releases.

Mrs. Baker-Henry: They get their releases on time.

Ms. Ameen: That is my question. Whether you are getting your releases on time?

Mrs. Baker-Henry: They are getting their releases on time.

Ms. Ameen: Not from the Division, but from central government.

Mr. Frederick: Yes. Yes.

Ms. Ameen: Thank you.

Dr. Carrington: Could I just be allowed to follow up that?—to also say that we in the THA we have learned to do more even if it were less, we will do more with less. We pay attention to that, and even if it may sound that it is all well, we understand that we are doing more with what we have. Thank you.

Mr. Chairman: And, Ms. Carrington, I saw you all have public meetings where you are actually—you are thrown to the wolves—where people come, they question, they ask things so, at least, that level of accountability to your population and their needs, I think this is something that, again, we would like to commend because I have seen the deficiencies, I have defended it in a lot of the articles that were brought forward from the newspapers.

Dr. Carrington: May I say as well on that, that is part of our planning process. This is the second cycle, we had a 2017 edition where we had outreached the communities where it is important to have the community participate in the planning process, and we will continue to do that because the feedback from the community would assist us as we respond to their needs.

Mr. Chairman: So, I would like to thank you, but I would like to say, if any of you now, we would like to get some closing remarks from, you know, Ms. Carrington, if you have any closing remarks you would like to give us?

Dr. Carrington: So, to Chairman and members, again, we are grateful for this opportunity to share the efforts that we have been making to respond to the emergency needs of our population. And I am saying, Tobago and Trinidad and Tobago and visitors, because we do have persons from Trinidad accessing our services as well.

As Chairman indicated that we are aiming to make Tobago the preferred destination for health care delivery, we are aiming. A lot more is to be done, but we feel certain with the commitment of our staff, and with the resources that we have, I did indicate a little while ago that we are doing more with less, whatever we have. And the intention of that

is to ensure that our population is well served.

The ideas mentioned, the suggestions mentioned, we will take those on board as part of our planning process allowing for us to improve areas in which we are deficient. I want to thank you sincerely for this opportunity.

Mrs. Baptiste-Primus: Perhaps, Mr. Chairman, before you close I just want to—

Mr. Chairman: Sure.

Mrs. Baptiste-Primus: I am sorry. Thank you for entertaining me. I would just like to commend the Tobago RHA and the Division of Health for the appointment of the very first female medical chief of staff in Trinidad and Tobago; it augurs well for the future.

Mr. Chairman: Dr. Rufaro. It is Dr. Rufaro, yes, an excellent doctor. I worked with her years ago as a student also. Ms. Ingrid Melville, would you mind giving us any sort of closing comments, please?

Ms. Melville: Briefly, Chairman, like the Secretary, I add my voice in thanks for this opportunity. The TRHA recognizes its role that it exists to serve the population. It is a small society that we serve, and we know on any given day any one of us, our loved ones, would need the service, and so there is a vested interest in making the service as effective as it can be.

So thank you and I hope that what we have provided today has been useful, and I look forward to any potential future collaboration. Thank you.

Mr. Chairman: Okay. The public is advised that the Committee's report on an enquiry into the efficiency and effectiveness of the regional industries commission—Regulated Industries Commission, RIC, was recently presented to the House of Parliament and is available for review on Parliament's website www.ttparliament.org. Some of the major issues which were highlighted/identified during the course of that enquiry included:

1. The status of the Rate Review that was being undertaken by the RIC in relation to WASA and T&TEC;
2. The contribution of the RIC to the development and improvement of the

public utilities;

3. The performance of the RIC with respect to treating with complaints filed against public utilities;
4. The line Ministry's plan to "modernize" the Public Utilities Sector;
5. Arrangements in place to finance the RIC's operations; and
6. The relationship between the RIC and the utility service providers.

If there is no further business for consideration, I would like to thank you all for being here, and declare this meeting adjourned.

12.15 p.m.: *Meeting adjourned.*

Appendix 10

National Ambulance Online Survey

INQUIRY INTO THE EFFICIENCY AND EFFECTIVENESS OF THE NATIONAL EMERGENCY AMBULANCE SERVICE

Draft Survey

BACKGROUND QUESTIONS

1. Have you or any family member or relative ever used the National Emergency Ambulance Service?
   Yes **No**

2. If yes, how many times have you/family member(s) ever used the National Emergency Ambulance Service?
   Never **1-2 times** **3-4 times** **5 times or more**

3. Which of the following best describes the area in which you reside?
   a. **Urban (inner city or inner town)**
   b. **Residential Area/Development**
   c. **Rural**

4. Did you know that the hotline telephone number for the National Emergency Ambulance Service is 811?
   Yes **No** **Not sure**

EXPERIENCES OF THE NATIONAL AMBULANCE SERVICE

5. Regarding your most recent experience using the national ambulance service, what was the response time of the ambulance?
   0-5 minutes **6-10 minutes** **11-15 minutes** **16-20 minutes** **21 or more minutes**

6. How would you rate the response time of the ambulance?
   Excellent **Good** **Adequate** **Poor** **Unacceptable**

7. Do you believe that you would receive medical attention more quickly if you arrive at a public health facility in an ambulance?
   Yes **No** **Not sure**

8. How satisfied were you with the quality of service provided to you or your relative by the paramedic(s)/Emergency Medical Technician(s)?
   a. **Very Satisfied**
   b. **Satisfied**
   c. **Unsatisfied**
   d. **Very unsatisfied**

9. Based on your experience, or the experiences of others, do you believe that the national ambulance service is reliable and dependable?
   Strongly disagree Disagree Neutral Agree Strongly agree

10. Based on the performance of the ambulance service, how confident are you in requesting the service again in the future?

    Not at all confident not confident somewhat confident confident very confident

11. If you were not satisfied with your experience(s) with the national ambulance service, please briefly explain why.
    …….

12. Please provide suggestions to improve the national ambulance service.

    …….

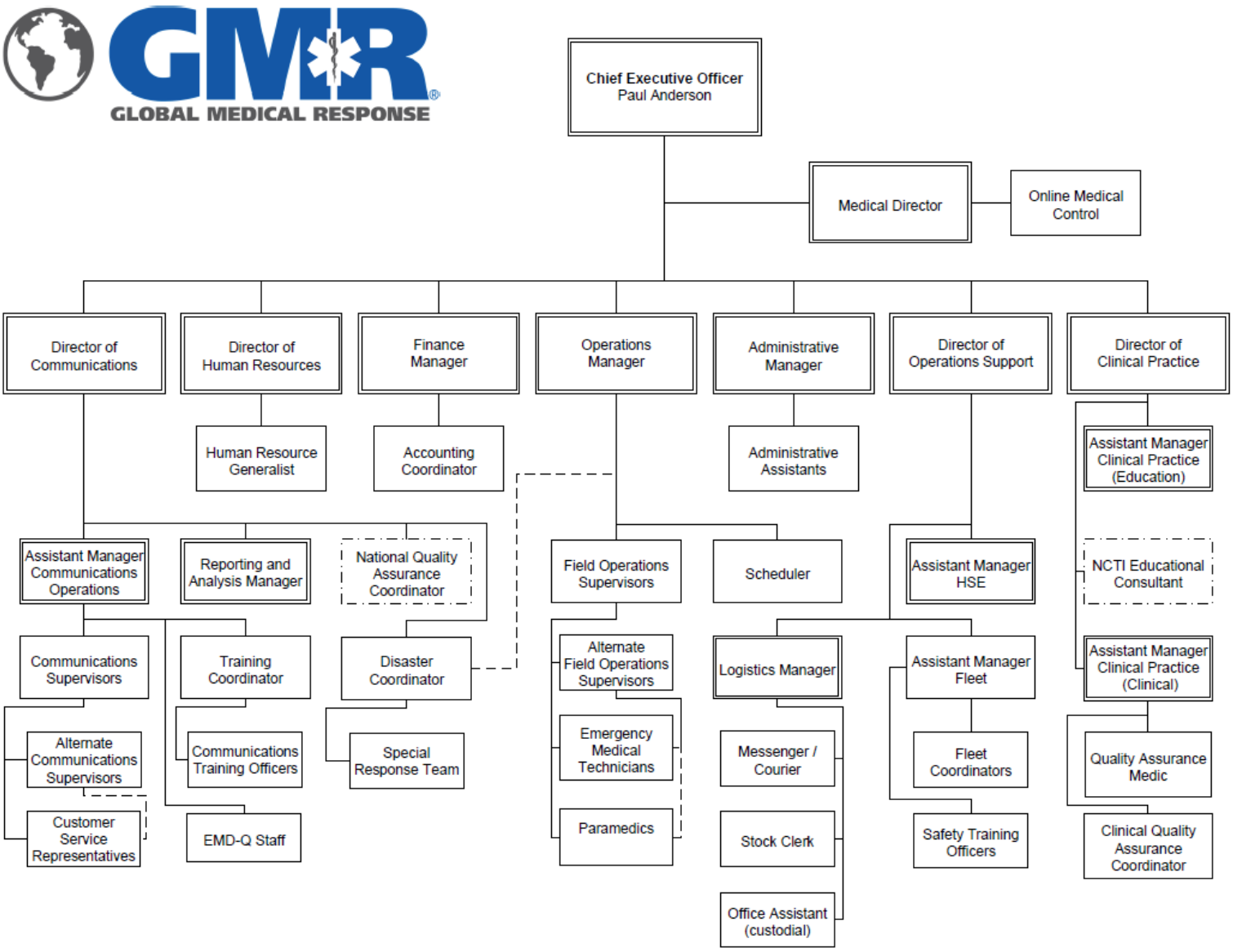
Sources

Marion County Ambulance District Satisfaction Survey. http://www.mcadems.com/patient-satisfaction-survey.html

Derry Fire Department EMS Division Customer Satisfaction Survey. https://www.surveymonkey.com/r/DFDEMSSurvey

Appendix 11

GMRTT Organisational Chart


GLOBAL MEDICAL RESPONSE
Chief Executive Officer
Paul Anderson
Medical Director
Online Medical Control
Director of Communications
Director of Human Resources
Finance Manager
Operations Manager
Administrative Manager
Director of Operations Support
Director of Clinical Practice
Human Resource Generalist
Accounting Coordinator
Administrative Assistants
Assistant Manager Clinical Practice (Education)
Assistant Manager Communications Operations
Reporting and Analysis Manager
National Quality Assurance Coordinator
Field Operations Supervisors
Scheduler
Assistant Manager HSE
NCTI Educational Consultant
Communications Supervisors
Training Coordinator
Disaster Coordinator
Alternate Field Operations Supervisors
Logistics Manager
Assistant Manager Fleet
Assistant Manager Clinical Practice (Clinical)
Alternate Communications Supervisors
Communications Training Officers
Special Response Team
Emergency Medical Technicians
Messenger / Courier
Fleet Coordinators
Quality Assurance Medic
Customer Service Representatives
EMD-Q Staff
Paramedics
Stock Clerk
Safety Training Officers
Clinical Quality Assurance Coordinator
Office Assistant (custodial)

Appendix 12

GMRTT Accreditation Certificate

The Commission on Accreditation of Ambulance Services

Certificate of Accreditation

Global Medical Response of Trinidad and Tobago Limited
Port of Spain, Trinidad and Tobago

The Commission on Accreditation of Ambulance Services presents this certificate of Accreditation in recognition of this service's voluntary compliance with the Commission's high standards. These standards have been established to encourage and promote improved quality patient care in the medical transportation system. This service has successfully completed a comprehensive external review to verify compliance with these national standards.

Issued: April, 2014

Expires: June 30, 2017

Margaret Keavney, Chair
Panel of Commissioners

ACCREDITED

Mark Meijer, Chair
Board of Directors