SECOND

REPORT FROM

The Public Administration and Appropriations Committee

EXAMINATION OF

The efficiency of the delivery of services to the public by the Regional Health Authorities and a follow up on the implementation of the recommendations presented in the Welch Report, First Session, Twelfth Parliament.

Office of the Parliament
Parliamentary Complex
Cabildo Building
St. Vincent Street Port of Spain
Republic of Trinidad and Tobago

PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

Public Administration and Appropriations Committee

The Public Administration and Appropriations Committee (PAAC) is established by Standing Order 102 and 92 of the House of Representatives and the Senate respectively. The Committee is mandated to consider and report to Parliament on:

(a) *the budgetary expenditure of Government agencies to ensure that expenditure is embarked upon in accordance with parliamentary approval;*

(b) *the budgetary expenditure of Government agencies as it occurs and keeps Parliament informed of how the budget allocation is being implemented; and*

(c) *the administration of Government agencies to determine hindrances to their efficiency and to make recommendations to the Government for improvement of public administration.*

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Dr. Lackram Bodoe	Vice-Chairman
Mrs. Amrita Deonarine	Member
Mrs. Ayanna Webster-Roy	Member
Mr. Clarence Rambharat	Member
Mr. Stephen Mc Clashie	Member
Mr. Wade Mark	Member
Ms. Yokymma Bethelmy	Member
Ms. Lisa Morris-Julien	Member
Mr. Hassel Bacchus	Member

Committee Staff

The current staff members serving the Committee are:

Ms. Keiba Jacob	Secretary to the Committee
Ms. Hema Bhagaloo	Assistant Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Rachel Nunes	Graduate Research Assistant
Ms. Kelly Cipriani	Parliamentary Intern
Ms. Anesha James	Administrative Support
Ms. Natoya O'Neil	Administrative Support

Publication

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Date Laid in HOR: November 10, 2021 **Date Laid in Senate: November 16,2021**

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Members of the Public Administration and Appropriations Committee

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Chairman

Dr. Lackram Bodoe
Vice-Chairman

Mr. Wade Mark
Member

Mr. Clarence Rambharat
Member

Mrs. Ayanna Webster-Roy
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Mr. Hassel Bacchus
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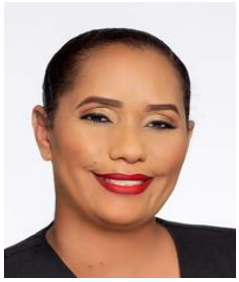
Mr. Stephen Mc Clashie
Member



Ms. Lisa Morris -Julien
Member

Ms. Yokymma Bethelmy
Member

EXECUTIVE SUMMARY

The objective of this Report of the PAAC for the Twelfth Parliament contains the details of the examination of the efficiency of the delivery of services to the public by the Regional Health Authorities (RHA's) and follow up on the implementation of the recommendations presented in the Welch Report on the health care system.

The Committee, in undertaking this examination employed two (2) mechanisms:

- Written Submission and reports; and
- A Public Hearing.

The Committee focused on the review and analysis of the following reports:

- Report 1A - The Levels of Health Care Delivery by the Regional Health Authorities (RHA); and
- Report 1B – The Rationalisation of the System of Public Sector Doctors in Private Practice.

Subsequently, the Committee conducted a Public Hearing with the Ministry of Health (MOH) and the following Regional Health Authorities based on the recommendations within the report:

- Eastern Regional Health Authority (ERHA)
- North Central Regional Health Authority (NCRHA)
- North West Regional Health Authority (NWRHA)
- South West Regional Health Authority (SWRHA)

The approach adopted by the Committee took into account the issues identified from the published Report and current news in the media. The Committee made recommendations related to the issues identified.

Observations and recommendations are presented in Chapter 3.

1. INTRODUCTION

THE COMMITTEE

The PAAC of the Twelfth Republican Parliament was established by the revised Standing Orders to:

- examine the current public expenditure, thereby capturing the full budget cycle by providing Parliamentary oversight of the implementation of the budget; and
- conduct a real-time examination of the expenditure of Ministries and Departments.

In the Twelfth Parliament the Members of the Committee were appointed by resolutions of the House of Representatives and the Senate at sittings held on Friday November 9, 2020 and Tuesday November 17, 2020 respectively.

Chairman & Vice-Chairman

By virtue of S.O. 109(6) and 99(6) of the House of Representatives and the Senate respectively, the Chairman of the Committee is the Speaker and at its First Meeting held on November 25, 2020, Dr. Lackram Bodoe was elected as the Vice-Chairman.

Quorum

Additionally, in order to exercise the powers granted to it by the House, the Committee was required by the Standing Orders to have a quorum. A quorum of three (3) Members, inclusive of the Chairman or Vice-Chairman, with representatives from both Houses, was agreed to by the Committee at its First Meeting.

2.METHODOLOGY

Determination of the Committee's Work Programme

At an in-camera meeting of the Committee held on Wednesday, November 25, 2020, the Committee agreed to conduct an inquiry into the efficiency of the delivery of services to the public by the Regional Health Authorities (RHAs).

Review of Documents

The Committee deliberated on the following documents, namely:

i. Written Submissions;
ii. Reports; and
iii. Current news.

The Inquiry Process

The Inquiry Process outlines steps to be taken by the Committee when conducting an inquiry into an entity or issue. The following steps outline the Inquiry process followed by the PAAC for its examination into the efficiency of the delivery of services to the public by the Regional Health Authorities (RHAs):

i. Identification of entity to be examined: MOH and RHAs;
ii. Preparation of an Issues Paper which identified and summarised matters of concern and recommendations presented in the Reports;
iii. Based on the recommendations and the issues identified, the Committee agreed to have a Public Hearing. The relevant witnesses were invited to attend and provide evidence on Februay 10, 2021.
iv. Following the Public Hearing, a request for further details was sent to the MOH on February 17, 2021, the responses were received on March 16, 2021.
v. Report Committee's findings and recommendations to Parliament upon conclusion of the inquiry.
vi. Request for Ministerial Responses. Review responses.
vii. Engage in follow-up.

3. ISSUES, OBSERVATIONS AND RECOMMENDATIONS

1. Implementation of Recommendations to Part 1A of Report

I. Approach

In Part A of the report, the Welch Committee presented a number of recommendations to improve the levels of health care delivery by Regional Health Authorities (RHAs). These recommendations were connected to the assessment of the seven (7) major pillars in the delivery of health care in Trinidad. These pillars are:

i. Primary Health Care;
ii. Secondary and Tertiary Institutions;
iii. Infrastructure;
iv. Vertical Services;
v. Executive;
vi. Office of the Chief Medical Officer; and
vii. The Ministry of Health, Head Office.

In its response to the Committee, officials explained the process for the implementation of the recommendations as follows:

- Each recommendation was broken down into sub-activites, in alignment with the seven (7) pillars;
- Sub-activities were then grouped with the pillar it was aligned to and a status report on each presented;
- Each status report was then grouped to determine an overall implementation rate; and
- Simultaneously, the status of the activities under each recommendation was assessed and a percentage of implementation was calculated in order to determine an overall implementation rate.

Officials from the MoH described this as a bottom-up approach, whereby, a status report was received on the implementation rate of each sub-activity which was aligned to the respective recommendation and pillar.

II. Status of the Implementation of the Recommendations

During the public hearing, the Committeee learnt that the implementation rate of the recommendations was low. In its response to a request for a status update, the following information was provided by the MOH:

- Due to the range of the thirty-nine (39) recommendations, the MOH divided the recommendations into approximately two hundred and fifty-one (251) sub-activities which were incorporated into the work plans of both the RHAs and the MOH;
- In 2018, the overall implementation rate was 61.79% with the status of the two hundred and fifty-one (251) sub-activities as follows:
    - 210 sub-activities are ongoing;
    - 12 sub-activities have been completed; and
    - 29 sub-activities have not started.
- As at 2020, the implementation rate increased to 82.7% with the status of the 266 sub-activities were as follows:
    - 215 sub-activities are ongoing;
    - 25 sub-activities have been completed; and
    - 26 sub-activities have not started.

The Committee enquired about the increase in the number of ongoing sub-activities between 2018 and 2020. Officials from MOH explained that the increase was due to continuous improvement and assessment of the progress made as well as changes in its circumstances and the environment. These assessments identified new activities that were relevant and worth pursuing. The activities not started and ongoing were included in the 2020 and 2021 work plans for both the RHAs and the MOH.

Observations:

- ***The Committee noted the continuous review of the Ministry's progress in the implementation of the recommendations; and***
- ***The methods used to calculate the implementation rate of the Welch Committee's recommendations.***

Recommendations:

- ***A copy of the work plans of each RHA and the MOH for fiscal 2022 should be submitted to Parliament by January 31,2022; and***

- ***The MOH should conduct an evaluation of the effectiveness and compliance with the sub-activities by the RHAs and submit the findings to Parliament by January 31 2022.***
- ***The MOH should submit to Parliament a status update on the implementation of the remaining recommendations as well as the new sub-activities that were relevant and worth pursuing at the end of the first quarter of fiscal 2022.***

2. <u>Status of the implementation of the recommendations in Part B of the Welch Report</u>

Part B of the Welch Report aimed to rationalize the System of Public Sector Doctors in private practice. Two options were delivered to the MOH as follows:

1. the termination of private practice; and
2. that doctors continue with some level of private practice, but utilise performance indicators in terms of managing the output of physicians.

In the written response provided by the MOH, it was stated that given the sensitivity and complexity of the subject matter and the repercussions that may arise in health service delivery, it was still considering its options. The MOH indicated that it plan to hold consultations with key stakeholders including the Medical Board of Trinidad and Tobago (MBTT) to discuss and determine the most suitable way forward as to avoid a possible fallout with medical doctors and other healthcare professionals. The Committee queried a timeline for these consultations. Officals indicated that consultations will be held during the third quarte and fourth quarter of fiscal 2021.

At the public hearing, the Ministry provided a status update and informed the Committee of its plans to focus on the second option put forth in the Report. Officials stated that it was reviewing the use of a performance management system with regard to the management of the contracts of physicians. The Committee sought an update from the Chief Executive Officer (CEO)'s of each RHA and the measures implemented. The following updates were provided:

- NCRHA – the Auhtority was focused on the outcomes and outputs associated with the services provided by physicians. As a result, the NCRHA recorded an increase in the number of surgeries. This was monitored at the executive level by the Board and its sub-committees. The Authority used the number of surgeries as a metric to monitor the achievement of outcomes and outputs by physicians.

- ERHA – In the short term, the Authority engaged its heads of departments and consultants to ensure there would be an increase in all services. For example, through this engagement the Authority was able to reduce waiting times, reporting times and reduce surgical waiting times. In the long term, the ERHA plans to look at the implementation of a performance management system to be able to monitor performance linking outputs.
- NWRHA – the CEO indicated that in addition to the measures highlighted by the previous RHAs, the NWRHA was in the process of reviewing its performance measurement tools. The CEO stated that roll out had started at the St. Ann's Hospital and the St. James Medical Complex. Additionally, medical directors were increasing its case reviews, which was a peer based related initiative where doctors were required to review each other's performance. These reviews were used as a supervisory tool to assess a doctor's performance, identify gaps and room for improvement.
- SWRHA – Similar to the previous RHAs, the SWRHA also increased its focus on performance outcome measures. The SWRHAassessed different tiers in its system and tailored its performance metrics to those areas e.g medical administrations, surgical services, heads of departments among others. Customer feedback as well as time motion studies were also were used as measurement tools.

Observation:

- ***The Committee recognises the efforts made by the RHA's and the MOH regarding the improvement of the performance and monitoring of physicians engaged in private practice.***

Recommnedation:

- ***A status update should be submitted to Parliament by January 31, 2022 on the consultations with the MBTT identifying the key points derived and the way forward; and***
- ***The MOH should implement a standardized performance management system and a monitoring and evaluation system throughout the RHAs and submit a status update to Parliament by January 31, 2022 as this would assist in strengthening staff efficiency and accountability.***

3. Hindrances to the implementation of the recommendations

The Committee learnt of several challenges being experienced including:

- Financial constraints;
- Human Resource Management and capacity constraints;
- The time lag in the approval and implementation process for the design and approval of projects and work activities;
- The bottlenecks of the procurement process for goods and services; and
- The creation of a parallel health care system to support COVID-19 treatment and care while maintaining existing services at existing public health institutions.

Given the challenges experienced, the MOH and the RHAs prioritised the key activities under each pillar for implementation. Given its limited resources, the MOH appointed Focal Point Officers to closely manage the effective implementation of the recommendations at each RHA. This responsibility was assigned to existing staff.

The Committee enquired whether additional funding was requested to assist in the implementation of the recommendations. Officials stated that the Ministry sought to finance these activities through its normal budgetary allocation. Regarding the improvement of any of the challenges identified, the Ministry stated that the human resource capacity constraints were being managed to achieve the best possible outcome for service delivery by maximising time and reporting on schedules.

Recommedations:

- ***The MOH and the RHA should provide a status on the alternative options or initiatives undertaken to source additional funding and/or equipment to assist in the implementation of the recommendations by January 31, 2022; and***
- ***The MOH and the RHA should assess the key constraints and challenges each faces in the implementation of the recommendations, identifying any further measures necessary to overcome them and submit the findings to Parliament by January 31, 2022.***

4. Recruitment of a Chief Executive Officer (CEO) for the NWRHA

The Committee questioned the timeline for the recruitment of a CEO to fill the vacant CEO's position at the NWRHA. Officials indicated that they were in the process of advertising to fill the position. At the time of the public hearing dated February 10, 2021, no advertisments were placed.The Committee requested a date for the placement of the advertisements and was informed that the decision was up to the Board of Directors of the relevant RHA.

The MOH indicated that the tenure of the NWRHA's Board of Directors will end on February 20, 2021 and it was awaiting the appointment of a new Board. It was stated that the timeframe for the recruitment of a CEO will be addressed and decided upon when a new Board of Directors has been duly appointed.

Recommendation:

- ***The MOH should submit to the Parliament by Janaury 31, 2022 a status update of the appointment of the Board at the NWRHA and the recruitment of a CEO.***

CONCLUSION

As a Health Authority, the RHAs were established to provide efficent systems for the delivery of health care across Trinidad and Tobago. The Welch Committee was set up to audit the current manner of operations of the RHA's and its ability to provide quality health care and to rationalise the system(s) and the framework that governs doctors who pursue private practice while employed in a public institution. During the First Session of the Twelfth Parliament, the PAAC conducted an examination into the efficiency of the delivery of services to the public by the RHA's and to follow up on the implementation of the recommendations presented in the Welch Report. Several issues were identified and a number of recommendations were highlighted to address these issues. However, due to constraints the rate of implementation was low.

The Committee is of the view that the adoption of its proposed recommendations will lead to greater efficiency in the health care system by the MOH and the RHA's. Moreover, the Committee intends to monitor the progress made in the implementation of the recommendations proposed in this Report and by extension the Welch Report.

This Committee respectfully submits this Report for the consideration of the Parliament.

Mrs. Bridgid Mary Annisette-George
Chairman

Dr. Lackram Bodoe
Vice-Chairman

Mrs. Ayanna Webster-Roy
Member

Ms. Yokymma Bethelmy
Member

Mr. Hassel Bacchus
Member

Mr. Wade Mark
Member

Mr. Stephen Mc Clashie
Member

Mr. Clarence Rambharat
Member

Ms. Amrita Deonarine
Member

Mrs. Lisa Morris-Julien
Member

APPENDIX I

The Inquiry Process

The Inquiry Process

The Inquiry Process outlines steps to be taken by the Committee when conducting an inquiry into an entity or issue. The following steps outlines the Inquiry process followed by the PAAC:

1. Identification of entity to be examined;
2. Preparation of Inquiry Proposal for the selected entity. The Inquiry Proposal outlines:
    - Description
    - Background;
    - Overview of Expenditure
    - Rationale/Objective of Inquiry; and
    - Proposed Questions.
3. Consideration and approval of Inquiry Proposals by the Committee and when approved, questions are forwarded to the entity for written responses;
4. Issue of requests for written comment from the public are made via Parliament's website, social media accounts, newspaper and advertisements;
5. Preparation of an Issues Paper by the Secretariat for the Committee's consideration, based on written responses received from the entities. The Issues Paper identifies and summarises any matters of concern in the responses provided by the entity or received from stakeholders and the general public;
6. Review of the responses provided and the Issues Paper by the Committee;
7. Conduct of a site visit to obtain a first-hand perspective of the implementation of a project (optional);
8. Determination of the need for a Public Hearing based on the analysis of written submissions and the site visit (if required). If there is need for a public hearing, the relevant witnesses will be invited to attend and provide evidence. There is usually no need to examine the entity in public if the Committee believes the issues have little public interest or the Committee believes that the written responses provided are sufficient and no further explanation is necessary.
9. Issue of written request to the entity for further details should the Committee require any additional information after the public hearing.

10. Report Committee's findings and recommendations to Parliament upon conclusion of the inquiry.

11. Engage in follow-up.

APPENDIX II

Minutes of Meetings

THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE
FIRST SESSION, TWELFTH PARLIAMENT
MINUTES OF THE THIRD MEETING HELD VIRTUALLY ON
WEDNESDAY FEBRUARY 10, 2021 AT 1:37 P.M.

Present were:

Mrs. Bridgid Mary Annisette-George	-	Chairman
Dr. Lackram Bodoe	-	Vice-Chairman
Ms. Amrita Deonarine	-	Member
Mr. Hassel Bacchus	-	Member
Mr. Wade Mark	-	Member
Mrs. Ayanna Webster-Roy	-	Member
Mrs. Lisa Morris-Julian	-	Member
Ms. Yokymma Bethelmy	-	Member
Mr. Stephen Mc Clashie	-	Member
Mr. Clarence Rambharat	-	Member
Ms. Keiba Jacob	-	Secretary
Ms. Hema Bhagaloo	-	Assistant Secretary
Ms. Rachel Nunes	-	Graduate Research Assistant

COMMENCEMENT

1.1 At 1:37 p.m. the Chairman called the meeting to order and welcomed those present.

EXAMINATION OF THE MINUTES OF THE SECOND MEETING

2.1 The Committee examined the Minutes of the Second (2nd) Meeting held on January 13, 2021.

2.2 There being no omissions or corrections, the Minutes were confirmed on a motion moved by Ms. Yokymma Bethelmy and seconded by Mrs. Ayanna Webster-Roy.

MATTERS ARISING FROM THE MINUTES OF THE SECOND MEETING

3.1 As per item 3.3: the Chairman informed Members that all responses with regard to the request for the Statements of Expenditure for the fourth quarter of fiscal 2020 were received by the Secretariat.

3.2 As per item 8.2: the Chairman informed Members that additional questions were sent to the Ministry of Social Development and Family Services (MSDFS) with a deadline of Thursday Feburary 18, 2021.

PRE-HEARING DISCUSSION: AN EXAMINATION INTO THE EFFICIENCY OF THE DELIVERY OF SERVICES TO THE PUBLIC BY THE REGIONAL HEALTH AUTHORITIES

4.1 The Chairman invited Members to review the Issues Paper based on the written submission received from the Ministry of Health.

4.2 The Chairman outlined the remit of the inquiry.

4.3 The Committee discussed the approach for the conduct of the hearing.

SUSPENSION

5.1 There being no further business for discussion in camera, the Chairman suspended the meeting at 2:03 p.m., to reconvene in public.

EXAMINATION INTO THE EFFICIENCY OF THE DELIVERY OF SERVICES TO THE PUBLIC BY THE REGIONAL HEALTH AUTHORITIES

6.1 The Chairman called the public meeting to order at 2:36 p.m

6.2 The following officials joined the meeting:

MINISTRY OF HEALTH

Mr. Asif Ali	-	Permanent Secretary (Ag.)
Dr. Roshan Parasram	-	Chief Medical Officer
Dr. Stewart Smith	-	Senior Health System Advisor
Mr. Lawrence Jaisingh	-	Director of Health Policy

NORTH WEST REGIONAL HEALTH AUTHORITY (NWRHA)

Ms. Salisha Baksh	-	Chief Executive Officer (Ag.)
Dr. Antony Parkinson	-	Director of Health
Mr. Terron Gilchrist	-	Chief Operating Officer
Ms. Aruna Singh	-	General Manager, Primary Care

SOUTH WEST REGIONAL HEALTH AUTHORITY (SWRHA)

Mr. Brian Amour	-	Chief Executive Officer

Mr. Stephen Alleyne	-	Chief Operations Officer
Dr. Pravinde Ramoutar	-	Director of Health
Ms. Denise Thomas	-	General Manager, Human Resources
Ms. Lystra Walters Balgobin	-	General Manager, Quality Risk Improvement

NORTH CENTRAL REGIONAL HEALTH AUTHORITY (NCRHA)

Mr. Davlin Thomas	-	Chief Executive Officer
Dr. Malachy Ojuro	-	Director of Health (Ag.)
Dr. Abdul Haleem Hamid	-	General Manager, Primary Health Care Services (PD)
Ms. Sharon Creft	-	Chief Financial Officer (Ag.)
Ms. Joanne Thomas	-	General Manager, Human Resources

EASTERN REGIONAL HEALTH AUTHORITY (ERHA)

Mr. Ronald Tsoi-A-Fatt	-	Chief Executive Officer
Dr. Allana Best	-	County Medical Officer of Health – St. Andrew/St. David
Dr. Sasha Sankar-Maharaj	-	Medical Director (Ag.)
Ms. Sonia Seecharan-Raphael	-	General Manager, Human Resources
Ms. Amy Ali	-	Manager, Para-Clinical Services

6.3 The Chairman welcomed the officials.

6.4 The Chairman outlined the mandate of the Committee and the purpose of the hearing. Introductions were exchanged.

6.5 **Key Issues Discussed**:

1. The improvements made since the implementation of the recommendations in the Welch report;
2. The status of the completion of the sub- activities in fiscal 2018 and 2020;
3. The engagement and re-allocation of staff in light of the COVID-19 pandemic;
4. The improvements of the healthcare system in spite of COVID-19 pandemic;
5. The meaning of the 61% and 82% implementation rate of the sub-activities and the metrics used to calculate the implementation rate percentages;

6. The financial constraints of the RHAs and the recommendations to address the constraints;
7. The status of the design and implementation of the Electronic Health Record system;
8. The satisfaction of the RHAs with regard to the interim Performance Management System being utilised;
9. The status of the completion of a suitable Performance Management System;
10. The construct of the team building exercise undertaken at health centres;
11. The meaning of the term "low risk" versus "high risk" at the SWRHA;
12. The doctors to patient ratio at the SWRHA;
13. The status of the block appointment system instituted at hospitals;
14. The services offered at the Point Fortin Hospital;
15. The improvements made with regard to the triage system at the San Fernando General Hospital;
16. The status of the completion of the National Blood Transfusion Service plans and the National Blood Transfusion Policy;
17. The status of filling the position of medical director of the National Blood Transfusion Service;
18. The opening hours of blood donation sites at the RHAs;
19. The installation and operationalisation of the Linear Accelerator at the St. James Medical Complex;
20. The plans to decentralise the public health dental services;
21. The review and assessment of the Chronic Disease Assistance Programme (CDAP);
22. The status of the filling of vacancies at the Nutrition and Metabolism Division;
23. The status of filling the position of Chief Executive Officer at the NWRHA;
24. The review and update of the handbook of policies for the Ministry of Health and the RHAs;
25. The assessment and evaluation of the contract arrangement between the Ministry of Health and NIPDEC for the procurement, storage and distribution of pharmaceuticals and non-pharmaceuticals

26. The review of the health sector funding arrangements and an appropriate governance structure to manage the health sector;
27. The status of the review and assessment of the structure of the RHA;
28. The status of the expansion and completion of the Arima Hospital;
29. The status of the budgetary allocation needed for the completion of the Arima Rehabilitation Centre;
30. The status of the Annual Services Agreement between the Ministry of Health and the RHA's in fiscal years 2020 and 2021;
31. The status of the review of the manpower plan;
32. The status of conducting a systems audit conducted by the RHAs and the Ministry of Health; and
33. The status of the consideration of the 2nd Report to rationalize the System of Public Sector Doctors in private practice.

6.6 The Chairman thanked officials for attending and they were excused.

SUSPENSION

7.1 At 6:00 p.m., the Chairman suspended the public meeting to resume in camera for a post-hearing discussion with Members only.

RESUMPTION

8.1 At 6:02 p.m. the Chairman resumed the meeting.

POST-HEARING DISCUSSION

9.1 The Chairman sought Members' views on the public hearing.

9.2 The Committee agreed that additional questions would be sent to the Ministry of Health.

[Please see Appendix 1]

ADJOURNMENT

10.1 The Chairman thanked Members for their attendance and the meeting was adjourned to **Wednesday March 10, 2021 at 1:30 p.m.**

10.2 The adjournment was taken at 6:19 p.m.

We certify that these Minutes are true and correct.

CHAIRMAN

SECRETARY

February 10, 2021

Appendix 1

Questions to the Ministry of Health

Status Update on Implementation of Recommendations

1. Has the Ministry been able to identify measurable improvement since the implementation of the recommendations?
    i. If yes, please describe.
2. How does the Ministry assess the performance of the outcomes from the implementation of the recommendation?
3. What were some of the major challenges that hinder the implementation of the recommendations?

Questions related to the key activities yet to be started under each pillar

Pillar 1- Primary Health Care

The Ministry mentioned its collaboration with the British High Commission to assess the Drug Inspectorate regulatory function. The Ministry indicated that recommendations from the assessment is being implemented.

Questions:

1. State briefly the type of assessment conducted
2. Provide a status update on the recommendations being implemented.

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3. Since the implementation of the recommendations, what has been the impact on Primary Health Care?

Pillar 3 - Infrastructure and Medical Devices

1. Has any progress been made with regard to the availability of funding for this project?
2. What is the status of the construction/repair work at the Arima Rehabilitation Centre, currently?
3. On average, how many persons access this facility?
4. How does the non-completion of this facility affect the citizens who access this service?

Pillar 5 - The Regional Health Authority Executive and Administration

The following activities were recommended:

i. Review the number of executive/senior management positions and their suitability for purpose as well as the number of organisational layers within the RHAs. In this regard, job analysis must be conducted to determine the positions required for each RHA;

ii. Redesigning of the roles of executives in consonance with product output/delivery namely the medical care product. Further, a job analysis must be conducted to align with product output/delivery namely the medical care product.

Questions:

1. Has the job analysis been conducted?
    i. If no, why not?
2. Has the MOH conducted the review of executive/senior management positions at the RHAs?
    i. If yes, what was the results?
3. How many executive/senior management positions exist at the RHA?
4. Has the Ministry reviewed the organisational chat of the RHAs?
    i. If yes, were any issues identified? Please state.
    ii. How were these issues rectified?
5. Have the roles of the executives been re-designed?
    i. If no, provide a timeframe for the redesign of this area.

Pillar 6 – Chief Medical Officer (CMO)

The Committee recommended that the office of the CMO be strengthened. This recommendation was split into two sub-activities:

a. The re-establishment of Principal Medical Officer positions in the areas of Epidemiology, Environmental Health and Institutional Strengthening; and
b. The ongoing process of strengthening the reporting relationships between the MOH and RHAs in terms of monitoring and problem-solving strategies to improve service delivery.

Questions:

1. Provide an update on the following:
    i. The strengthening process for reporting relationships between the MOH and the RHA;
    ii. The re-establishment of the Principal Medical Officer positions in the areas of Epidemiology, Environmental Health and Institutional Strengthening.

Upon receipt of the final reports of the Welch Committee, in 2017, the Ministry of Health, in collaboration with the Ministry of Public Administration and Digital Transformation, coordinated three (3) national public consultations on healthcare reform to advise and seek feedback from members of the public on the recommendations of the 'Welch Reports'.

Questions:

1. Provide further details on the national public consultations held on health care reform?
2. What was the Ministry's aim in conducting these consultations?
    i. Was it achieved?
    ii. If not, what were the challenges in gaining the intended results?
3. Could the Ministry provide, some of the feedback received from members of the public?
4. What were the results of the consultations held in conjunction with the Ministry of Public Administration and Digital Transformation?

The Ministry also indicated that stakeholder consultation was held with the Trinidad and Tobago Medical Association and the University of the West Indies, Faculty of Medical Sciences.

Questions:

1. What was the aim of the stakeholder consultation with the Trinidad and Tobago Medical Association and the University of the West Indies, Faculty of Medical Sciences?
2. What were the results of this consultation?

Key Limitations and Constraints

Questions:

1. What steps were taken by the Ministry to address the following challenges:
    i. The creation of a parallel health care system to support COVID-19 treatment and care
    ii. Financial constraints;
    iii. Human Resource and capacity constraints;
    iv. Time lag between implementation and approval; and
    v. Bottlenecks within the procurement process.
2. How has the COVID-19 pandemic affected the Ministry's ability to implement its recommendations?
3. Has there been any improvements in the challenges listed above?
4. What system was used for prioritizing key activities for implementation?
5. How many focal point officers were appointed to manage the implementation of the recommendations?
    i. Were these officers' new employees or existing employees at the Ministry of Health?
        a. If yes to existing employees, what were the previous positions held?
        b. If yes to new employees, what are the contractual terms?
6. Provide a status update on the consideration of the 2nd report.
7. What repercussions is the Ministry alluding too?

The Ministry of Health proposed to hold consultations with key stakeholders including the Medical Board of Trinidad and Tobago to discuss and determine the most suitable way forward in dealing with this ongoing issue.

Questions:

1. When will the Ministry embark on this consultation with the Medical Board of Trinidad and Tobago?
2. What outcomes can be expected from this consultation?

Provide the following:

1. The framework used to measure the weight of each sub-activity developed by the Ministry with regard to the recommendations presented in the Welch Report;
2. The criteria used to determine the prioritisation of each activity;
3. The role of a Customers Relations Officer at the hospitals;
4. Data on the number of postponements of surgical and non-surgical operations conducted by the eachRegional Health Authority;
5. Data on the waiting times and waiting list for surgical and non-surgical operations a the RHA's;
6. The innovations introduced by the North Central Regional Health Authority and the derived results;
7. The number of citizens who access healthcare on an annual basis at the Eric Williams Medical Sciences Complex;
8. A copy of the annual survey plans of each Regional Health Authority for the period 2018 -2021;
9. The timeframe for the advertisement of the vacant Chief Eexective Officer post at the North West Regional health Authority;
10. The findings of the report on the decentralization of the Mental Health;
11. The sum expended annually on cardiac care in Trinidad and Tobago;
12. The outstanding balances, if any, with regard to the payments of the Ministry of Health outsourced services; and
13. The date of and the key findings of the last system audit conducted at each Regional Health Authority as well as the remedial steps taken based on the findings.

APPENDIX III

Additional Information Requested

Questions to the Ministry of Health

Status Update on Implementation of Recommendations

2. Has the Ministry been able to identify measurable improvement since the implementation of the recommendations?
    ii. If yes, please describe.
4. How does the Ministry assess the performance of the outcomes from the implementation of the recommendation?
5. What were some of the major challenges that hinder the implementation of the recommendations?

Questions related to the key activities yet to be started under each pillar

Pillar 1- Primary Health Care

The Ministry mentioned its collaboration with the British High Commission to assess the Drug Inspectorate regulatory function. The Ministry indicated that recommendations from the assessment is being implemented.

Questions:

4. State briefly the type of assessment conducted
5. Provide a status update on the recommendations being implemented.
    .
6. Since the implementation of the recommendations, what has been the impact on Primary Health Care?

Pillar 3 - Infrastructure and Medical Devices

5. Has any progress been made with regard to the availability of funding for this project?
6. What is the status of the construction/repair work at the Arima Rehabilitation Centre, currently?
7. On average, how many persons access this facility?
8. How does the non-completion of this facility affect the citizens who access this service?

Pillar 5 - The Regional Health Authority Executive and Administration

The following activities were recommended:

iii. Review the number of executive/senior management positions and their suitability for purpose as well as the number of organisational layers within the RHAs. In this regard, job analysis must be conducted to determine the positions required for each RHA;

iv. Redesigning of the roles of executives in consonance with product output/delivery namely the medical care product. Further, a job analysis must be conducted to align with product output/delivery namely the medical care product.

Questions:

6. Has the job analysis been conducted?
    ii. If no, why not?
7. Has the MOH conducted the review of executive/senior management positions at the RHAs?
    ii. If yes, what was the results?
8. How many executive/senior management positions exist at the RHA?
9. Has the Ministry reviewed the organisational chat of the RHAs?
    iii. If yes, were any issues identified? Please state.
    iv. How were these issues rectified?
10. Have the roles of the executives been re-designed?
    ii. If no, provide a timeframe for the redesign of this area.

Pillar 6 – Chief Medical Officer (CMO)

The Committee recommended that the office of the CMO be strengthened. This recommendation was split into two sub-activities:

c. The re-establishment of Principal Medical Officer positions in the areas of Epidemiology, Environmental Health and Institutional Strengthening; and

d. The ongoing process of strengthening the reporting relationships between the MOH and RHAs in terms of monitoring and problem-solving strategies to improve service delivery.

Questions:

2. Provide an update on the following:

iii. The strengthening process for reporting relationships between the MOH and the RHA;

iv. The re-establishment of the Principal Medical Officer positions in the areas of Epidemiology, Environmental Health and Institutional Strengthening.

Upon receipt of the final reports of the Welch Committee, in 2017, the Ministry of Health, in collaboration with the Ministry of Public Administration and Digital Transformation, coordinated three (3) national public consultations on healthcare reform to advise and seek feedback from members of the public on the recommendations of the 'Welch Reports'.

Questions:

5. Provide further details on the national public consultations held on health care reform?
6. What was the Ministry's aim in conducting these consultations?
    iii. Was it achieved?
    iv. If not, what were the challenges in gaining the intended results?
7. Could the Ministry provide, some of the feedback received from members of the public?
8. What were the results of the consultations held in conjunction with the Ministry of Public Administration and Digital Transformation?

The Ministry also indicated that stakeholder consultation was held with the Trinidad and Tobago Medical Association and the University of the West Indies, Faculty of Medical Sciences.

Questions:

3. What was the aim of the stakeholder consultation with the Trinidad and Tobago Medical Association and the University of the West Indies, Faculty of Medical Sciences?
4. What were the results of this consultation?

Key Limitations and Constraints

Questions:

8. What steps were taken by the Ministry to address the following challenges:
    vi. The creation of a parallel health care system to support COVID-19 treatment and care
    vii. Financial constraints;
    viii. Human Resource and capacity constraints;

ix. Time lag between implementation and approval; and
x. Bottlenecks within the procurement process.

9. How has the COVID-19 pandemic affected the Ministry's ability to implement its recommendations?
10. Has there been any improvements in the challenges listed above?
11. What system was used for prioritizing key activities for implementation?
12. How many focal point officers were appointed to manage the implementation of the recommendations?
    ii. Were these officers' new employees or existing employees at the Ministry of Health?
        c. If yes to existing employees, what were the previous positions held?
        d. If yes to new employees, what are the contractual terms?
13. Provide a status update on the consideration of the 2nd report.
14. What repercussions is the Ministry alluding too?

The Ministry of Health proposed to hold consultations with key stakeholders including the Medical Board of Trinidad and Tobago to discuss and determine the most suitable way forward in dealing with this ongoing issue.

Questions:

3. When will the Ministry embark on this consultation with the Medical Board of Trinidad and Tobago?
4. What outcomes can be expected from this consultation?

Provide the following:

14. The framework used to measure the weight of each sub-activity developed by the Ministry with regard to the recommendations presented in the Welch Report;
15. The criteria used to determine the prioritisation of each activity;
16. The role of a Customers Relations Officer at the hospitals;
17. Data on the number of postponements of surgical and non-surgical operations conducted by the eachRegional Health Authority;

18. Data on the waiting times and waiting list for surgical and non-surgical operations a the RHA's;
19. The innovations introduced by the North Central Regional Health Authority and the derived results;
20. The number of citizens who access healthcare on an annual basis at the Eric Williams Medical Sciences Complex;
21. A copy of the annual survey plans of each Regional Health Authority for the period 2018 -2021;
22. The timeframe for the advertisement of the vacant Chief Eexective Officer post at the North West Regional health Authority;
23. The findings of the report on the decentralization of the Mental Health;
24. The sum expended annually on cardiac care in Trinidad and Tobago;
25. The outstanding balances, if any, with regard to the payments of the Ministry of Health outsourced services; and
26. The date of and the key findings of the last system audit conducted at each Regional Health Authority as well as the remedial steps taken based on the findings.

Appendix IV

Verbatim

VERBATIM NOTES OF THE THIRD VIRTUAL MEETING OF THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE HELD, (IN PUBLIC), ON WEDNESDAY, FEBRUARY 10, 2021 AT 2.00 P.M.

PRESENT

Mrs. Bridgid Annisette-George	Chairman
Mrs. Ayanna Webster-Roy	Member
Mr. Stephen Mc Clashie	Member
Mrs. Lisa Morris-Julian	Member
Dr. Lackram Bodoe	Member
Ms. Yokymma Bethelmy	Member
Mr. Clarence Rambharat	Member
Mr. Hassell Bacchus	Member
Mr. Wade Mark	Member
Ms. Amrita Deonarine	Member
Ms. Keiba Jacob-Mottley	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Hema Bhagaloo	Assistant Secretary
Ms. Rachel Nunes	Graduate Research Assistant

MINISTRY OF HEALTH

Mr. Asif Ali	Permanent Secretary (Ag.)
Mr. Lawrence Jaisingh	Director of Health Policy, Research and Planning
Dr. Roshan Parasram	Chief Medical Officer
Dr. Stewart Smith	Senior Health Systems Adviser

NORTH WEST REGIONAL HEALTH AUTHORITY

Ms. Salisha Baksh	Chief Executive Officer (Ag.)
Antony Parkinson	Director of Health
Terron Gilchrist	Chief Operating Officer
Aruna Singh	General Manager, Primary Care
Shemiah Walcott	Senior Health Planner (Ag.)

NORTH CENTRAL REGIONAL HEALTH AUTHORITY

Mr. Davlin Thomas	Chief Executive Officer
Dr. Malachy Ojuro	Director of Health (Ag.)
Dr. Abdul Haleem Hamid	General Manager, Primary Health Care Services (PD)
Ms. Sharon Creft	Chief Financial Officer (Ag.)
Ms. Joanne Thomas	General Manager, Human Resources

SOUTH WEST REGIONAL HEALTH AUTHORITY

Dr. Brian Armour	Chief Executive Officer
Stephen Alleyne	Chief Operations Officer
Pravinde Ramoutar	Director of Health
Denise Thomas	General Manager, Human Resources
Lystra Walters Balgobin	General Manager Quality, Risk Management

EASTERN REGIONAL HEALTH AUTHORITY

Mr. Ronald Tsoi-A-Fatt	Chief Executive Officer
Dr. Allana Best	County Medical Officer of Health – St. Andrew/St. David
Dr. Sasha Sankar-Maharaj	Medical Director (Ag.)
Ms. Sonia Seecharan-Raphael	General Manager, Human Resources
Ms. Amy Ali	Manager, Para-Clinical Services

Madam Chairman: Good afternoon to the members of the public, members of the media, the representatives of the Ministry of Health and the various Regional Health Authorities, to the members of the Committee. Today our examination is into the efficiency of the delivery of

services to the public by the Regional Health Authorities and I therefore welcome the officials of the Ministry of Health and of the North West Regional Health Authority, North Central Regional Health Authority, the South West Regional Health Authority and Eastern Regional Health Authority.

I am Bridgid Annisette-George and I am the Chairman of this Committee. The Committee on Public Administration and Appropriations, the PAAC, has the mandate to consider and report to the House on:

A The budgetary expenditure of government agencies to ensure that expenditure is embarked upon in accordance with parliamentary approval;

B The budgetary expenditure of government agencies as it occurs and to keep Parliament informed of how the budget allocation is being implemented; and

C The administration of government agencies to determine hindrances to their efficiency and to make recommendations to the Government for improvement of public administration.

The purpose of this meeting is examine the efficiency of the delivery of services to the public by the Regional Health Authorities. The Committee intends to follow up on the implementation and the recommendations presented in the Welch report. The role of the Committee to assist the stakeholders in achieving the efficient delivery of services while ensuring that expenditure is embarked upon in accordance with parliamentary approval.

This meeting may be broadcast live on the Parliament's Channel 11 and radio 105.5 FM and the Parliament's YouTube Channel *ParlView*. May I ask all participants to ensure that their mikes remain muted until recognized by the Chair.

I will therefore now invite the representatives of the Ministry of Health and the four Regional Health Authorities to introduce themselves and immediately thereafter I will ask the members of the Committee to introduce themselves. So we can start with the Ministry of Health. I believe we have the acting CEO, so we can start with him.

[*Introductions made*]

Madam Chairman: Can we then therefore go on to the North West Regional Health Authority?

[*Introductions made*]

Madam Chairman: Okay, thank you very much, Madam CEO. Can we then go on to the North Central Regional Health Authority?

[*Introductions made*]

Madam Chairman: Thank you very much. Can we move on to the South West Regional Health Authority?

[*Introductions made*]

Madam Chairman: Thank you very much. And can we now move on to the Eastern Regional Health Authority?

[*Introductions made*]

Madam Chairman: Thank you very much. And may I ask the members of the Committee to kindly introduce themselves?

[*Introductions made*]

Madam Chairman: Right. So as we all know we would have been in receipt, the Committee has been in receipt of the response to questions sent to the Ministry of Health and the various agencies. I would like to take this opportunity to invite the acting CEO of the Ministry—excuse me, the Permanent Secretary of the Ministry of Health to make an opening statement if he so wishes.

Mr. Ali: Thank you, Madam Chair. Good afternoon again, Madam Chair, members of the Committee, my colleagues from the Ministry of Health and the RHAs. So we welcome this opportunity to review and examine the efficiency of the RHAs in the delivery of services to the public. We would have used the findings of the Welch report to inform our interventions that were needed to improve not only our national health outcomes but also our level of service delivery. And I just want to expand a bit on how we went about doing that. The Welch report had approximately 39 broad recommendations. What the Ministry did in 2017, we held three national public health consultations where we sought to share these reports with the public but also seek their feedback on those recommendations.

We also held consultations with the Trinidad and Tobago Medical Association, as well as the Faculty of Medical Sciences of UWI. Coming out of those consultations we then came up with some discrete activities under each recommendation which we then used to inform the work plans of the Ministry and the RHAs from that point going forward.

In 2018, when the Ministry conducted its first status report on those recommendations, we had an overall implementation rate of 61 per cent with 12 activities being completed and the others at various stages of progress.

In 2020, we did a second status update, we had moved to 82 per cent implementation with 25 activities being completed and, again, the others at various stages of completion.

Madam Chair— [*Technical difficulties*] —of the concerns of the population with regard to the limitations and issues— [*Technical difficulties*] —raised in the Welch report by the Ministry—very quickly, 50 to 60 maternal deaths per 100,000 in 2015, to currently under 30 per 100,000. [*Technical difficulties*]

Madam Chairman: Mr. Ali. Mr. Ali, can you hear me?

Mr. Ali: Yes, I can.

Madam Chairman: I am seeing that you are having a low bandwidth and maybe that is why you are breaking up. Maybe let us try and see if you turn off your camera if we can hear you a little better because we have lost you along the way.

Mr. Ali: Is that better?

Madam Chairman: Okay. So let us see. Could you go back to when you started giving some statistics on maternal deaths?

Mr. Ali: Sure. Can you hear me now?

Madam Chairman: Yes, we are.

Mr. Ali: Yeah. Great. Okay. I was speaking to the issue of maternal deaths where we have moved from 50 per 100,000 in 2015, where we are currently at 30 per 100,000. That is for maternal deaths. In the case of neonatal deaths, we have moved from 12 per 1,000 live births in 2015, where we are currently at under seven per 1,000 live births.

The other achievement I just want to highlight would be the various interventions we would have taken starting in 2020, with regard to interrupting and reducing the transmission of the COVID-19 virus, as well as our parallel health care system in respect of COVID-19.

Madam Chair, we look forward to today's— [*Technical difficulties*] —we look to continuously improving our health care. Did you lose me again?

Madam Chairman: Thank you, Mr. Ali. Can I invite the Acting CEO of the North West Regional Health Authority to make an opening statement if she so wishes.

Ms. Baksh: Hi, good afternoon, all, just a brief feedback as it relates to the improvement that we have engaged at the NWRHA as it relates to the recommendations coming out of the Welch report. We would have done significant improvements in both primary care, as well as in secondary care. The details, of course, would have been submitted to the members of the

Committee. And as it relates to our infrastructural programmes, we have done significant progress as well too, culminating with the commencement of the start of the construction of the new central block which is presently ongoing. And as I said, further details were already provided in our updates to the Welch report. Thank you.

Madam Chairman: You are welcome. May I invite the CEO of the North Central Regional Health Authority to make an opening statement if he so wishes.

Mr. Thomas: Good afternoon, Chairman, again. The North Central Regional Health Authority under the guidance of the Ministry of Health had embarked on structured and continuous improvement utilizing a systems approach which implied that we were engaging in a lot of structural changes to facilitate continuous improvement. Some of the highlights that I just want to put on the table are we would have seen based on our own monitoring, decreases in complaints by as much as 66 per cent. We would have subsequently as well had a corresponding increase in, of course, commendations by 30 to 35 per cent. In addition, our adverse events had decreased between 2018 to 2020, by as much as 50 per cent, and our ongoing continuous improvement strategies are ongoing. Thank you.

Madam Chairman: The CEO of the South West Regional Health Authority, you are invited to make a brief opening statement, if you so please.

Mr. Amour: Thank you, Madam Chair. The South West Regional Health Authority as part of the national architecture, I would just like the Committee to appreciate the expanse. We go from Freeport in Tabaquite in the north to Moruga, as well as to Icacos in the south-western tip. We have 33 health centres, three district health facilities, and San Fernando General, San Fernando Teaching Hospital and we recently opened a Point Fortin Hospital.

By the sheer size of our throughput we see an average of about a quarter million patient encounters in our out-patient clinic services. Similarly, in our emergency department for 2019, we had close to a quarter of a million encounters there as well. In terms of emergency department visits, and even more so in our health centres where we have crossed over 400,000 visits in 2019 from our data.

We too have seen a lot of strides in our operations areas of improvement having completed a lot of our projects that depend on funding for the Public Sector Investment Programme. And pre-COVID, during COVID and even in 2021, we also continually monitor patient care and quality process improvement with our—we ensure quality departments. And we

contribute this as all part of the national architecture taking direction from the Ministry of Health.

Madam Chairman: Thank you very much. And may I therefore invite the CEO of the Eastern Regional Health Authority to make his brief opening statement.

Mr. Tsoi-A-Fatt: Thank you very much, Madam Chair, and again greetings to the rest of the Committee. The Eastern RHA is perhaps geographically the largest of all because we take about a 1/3 vertical slice of the island, taking in from in the north, Matelot, in the north coming down the entire of the sea board with Manzanilla, Mayaro, Guayaguayare, Rio Claro, Brother's Road, Biche, you know. Most of those communities are distanced apart and rural, and we try our very best to ensure that we provide services that are equitable in access, you know, and quality to all the people that we serve.

We try to keep in touch with our public. Annually we do our community consultations where we host our public at each facility, each health centre and the hospital and so on, and listen to some of their concerns, listen to some of the things that they would like to see happening.

Just as a success story for that as an example, two years ago we had our community consultation at Toco and the public actually pointed out that they needed an X-ray service at the accident and emergency. I am proud to say that within a year after that we did put in an X-ray service. So that we try to be responsive to the public in terms of their needs.

I want to take the opportunity also to express our deepest thanks to our staff who continue to, you know, serve under our active banner of "caring is the key", focusing on our patients and trying to ensure the quality of service that we provide.

To note, for example, our complaints, our annual client feedback survey, we had some comments of 358 comments for the last 2019/2020 period. Out of that we had about 200 complaints with a resolution rate of 88 per cent. So we try to ensure that we give feedback, that we maintain contact, and that we ensure that the quality of service that we give to our clients is second to none. And we are also, I should say, we enjoy the cooperative kind of atmosphere between ourselves, the other Regional Health Authorities and the Ministry of Health. Thank you.

Madam Chairman: Thank you very much. And I would like start off the conversation with something that was said by Mr. Ali and which is also in the response that, you know, I find quite interesting but would like to get some clarification. Mr. Ali mentioned that in 2018, you had

identified 200, I think, it is either 50 or 51 activities and from those activities you have an implementation rate of 61, say roughly 62 per cent. And in 2020, you have identified 266 sub activities. So I am trying to get some clarification if it is that these sub activities expand over time as you try to implement? What accounts for the difference?

Mr. Ali: Sure, Madam Chair. Maybe I can start and then I will let Mr. Jaisingh just continue. So as I said, we would have taken those broad recommendations and then broken out from there discrete activities. And you are right. As we continuously review our progress and as circumstances change and the environment changes, there will be new activities that we would identify that we would think that needs to be pursued. All right? So that is why we moved from 251, as you said, to 266. And if you ask us in two months' time, that number might go up to 275. Yeah? So it is a process of continuous improvement as I said, and we are continuously looking at our activities and assessing the environment and reacting to those challenges as they come up.

Madam Chairman: Thank you. So of the 15 additional or—let me put it this way. In getting to the 266 in 2020, would you have an idea of how many of them were activities which were identified in 2018 and which have not been accomplished or achieved or completed?

Mr. Ali: I would let Mr. Jaisingh maybe speak to that. I do not have that information in front of me. I am not sure if he can maybe shed some light.

Madam Chairman: Sure. Thank you.

Mr. Jaisingh: All right. Madam Chair, yes, in terms of, the PS said it, in terms of the sub activities, as the recommendations were broad, we narrowed it down to our work plans within the Ministry and within the RHA as well. So the activities have broadened based on their work plan framework as well and in terms of implementing the recommendations.

Just to answer your question as well, in terms of from 251 to 266, some of the activities came out from direct work plans, and when you look at the report itself, it went in terms of the contents of the report, other activities came out from there as well. So what we try to do is align the recommendations as much as possible to the contents of the report as well, because it was arranged through different pillars and therefore more activities came out as we actually went in depth in the report itself.

And to answer your question, yes, we have incorporated these activities in the work plans, and some have been started and some are ongoing, so we are actually trying to monitor and track these activities accordingly.

Madam Chairman: Okay. So, Mr. Jaisingh, if I understand well, there is unlikely to be any finite number of sub activities which one could collate to say that you have achieved the objective of the report.

Mr. Jaisingh: Well, basically when we reviewed the second round in 2020, we saw that there were still some gaps between the recommendations, the broad recommendations and what was said in the report itself. So that is why we try as much as possible to align the contents of the report to the recommendations. So yes, I agree, there should be a cut off in terms of the actual recommendations and list of activities under the recommendations, and we are trying to achieve that probably as much as possible together with the RHAs as well, because there must be a completion side in terms of achievement of the report in essence.

Madam Chairman: Okay. Let me ask, what would be a completion? What would you consider a completion?

Mr. Jaisingh: A completion basically looks at, because of the broad nature of the recommendations, we were looking at to see exactly as much as possible with the work plans of the RHAs and the Ministry, how much could fit under the recommendations itself. So we are hoping that based on the 2020 plan that we have in terms of the reporting template, that this might just be the list that takes place that is aligned directly to the recommendations. So it is really just reporting on those activities now, so hopefully within the second or third quarter of fiscal 2021, we could have in the next couple of months we could have a timely, again, report done as much as possible to see exactly where the recommendations are in terms of the cut-off dates.

Madam Chairman: Okay. So let me ask this: There are 39 recommendations, okay?—which of course when fleshed out will lead to a number of sub activities. But in the report the Committee had identified under some of the pillars what should be, what is best case. Are these sub activities aligned with not just the recommendations but the best case?

Mr. Jaisingh: Yes, as much as possible because what we try to do as well is also align the activities under the pillars with the recommendations. Because in the report there was no reporting template or no implementation plan, and the Ministry had to develop that with the consultations, as PS indicated, and together with consultations with the RHAs as much as possible, so to make sure that the activities under each pillar are aligned to the recommendations accordingly.

Madam Chairman: Yeah. I understand that. But say for instance in the report, let us say for instance they are looking at the functioning of an A&E department. Okay? And the Committee would have, I think, listed about 22 characteristics which would speak to a functioning A&E department, and they do that with ward management, they do that throughout the report.

3.05 p.m.

Madam Chairman: Yeah, I understand that, but say for instance in the report, let us say for instance they are looking at the functioning of an A&E Department, okay, and the Committee would have, I think, listed about 22 characteristics which would speak to a functioning A&E Department, and they do that with board management, they do that throughout the report. What I am trying to find out is, in your sub-activities when you define them and you tick them off, do they speak to becoming a functioning A&E Department in terms of your day, in terms of your proprietary work? I want to know if they are tied back to that and not just to these, as you yourself pointed out, these very broad recommendations which could be interpreted, in my respectful view, in any which way.

Mr. Jaisingh: That is correct, but also not only the activities were placed from the report, but also the activities from the work plan of the RHAs. So if you are looking at A&E as the example, they would have had their improvement programme as well. So we incorporated that together with the contents of the report under A&E as well. So, yes, in the ideal state we look to see exactly—with these recommendations and activities, well their thinking is then, that we get a deal functioning A&E department, or even infrastructure, infrastructure by itself taking together the recommendations for the report and the work plans from the RHAs, and the Ministry's framework, what is the composite set of infrastructure works that need to be completed. Was it captured in the report itself? Yes, you are quite correct.

Madam Chairman: Okay, so let me ask this. What does 61 per cent implementation rate mean? What does 82 per cent implementation rate mean? What does that mean?

Mr. Jaisingh: Right, what we did basically was looked at each pillar, looked at activities under each pillar together with the recommendations, and line up together in one reporting template exactly what was the status implementation of these sub-activities. We then grouped each sub-activity into whatever pillar it was aligned to and then we got status report of each pillar. Then we grouped all the pillars together and got an overall implementation rate. But there is one side of it as well, what we also did from the recommendation side was look to see now, each activity

under the recommendations, calculate to a percentage of status of be it of each recommendation and then pool all the recommendations together. We are taking that recommendation to get an average rate. So the 61 and the 82 are the average rates that we from the recommendations and the pillars, that we pool together from the activities itself.

Madam Chairman: Okay. So that overall rate that you have given, you would admit does not really speak to where you would have reached with respect to, say, sub-activities in any pillar?

Mr. Jaisingh: Well, the sub-activities is a bottom-up approach. So we got the status report and the implementation rate of each sub-activity which lined back to each recommendation and each pillar, and then we got an overall implementation rate of each pillar and each recommendation, and then an overall percentage, average. So it is a bottom-up approach.

Madam Chairman: So you are waiting? How is your waiting arrived at?

Mr. Jaisingh: It is based on the status of the activities in the RHAs itself.

Madam Chairman: Okay. So, might I ask, this model of assessment is designed by you, judged by you and assessed by you? When I mean you, not you individually, within your Ministry.

Mr. Jaisingh: Well, both within the Ministry and the RHAs, because the RHAs we gave them the framework, and the RHAs inputted their data accordingly.

Madam Chairman: So there is no independent assessment, or no international benchmark, or anything else to arrive at this 61? It is purely subjective?

Mr. Jaisingh: Purely internal, calculation at the Ministry of Health and the RHAs.

Madam Chairman: And purely internal by the process, and purely subjected, because the weight you put on it, is the weight you put on factors or sub-activities that you would define. Okay? And according to you, if I understand well, you would admit that even the sub-activities that you have defined in 2020 may not be a full basket of goods. Yes?

Mr. Jaisingh: To some extent, yes.

Madam Chairman: Okay. All right, thank you very much. Member Bodoe would you like to join the conversation all this stage?

Dr. Bodoe: Yes. Thank you very much, Madam Chair, officials of the Ministry of Health and the RHAs, PS, CMO, CEOs of the RHAs and other staff, thank you very much. I know that you are bearing the brunt of dealing with the COVID crisis, and I just want to thank you for your important service to date. PS if I may, I just want to take you to the last page of your submission, which is page 14, and the item there is key limitations and constraints, and if I may just read

just a few lines from your submission:

> The Welch Recommendations are being implemented using the current work plans of both the Ministry of Health and the Regional Health Authorities.

And I believed you confirmed this in your opening submission. And it goes on to say:

> There are several challenges being experienced in the implementation of the recommendations, including financial constraints, the time lag in the approval and implementation process for the design and approval of projects and work activities, bottlenecks and the creation of a parallel health system.

I just wanted to ask a few questions with regard to this bit of the submission. Now, in terms of the financial constraints, when I looked at the budget allocations for the RHAs for 2019, 2020 and 2021, based on previous records and so on, I do not detect any additional allocation for the implementation of these recommendations. So, is it that these recommendations would have been expected to be incorporated within the normal allocations for the RHAs? So if I can pause just to ask you to go ahead before I continue?

Mr. Ali: Sure, thank you. Through you, Chair—so member Bodoe that is correct. As I would have said at the start, we would have taken those activities and incorporated them into our work plan, and by extension our budget both at the Ministry level and at the RHA level. So, by and large, we would have sought to incorporate these recommendations and activities as part of our business going forward. So we did not see as a totally separate and discrete intervention. We sought to let that be part of our business, and it was included in our budget submissions both for recurrent and development programme, because as you said, part of the recommendations spoke to infrastructure also. So short answer to your question, yes, we sought to finance these activities through our normal budgetary allocation.

Dr. Bodoe: Thank you PS. So, let me just go down to the creation of the parallel health system to support COVID-19 treatment, and of course we have been very fortunate to be able to have a parallel health system. Now, with regard to the staffing, and perhaps the RHAs, maybe the NCRHA and the SWRHA, which I know would have been more involved in the supervision and administration of the facility—

[Technical difficulties. System crashed, new link resent]

Committee resumed at 3.30 p.m.

Dr. Armour: Madam Chair, thanks for the question member Bodoe. Similar to North-Central,

the experience of South-West was that from March to the onset of the COVID cases and the system response, we were able to go in initial emergency mode cooperating with the Ministry of Health and other Regional Health Authorities. So, we were able to internally redeploy staff to the emergency departments as the frontline in order to manage cases, and as the parallel system started to emerge through Ministry of Health policy, we too depended, like the other RHAs initially, on the North Central Regional Health Authority through Couva and Caura in the first instance, and as the facilities matured Augustus Long came on stream around July/August, and we were able to with the support of the Ministry go from internal redeployment, even at the request of North-Central at the time, been able to assist doing our part with the other RHAs to support North-Central initially, to then be in a position to hire as our parallel health care system matured, so we were able to keep pace with the emergence of the parallel health care system that now is relatively mature at this point in time. So, we have been able to work with our internal resources to effect the additional hires that were eventually needed.

Madam Chairman: Yes, Dr. Bodoe.

Dr. Bodoe: Yes, thank you CEOs. Again, through you PS to the CEOs, in view of those responses, and for the information of the public and in view of the fact that our COVID-19 cases and so on seem to be slowing down a bit, what is the status of the regular normal services in terms of clinics and surgeries at the various RHAs, in particular the NCRHA and the SWRHA, and perhaps the others as well? I am sure that the public would want to know.

Dr. Armour: Through you, Madam Chair, we still maintain some of the constraints based on the pandemic which determine how many persons can occupy a space at any given time. That is critical, so that we mitigate against the possibility of the spread of COVID-19, which arguably is still around, if we look at what is happening throughout the world. The issue though, is that even in those circumstances we would have engaged telemarketing. To date we would have engaged at least 28,000 calls particularly from our medical clinics. We have put our—engaged our primary care to assist in this regard simultaneously, particularly to distribute pharmaceuticals.

So arguably one of the things that we are doing is ensuring that when we do our telemedicine and we do the consultations with patients, based on the need for pharmaceuticals we distribute the pharmaceuticals close to those—to the health centres closest to them for them

to pick up. We have noticed as well that there is an increased compliance based on the telemedicine services in persons taking their pharmaceuticals. The implications of that is that we have also now overlapped what we call our tele-pharmacy services, to reinforce to patients that they need to take their medicine. The net effects are better outcomes for patients. On the one hand, we have engaged telemedicine services for those services, those patients that we could engage.

Initially, when we started that service some of the patients would have interpreted those calls as cancellation conservatory calls. But what we did was we streamlined our script to ensure that they knew they were speaking to a doctor and that that doctor was in fact providing health care on the phones, and we have noticed in addition to that, increased commendation. But, we have overlap that now with the preregistration of our first visit simultaneously to ensure greater efficiencies. But those were for those medicine patients. We met during the COVID-19, even at the early stages we were committed as a RHA, and certainly after discussion with the Minister to continue to provide our surgical services. Particularly, of course, we continued the emergency services, but there were urgent surgeries that we felt that should take place, and we continued with at least 6,000 surgeries. With those surgeries that would have come, there was a corresponding need to ensure that we had clinics running simultaneously, so we would have put tents and so on to facility those that were improving as we went.

The issue though is that, even within the tents and within the building we still had to adhere to some of the constraints that were put in place based on the COVID regulations. And that would have told us, based on when we did the numbers, how many persons could be inside, and so we basically had to mitigate against any activity. Ensure that we did not engage in any activity that breached the regulations, and therefore restricted the numbers. But for the most part, we continued. As I said we did over 6,000, it was around 6,400 surgeries during that period. But we really take the opportunity to commend the staff, surgeons, anaesthetists, patient escorts, et cetera, for their dedication during that period, and we trod on, with continuous improvement. As I said, we instructed on continuous improvement and we are utilising those systems remotely to do so.

Dr. Bodoe: If I may continue, Madam Chair, just one more item I would like to address or have address with regard to the key limitations and constraints, and that speaks to the time lag in the approval and the implementation process for the design and approval of projects and work

activities, and I want to relate this, and perhaps I could address this, maybe PS could address this. I want to relate this back to page 8 of your report which speaks to the infrastructure and medical devices pillar, and I am speaking specifically here PS to Item VI, Roman numerals. In fiscal 2021 the Ministry will seek to commence construction works for the establishment of a cardiac catheterization lab at the San Fernando General Hospital. The project is at an advanced stage where the tendering has been completed and it has been evaluated. And I just asked to tie that in, in terms of the time lag and the approval and implementation, because I know that this is a project that has been in the pipeline since about 2014, so I do not know if I can ask the PS or perhaps the CEO of the SWRHA to shed some light on this challenge with this particular example?

Mr. Ali: Sure. Through you, Chair, thank you member. So just very quickly, with regard to this particular project, the evaluation has been completed, and we are currently looking at possible financing options member, in terms of going further with the project. All right. We are considering alternative financing models before we proceed further with that particular project, but it is a priority for us, and for the South West Regional Health Authority. We really want to get that project started this fiscal year. So that is still the intention. All right?

Dr. Bodoe: Thank you, Madam Chair, I would leave it there for now.

Mr. Tsoi-A-Fatt: Can I just inject, Madam Chair?

Madam Chairman: Yes, please, CEO.

Mr. Tsoi-A-Fatt: I just wanted to point out perhaps a lil further on the question earlier asked by Dr. Bodoe with respect to services, given the parallel system and the COVID system. The fact is, that we have had to be very vigilant. We have faced challenges, but we had to be very vigilant to prevent the overspill from one stream into the other. All right? But I want to point out that we have not been overwhelmed in the Authority, and in particular I can speak for the ERHA, because although we have faced these constraints, we have continued to develop our services.

So, for example, we have opened the dialysis centre, a new dialysis centre in Rio Claro. So that we have not been overwhelmed and curtailed fully by COVID. COVID is there and we are coping and dealing with COVID through the efforts of our staff and the rallying and so on of the country, but at the same time, you know, with the challenges the service continues. We have decentralized other services into primary care, ultra-sonography, ophthalmology and

others. So that while we are facing those challenges, the fact is, the normal system has continued to develop and to move forward. I just wanted to add that. Thank you.

Madam Chairman: Thank you very much CEO. Might I now invite member Bacchus.

Mr. Bacchus: Yes. Thank you, Chair, and welcome again to all members and participants, and I too would like to join in what I am sure would be a continuous chorus of praise for all health care professionals who are working to keep all of us safe during this time. Yeoman's job you are doing, and I want to add my congratulations and compliments for a job well done, and keep up the good work.

I want to go back just to deal with the initial thing you were looking at, and I did the math, and I know you were talking about the waiting as it related to these implementation rates. And I am truly concerned about it, because basically what happened, as explained, is that all of the individual implementation rates were added together and divided by the number, and then you got that 87 per cent number. The danger in that is that it can create somewhat of a false narrative, and I say that from the point of view that some pillars only had two activities, some pillars had as many as 130. And in looking at the implementation percentage numbers, you would see that had 130 had one of the lowest rates at 63. But because the others were so high, 80/90 per cent, you would have found that the overall rates seemed to be higher than it is.

I think you need to find a different way that more depicts in a fairly accurate way what is happening at the individual levels. I also was interested to try to figure out, but, Chair, you cleared it up, what implementation rate actually meant, and these numbers where for the previous period of 12 activities were completed and now 25 were completed, it is really to figure out whether accumulatively now that number is 37, or is it that it is 25 that they included the other 12? So it is really to get clarity in terms of definition or a taxonomy of how you define the language, as well as probably a clearer way to depict the numbers so that there is not this nebulousness about what we are dealing with.

I wanted to touch on one area of the report at 7. I think it is classified as (g), the Ministry of Health Administration Pillar with the 130 sub-activities, is (g), and it is on page 11. And I know there is the relationship that exists between the Ministry of Health and all of the RHAs, but I was looking at—I am very interested in Roman numeral (i) and (ii), (i) in particular to the reference of the design for the electronic health record system, and whether that is a subset of Health Information Management System. What is exactly happening from the perspective of

the Ministry of Health and from the perspective of the RHAs in terms of where this thing is going? In terms of, is it that the RHAs have their own sanctions that they built, continue to build them out? And I see a number of things in the press about that, and yet I am hearing at the stage of design for a record system by the Ministry of Health. Could that be cleared up for me so I have an understanding of the relationship, and where exactly this is going, and who are the key players as far as the Ministry of Health and the RHAs are concerned? Thank you.

Mr. Ali: Sure. Through you, Chair. So with regard to the electronic health record, you are correct member, this is just one component of our Health Information System. That is one component of it. You are also correct that the RHAs do have some standalone IT applications in place of health administration, Health Information Systems at this point. Those are, if I want to use the term, interim solutions, and the data that they are capturing will be migrated into this holistic complete national Health Information System, which is what Roman (i) alludes to. So where we are with that particular project, we have together with iGovTT, they are the project managers, and we are currently at the point where we have engaged a consultant through iGov to assist in developing the functional—well, not even developing, in reviewing our functional and technical requirements for NHIS, would agree to go into tender for a solution. We do expect to have that particular consultancy completed by, what, May or June of this year, to then go out to market for a solution. The intention thereafter is that once that solution is implemented at the health facilities, the different applications that exist at the RHAs will be migrated into that application. So that would be our National Health Information System. I am not sure if that cleared it up for you.

Mr. Bacchus: It has. It has in some way, and, of course, this is getting it to the position of an RFP, and then, of course, the evaluations come back, and then you start work on that solution as it is. So, do you have a potential timeframe, an outlook as to when you might be coming back, maybe through iGov, as to, you know, the duration this is going to take. What is going to happen in the interim as these individual ones continue to happen? Do they continue to grow them? Do they kind of—does development kind of come to a halt? And, you know, what is exactly going to happen, and I am looking at this from the point of consumption, walk into the hospital in Port of Spain, you walk into the hospital in San Fernando? Is there a collaboration between the two that the records being able to be exchanged, et cetera? I am trying to get to the point where what we have in the interim, is it suitable for us to have and maintain what we

have for now while we get this thing going, and how long does this interim procedure have to work with it, and how comfortable are the RHAs with what they have?

3.50 p.m.

Mr. Ali: Sure, thank you. Through you, Chair, again. So let me take the question about timelines, first of all. So we expect, having done the RFP, gone out to market, done the evaluation—I am being realistic—we would expect to start implementation by the first quarter of 2022. So it means that this fiscal year—or this calendar year, sorry, complete the RFP, go out to market, do the evaluation, identify the funding and what have you, and then start.

I want to say also, which I did not say at the start, that we are starting it in two hospitals to begin with, which is at the new Arima Hospital and the new Point Fortin Hospital. Again, there are greenfield sites, if I want to use that term. So we would start off there first, the intention being thereafter to start rolling out. Yeah? So that is it for the timeline. With regard to the other part of the question, what do we do in the interim? Yes, the RHAs will continue to use what they have and maintain an acceptable level of delivery using those solutions as we implement. Of course, when we implement that solution at those two hospitals, we would appreciate that an HIS is modular in nature. So, for example, you have patient registration, pharmacy, bed management, patient scheduling, et cetera.

So there is nothing preventing us from starting to roll out, for example, the patient registration across the sector and then thereafter start incrementally rolling out the other modules as we go forward. Yeah? So that is something we have to work out. We have not clearly worked out exactly what is happening beyond those two hospitals in terms of the roll out plan, but it is possible using a modular basis.

Mr. Bacchus: Thank you, Madam Chair. And just the final piece on the performance management system. Is it that we are at the same point with that? And performance management system, in this case, being defined as managing the performance of what?

Mr. Ali: Thank you, again. Through you, Chair. So, in this instance, we are looking at a performance management system starting at the organizational level and then drilling down to the employee level. Yeah? So that is what is intended in terms of this particular bullet where we are with developing that particular system. Where we are in that process is that we are—through the IDB, we have a loan with the IDB right now and part of the funding for that loan will be to engage a consultant to develop such a system. What we are doing in the interim—work is

continuing in the interim. What the RHAs have been doing, together with the Ministry, is looking at a—tweaking our existing performance management system at the level of the employee while we await that holistic review. So it is not that we are not doing anything while that happens. We are looking to tweak and revise within the current environment and then when that consultancy kicks off, we will then do a holistic overview and overhaul. Thank you.

Mr. Bacchus: Thank you, and thank you, Chair.

Madam Chairman: Okay. May I call on member Deonarine to join the conversation, please?

Ms. Deonarine: Thank you, Madam Chair, and welcome again everyone. I too want to extend my gratitude to the entire team at all the RHAs and the Ministry of Health with regard to the excellent work and the outstanding efforts that you all have been providing this country with, especially during this difficult time.

Now, I just have some follow up questions following on from what Madam Chair and also member Bacchus would have asked. I too am having some difficulty in understanding the rate of implementation that you all have established. So my question is, is it that you all used a particular framework to come up with this map of sub-activities to fulfill the key recommendations coming out of this report? So, for example, what I really asking is that, is this map sort of done in a logframe matrix using some sort of vertical logic or so on?

Mr. Jaisingh: Hi member, thanks for the question. Yes, it is done via looking at that bottom-top approach from looking at the sense of what activities were in the RHAs incorporated into the report itself. So we also have a case where activities are not against the recommendation as well as the pillar itself. So it is a bottom-top approach that was used to actually gauge the activities together with consultations— together with consultations with not only the RHAs but also the public as well, to flesh out the broad nature of the recommendations as much as possible to frame the activities and integrate it into the work plan, in terms of the—and provided a status report on each activity which then builds up to the recommendation and the pillar itself.

Ms. Deonarine: Okay. So then you are telling me that you have clearly defined activities, outputs, outcomes that all rolled up into achieving a goal which is verified by means of verification. Right? You have an indicator that verifies achieving all of this.

Mr. Jaisingh: Well, not all of the means of justification or outcome because the means of justification was basically looking at the type of recommendation, alignment to the work plan and the activities in the report itself that aligned to the pillar itself. It is a means of justification.

Ms. Deonarine: Okay. I understand. So tell me then something, you did indicate too, Madam Chair, that you attribute weights to certain things, right? So could you tell me how you determine these weights? For example, one activity or sub-activity that may be of more priority or more importance of another. Tell me, how you go about weighting these activities? What are the factors that influence the weight?

Mr. Jaisingh: Well, the first thing was really looking at to see—the weighted part was looked at on the priorities of the Ministry, together with the priorities in the report itself. So we looked at exactly—for instance, we looked at the infrastructure side of it was marrying both the constraints from the different factors, whether it be the consultation, whether it be from the report itself, whether it be from the work plan from the Ministry. We actually brought all together in terms of highlighting the priority areas within infrastructure and map it together into one set of sub-activities to support that pillar itself.

So it was marrying from, not only the report, but from the different areas of the work plans and consultations with different stakeholders, together in one, as a means of priority. Because the list—as, Madam Chair, indicated we do not want to have an infinite list as much as possible but at the same time, pulling the essence of the report on the recommendations as well.

Ms. Deonarine: Okay. I understand what you are saying but to facilitate or to help the rest of the Committee members, including myself, is it—I am sure that you have some sort of documentation that maps out this entire framework, this vertical logic framework that you are referring to. Is it possible, through you, Madam Chair, for you to submit that document for the Committee for our perusal?

Mr. Jaisingh: Sure, no problem. Yes, it could be available, yes.

Ms. Deonarine: Okay. Thank you. Now I want to move on to, on page 5 of the submission. And on page 5, under pillar 7, "Primary Health Care Pillar I", you all indicated that:

> In the first instance…

And I quote:

> In the first instance, there was an upgrade of the operations at the Accident and Emergency Department at the San Fernando General Hospital inclusive of layouts, staffing, equipment, process flow, patient management procedure, protocols and or standard operating procedures.

So, could you elaborate for not only the Committee members but for the listening public, what

exactly that included?

Mr. Ali: Madam Chair, through you, I would probably want the CEO of South-West to maybe speak to what would have happened at San Fernando in terms of what was listed there, please. Thank you.

Madam Chairman: Sure. CEO of South-West Regional.

Dr. Armour: Yes. Through you, Madam Chair, for the fiscal period 2019/2020, several initiatives were taken into consultation with staff and client feedback. Some may seem operational granular but they have had an impact. We have looked at our staffing workflows where we have had dedicated staff position called "medical orderlies'. We have rectified issues that would impact with respect to transport of patients from the ambulance to the trolley, from trollies to bed, to wards and so forth. We have reengineered our triage and continual process improvement of our best practice. So we do have more staff manning the triage areas that have more efficient triage.

We would have done some business flow as well as some, for want of a better word, aesthetic, so that a patient experiences such that you know from simple things like the colours of the walls; staff badges are different colours; when you go from triage; when you go through assessment; when you are known to have been assigned a bed, and when it is that, of course, you would go to the ward. We would have put in some more equipment infrastructure, some intercom communications. We would have reviewed, again, the role of the customer relations officers speaking with the patients, relaying concerns of patients to staff, focusing on next of kin. So we are very much focused based on the feedback with the customer care experience with respect to reengineering. So we would have also even done some stock management where we would have been able to create census. So the flow is that if somebody comes in, you are assessed, you determine your level of acuity and then you are assessed in different areas of the emergency department. And once you are determined to be admitted, then you wait in certain areas.

We would have bought more recliners; more patient-friendly recliners. We would have reorganized the bed management system in the emergency department and we would have also arranged the concomitant stock of consumables and supplies so that the doctors and nurses could administer care. What we have seen over the last fiscal year—even before COVID came on in March, we were starting to see the process improvement. So we used our KPIs as to the number of persons awaiting bed at an eight-hour interval and a 24-hour interval.

We also collaborated with the Ministry and GMRTT to look at the transfer rates of

patients from ambulance to trolley and look at those metrics, and we have seen a very much improved process; improvement of those metrics meeting our SWRHA targets and even the targets as desired by the Ministry of Health. So challenges would still naturally remain, yes, and when we have some surge, as would have happened post-Christmas a couple of weeks ago. But by and large, those are the specific issues and processing improvements.

I would say it has been a bit more on business flow and business process reengineering and some equipment. And well, that is benchmarked against our bed management on the hospital wards and for which we pay a keen eye to the surgical services, and South-West also has a discharge lounge through policy and affirmative action so that we are able to have the continuum of flow. So from the ED to the ward, to the discharge, and those metrics are monitored several times a day, literally, with several data metrics. But in terms of answering the question with the ED, those are the specific things in the ED that—to elaborate in some more detail.

Ms. Deonarine: Okay. So then, all of this sounds quite nice. But I want to know, how does that redound to the waiting time that a patient or a citizen would encounter from entering the Accident and Emergency Department to getting attention from a doctor? What it was before and what was your target to achieve through implementation of this recommendation? How much time has it been reduced by? And I am a frequent user of the South-West Regional Health Authority facilities so I can give you some examples where the wait time is nowhere close to at least four hours that is internationally recommended.

Dr. Armour: Okay. So there have been improvements. Our target time has been eight hours and 24 hours in terms of the macro times, the strategic look is in terms of from the time you come in, to the time you get a bed being eight hours. And, of course, we do not want you to go over to another day which sometimes used to be the case in years gone by, so which we would look at as core markers.

We are aware of the patient experience that there are delays. They are generally very efficient in triage. It takes a couple of minutes to an hour. We do have sometimes process delays in terms of getting investigations done. So that is where the couple of hours may start to naturally creep up from a patient care experience. So from the time you are assessed, doctors have to run blood tests or they have to do X-rays or they have to do CT scans, the popular sort of imaging test, that may have challenges. We have had some instances where it may not have all the equipment function optimally at all times. But for the majority of times, that is what tends to

occur.

Critically ill patients are generally seen very quickly, those who have life and limb-threatening injury. We tend to have patients who fall into the categories of what we would call "medium risk". In terms of medium risk—so like, heart attack, strokes and so forth, those patients tend to relatively, speaking to the critically ill, would have more wait time because they have to get more investigations done. But at the same time, noting that reality, we have seen the improvement. And then beyond that, once you get the investigation on a definitive diagnosis, well then, you now have to await getting to the ward. And as I said before, we have improved their comfort level while they have to wait, in some instances, in the emergency department to get to the ward. So whether it is a bed in the emergency department area or whether it is—once you are not as critical, you may get into our patient-friendly recliners and well, as I said, we focus on the orderlies.

So I do know that there are outliers that some patients described as a longer waiting time relative to others. We do have customer relation officers on the floor. And all of us as executives and managers, anyone can reach out to us from the Ministry straight down to the patient, and once we get a call or a WhatsApp message, we certainly try to resolve individual request. But looking at the health system as a whole, there are process improvements in terms of the data analytics. In terms of our key marker, it is time to be triaged and time to get a bed if you need a bed.

Ms. Deonarine: Okay. Madam Chair, if you would allow me to continue? I have two more questions pertaining to this matter.

Madam Chairman: Yes, you may.

Ms. Deonarine: Thank you. Dr. Armour, could you tell me then, what practices have been adopted in the waiting area of accident and emergency in terms of making sure that patients, who are awaiting attention, adhere to COVID-19 protocols? Because I was there in early January and everybody was, in local parlance, "stick up next to one another". It had nowhere where we were, at least, the recommended distance apart. So I saw the two recliners that you were referring to but there were at least 12 persons inside there— I counted—and every one was next to one another. There was no social distancing.

And also, my question to you then is, what is the nurse to patient ratio and the doctor to patient ratio. Because I cannot even get attended to when I entered accident and emergency. I

waited three hours and I left because the issue was so severe that I had to go and seek private health care somewhere else. So tell me, what is the average time from entering there and receiving attention from a doctor? I know you said it is depending on what type of service, what type of disease or what type of threatening illness that you may have. Also, give us an explanation as to what is considered low risk and high risk, because you alluded us to what is considered a medium risk?

Dr. Armour: In terms of the actual numbers of the doctor to patient ratio, as I said before, we have a quarter million encounters per year across our five emergency departments. San Fernando Emergency Department, in particular, for 2019, we had about 92,200 encounters over a 12-month period. I say encounters versus patients because patients may obviously come in more than once depending on the chronicity of their condition. But in terms of our staffing complement levels, it is never 100 per cent. I know off hand, overall, for example—[*Audio drops*]

Ms. Deonarine: Dr. Armour, you are muted.

Dr. Armour: I am so sorry. Okay. Yes, I was saying that in terms of our encounters, it is 92,000 for San Fernando General Hospital patient encounters as opposed to—because a patient may encounter the service more than once. In terms of the nurse and doctor to patient ratio, well then, we would measure in terms of—we look at the number of doctors that is required to man the areas per shift. Generally, the medical staffing is adequate. Sometimes we may have challenges with nursing shortages, intermittent, but that is managed departmentally.

The medium risk, speaking in lay terms, in terms of—there is an established process of triage, as we called it, and it is based on a Canadian system where patients are assessed as most critical as level one and not as critical or very low risk is what you call—they can walk into the ED then rather than being trolleyed in or carried in, as level five. So generally, level one and level two are very critically ill patients. Those are patients with, like gunshot wounds and are at risk of dying from whatever complications, severe heart attack, they come in semi-conscious. Those patients are generally seen immediately and, of course, managed immediately and once they survive their acute illness and stabilized, they go to the ward. Levels four and five are those patients who are generally able to walk in. They prefer to access health care at the emergency department and they believe, based on their health condition, they need treatment. Most of those patients tend not to be admitted after assessment but they are counselled appropriately, given medication if warranted, or if there are any minor surgical—like basically cuts and sprains and

strains of joints, those sort of patients are seen.

What we find is that it is—or what I call the medium risk are really our level three clients. They are not well enough to go home but they are not critical enough to need the immediate attention, but they would need some days on the ward. And those are the sort of patients that would generally—those who have chronic diseases and naturally, chronic disease brings a lot of complications to your organs. Those are the patients—when we look at our analysis, those are the patients that are very mindful and aware of the length of time it takes for them to be seen. They are anxious, their relatives are anxious. But I just elaborate a bit, because in the scheme of things, that is the wide spectrum of patients that come to the emergency department. So we are very mindful that those level three, what I called before, medium risk, those are the patients that take the time. They require investigation, whether it is blood test, whether it is X-rays and they need multiple reviews. So they would review by the emergency doctor, by the specialist doctor and decisions are made collaboratively, and that generally does take some time in those instances.

Ms. Deonarine: Okay. Thank you. So generally, tell me something. How many doctors are usually working in accident and emergency at any particular shift?

Dr. Armour: I do not have that precise answer but I would probably ask for assistance from my Director of Health, Dr. Ramoutar, because we do have both specialists, senior doctors, registrars and even house officers who work in the department. But I would ask my Director of Health to add clarification to your question.

Ms. Deonarine: Thank you.

Dr. Ramoutar: Madam Chair, through you, so on every shift we have one SMO, two registrars and approximately eight house officers. The officers—you have one registrar would be in what we would consider to be a trauma section, devoted to dealing with the acute injuries and so on, and another one in the general non-trauma area. The officers are deployed according to the severity. So you will have some in what we call the resuscitation room dealing with the acutely ill and those—then you have some—there is a filter clinic for the what we would call the level four's and five's. So you would have one or two officers there and the others would be dealing with the level two's and three's. So the staffing is really deployed according to where the risk is.

Ms. Deonarine: Okay. Thank you. Madam Chair, I would pause here.

Madam Chairman: Thank you very much and I want to really tell all other members who have been waiting that I do appreciate their patience. I will therefore call on member Mark, after

member Bethelmy and then Dr. Bodoe. So member Mark. Thank you.

Mr. Mark: Thank very much, Madam Chairman. Madam Chairman, let me join you and my other colleagues in extending my appreciation to the various RHAs and their leadership and, of course, the personnel who have been doing yeoman service in a very difficult period in our country's history. So I would like to join you in extending my compliments as well to the people who are with us today.

But, Madam Chairman, there is no doubt that the health care system seems to be broken. Like the criminal justice system in our country, there are challenges and I think that to overcome those challenges, we have to face reality. And in this context, I wanted to ask the CEO of the North Central Regional Health Authority a few questions. Now, Madam Chair, through you, to the CEO, and I would like him to correct me if I am wrong immediately. I did write that, in terms of complaints at the North Central Regional Health Authority, they got a percentage of 66 per cent. Is that right, Madam Chair?

Mr. Thomas: No. Through you, Madam Chair, there was a decrease between 2018 and 2020 to the tune of 66 per cent.

Mr. Mark: Okay.

Mr. Thomas: So we had a decrease in complaints. We also had an increase, correspondingly, in commendations of 30 per cent. So there was a decrease in the complaints, simultaneously with an increase—with corresponding increases in services and simultaneously an increase in commendations.

Mr. Mark: Well, I am very happy for this institution for having received from your own assessment and analysis, 66 per cent based on your scientific work. The query I would like or the area I would like to clarify, I am sure that you are familiar with a headline—it was a glaring headline in the *Trinidad Express*, 17th of January, 2021:

"Hospital Horrors: Fed up of waiting"

Now this was on the 17th of January, 2021. So it tells me that something is not synchronizing well at the NCRHA. Because if you have citizens complaining—I want to tell you whilst myself, if I go there, I know you, Mr. Davlin Thomas will look after me and give me top attention and anyone of my family. But I am not concerned about me, I am concerned about the ordinary citizens who are complaining vociferously about the length of time it takes to even get an appointment and when they get the appointment, it is just "kick down de road" like the bucket

or the football, and they keep going. Some talk about eight months, some talk about one year, some talk about two years. Now that is extremely frustrating. Do you have data or statistics to share with this Committee as it relates to the number of citizens who might be in that category where they come in and they have to be religiously and faithfully postponed or receive a postponement, after a postponement, after a postponement? Is there any data you can share with us as it relates to the number of citizens who access your health care who might be involved in that kind of waiting exercise, Mr. Davlin Thomas?

Mr. Thomas: Particularly—through you, Madam Chair, particularly during the COVID season, as we call it, and in particular as well with surgical patients, if you remember the complaints that emerged in the newspaper on that day, they were particularly surgical patients. The patients who required care for chronic diseases, heart disease, diabetes and hypertension and so on, we were able to engage them directly via the telemedicine services. The surgical procedures, in particular, required one on one interfacing and interaction.

Now, if you recall what was taking place as we traverse the COVID-19 engagement, there were regulations that would have changed from time to time that would have identified and stipulated for us just how many persons can be within a confined space and which eventually went down to, at times, just five persons. The net effect of that is that four surgical patients, in particular, we would have had periods when we—for the non-urgent surgeries, in particular—deferred some of those patients to subsequent appointments. I do not have the exact number of those patients before me now, but we do track them and we have been engaging them.

4.20 p.m.

Mr. Mark: Would you be kind enough, Mr. Thomas, to provide to the Chairman of our Committee data on the amount of postponements that have taken place with patients who are seeking what you call non-surgical operations, as well as those who are seeking surgical operations within your institution? So since you do not have that data and I can understand that you would not walk with everything, could you provide that in writing for us? The second area I would like—

Madam Chairman: Member Mark, just so that—please allow me to intervene? Just so that we are clear with what we are asking Mr. Thomas to provide, over what sort of period, we are looking over the last year for that sort of information?

Mr. Mark: Well, Madam Chair, I am looking at the period of implementation of the Welch

recommendations. That is the period to the present, and it began to implement in 2018.

Madam Chairman: Good. So at least you are looking from 2018, yes?

Mr. Mark: To the current time. Yeah. The second area, Madam Chair, through you, I would like to ask my colleague and friend, Mr. Davlin Thomas, is: Could you supply this Committee with information concerning the number of let us say patients who access medical services, health care services at the North Central Regional Health Authority on a total basis? When I say total, I should say on an annual basis. And if you were to go down to a subset, which is the Eric Williams Medical Sciences Complex, could you also share with this Committee the number of citizens who would have accessed health care on an annual basis at the Eric Williams Medical Sciences Complex? Do you have that information? If not, you can put that in writing as well.

Mr. Thomas: We have some of that information here. For example, primary care would see at least over 600,000. That is the impact during the fiscal. For Eric Williams Medical Sciences Complex, the emergency department would see at least eight new patients per hour, which is about 4,500 to 4,600 patients monthly. That is just the emergency department. What we would have is as breakdown of each department, but our catchment is about 400,000 or so. The net impact at the facilities, we are basically approximately about per month anywhere between 100,000 to 300,000 patient visits. In particular our paediatric department, we see somewhere between 40,000 persons a year, 2,900 patients monthly. We are looking at every hour at least two children come into the department.

Our inpatient admissions every single day at the Eric Williams Medical Sciences Complex, we have about 70 patients admitted daily. That is 2,137 patients admitted to ward on a monthly basis. This is over 25,000 to 28,000 visits per year in terms of inpatient admissions to the ward. So just to give you a sense of the magnitude, our clinics, we see nine visits per hour, about 75 visits daily. We see between 27,000 and 41,000 people within the year. This is only in our medical clinics. Our surgical clinics can go anywhere within a year to 66,000. We are talking about 16 patient visits per hour at 126 visits per day. The outpatients for paediatrics are about 20,000 children per year. Our surgical procedures, as I told you, they range between—and this is 18 surgeries per day at a rate of about 6,000 to 8,000 during a year.

Our diagnostic lab does about 289 tests per hour. That is 6,944 tests per day. Every single day we do tests in our lab for 6,944. That is 2.5 million blood tests done every single year at a rate of 200, nearly 300 tests per hour. Our radiology procedures are just at—the magnitude of

the throughput I think is clear now.

Mr. Mark: Yes, Mr. Thomas, that is why I complimented you and all our colleagues who are with us today on the kind of work that you all have been doing. What I want to get from your good self is whether you can provide our Committee with some kind of data that would really reflect not only the numbers that you do in terms of seeing people in the different areas that you have identified, not only the number of tests that you have conducted, but if you can share with this Committee how many people out of those many tens of thousands actually receive what you call the kind of active, positive and sensitive service so that at the end of the day they get their test, but within, for instance, a couple of hours, they get their results. And if they say look, this person has gallbladder or gallstones, you need to have an operation, how many people from a statistical point of view you would say are able to get not only results, not only to take tests of these people, but to get actual results at the end of the exercise so that they could walk out feeling happy? Do you have data on that so you can show that look, 10,000 people visited Eric Williams Medical Sciences Complex—break it down—how many came for this, how many came for that, and at the end of the year so many of them were given first-class treatment and they left? Do you have data on that?

Mr. Thomas: Well, we have two kinds of data that could lead you to some conclusions. One is that, for example, some of those value added processes like the lab, when you come into the lab those 289 persons, they receive—for example, they may not all go to the lab. They may be at the emergency department, and so on, and just to give you an idea of some of the innovations that took place within the recent past, when you go into the emergency department, prior to last year or so, there were situations where you would go into the emergency department, we would have had to take blood tests. When the consultant does come around to see you, your blood results may not have been—they may either have been ready and not issued to the emergency department at that time.

There was a lot of discussion earlier about the HIS system. What we did was, we did our own home-grown lab information system. I am speaking now not just to the test, but the value of distributing the information from the test or the test results directly to the places that it needs to go. So we created a home-grown through our **ISIT** Department and lab information systems. So when that patient—that test is sent directly to the lab every half an hour, the results now are sent immediately via a computerized system to the emergency department. The net effect is that

when that consultant does arrive at the emergency department, the information is now available. The net effect of that is a decreased waiting time for that patient in that department, and that is just one example of the innovations. We have spread that system to the wards as well. So the lab information is now information available and distributed to the wards, clinics, et cetera. So we have managed now—

Mr. Mark: Thank you. Mr. Thomas, I want to thank you very much, and if you could commit the rest of your reflections in writing, we would appreciate it because you know, time is of the essence for us and we have to do it in a certain time and you too. Let me ask just you another question. Mr. Tsoi-A-Fatt if I—is Mr. Tsoi-A-Fatt the CEO of the Eastern Regional Health Authority? Yes, I think so.

Madam Chairman: Yes, he is.

Mr. Mark: He made a very powerful contribution when he was speaking earlier and it caught my attention. He says that the Eastern Regional Health Authority, they conduct annual feedback surveys and that is to get a feedback from their customers, the patients who visit that Eastern Regional seaboard as it relates to the RHA in this instance. I would like to ask Mr. Davlin Thomas whether at the North Central RHA there is a similar annual feedback survey in effect.

Mr. Thomas: Yes, it is. In fact, it is consistent within the entire RHA system. So we do have those quality feedback surveys, but in addition to that we would have been measuring, for example, our waiting times that are consistent with international standards. For example, the discussions that you would have had before about the CTAS in the emergency. We were able to decrease our waiting times that were initially in 2018/2019 at one hour and 50 minutes in at least level 2, to 38 minutes and, for example, level 3, 78 minutes. So these are things that we track, but in addition we also had recently our mystery shoppers who enter the system to give us a clearer picture of what was happening within the services. But the client feedback is consistent throughout the sector.

Mr. Mark: Mr. Thomas, could you provide to the Committee a copy or documentation on your annual survey plans in terms of what the results have been and what has been—in other words, on an annual basis you conduct it. So we would like to have documentation to that effect from 2018 to the present time. I would now like to ask, Madam Chair, a question to the Chief Medical Officer.

Madam Chairman: Okay. So, member Mark, might I add—[*Interruption*] Member Mark, one

minute. Might I ask that information, I would think we would want it for all the RHAs seeing that the practices are supposed to be consistent, the policies.

Mr. Mark: Yes.

Madam Chairman: All right. So you—

Mr. Mark: Madam Chair, I am going to just ask two questions and then I will pause for a little while and allow my other colleagues to come in with your leave, of course. This question deals with Pillar VI and it deals with the Office of the Chief Medical Officer. I do not have to regurgitate what the Welch Committee had recommended because the medical personnel who are with us and the administrative staff would be aware of it. But I would just say briefly one was to re-establish the Office of Principal Medical Officer in areas that have identified epidemiology, environmental health, institutional strengthening and, of course, to have a better reporting, strengthening the reporting relationships between the Ministry of Health and the RHAs. So the first question I would like to ask here and maybe that will go to, as I said, the CMO: As it relates to the re-establishment of the Principal Medical Officer positions in the areas of epidemiology, environmental health and institutional strengthening, can you provide this Committee with a status report briefly and then you could put it in writing thereafter?

Dr. Parasram: Thank you. Thank you, member. So in terms of when I began as CMO in January of 2017, there were none of the positions re-established. We quickly went to and had meetings with the DPA with regard to re-establishing based on the need and what was in the Welch Committee's Report. So there were four positions that needed re-establishment: the Principal Medical Officer of Environmental Health, Principal Medical Officer of Epidemiology, Principal Medical Officer of Institutions and that of community services. At the time there was suppression of the community services post in lieu of another post that was in the Ministry of Health for a Senior Technical Officer, and that person had just started a contract which was lasting three years. So we were able to, I think, advertise the positions of EH, epidemiology as well as institutions during that time, and we were successful in actually appointing two persons to the post of Environmental Health I believe in either '18 or '19, and Epidemiology would have been thereabouts just a little while after the Environmental Health positions.

So we have two appointed officers in the Epidemiology post and in the Environmental Health post. There is one acting officer at present in the Principal Medical Officer Institution post. I think we would know that person as Dr. Richards. And in terms of the CS post, now that

the person has demitted office from the Technical Advisory position, Cabinet would have agreed that we can now advertise through the DPA the position of PMO CS which we have liaised with the DPA and hopefully that position would be advertised soon, together with a—although the PMOI positon was advertised in the first instance, DPA may decide to re-advertise based on—the number of persons that were shortlisted was quite small. So there may be re-advertisement of both the PMOI as well as the PMO CS position hopefully in the near future so we can all four PMOs in the Ministry of Health.

Just to say that the positions, I would have been about six to eight months as the CMO without those positions in place and I think the addition of the PMOs position to support the CMO has gone a long way and assisted especially during the COVID-19 pandemic to give us that needed support in the Office of the CMO. I hope that suffices by way of an update?

Mr. Mark: Yes. Thank you very much, Dr. Parasram. I would like to ask the Acting Permanent Secretary in the Ministry of Health this question: What is happening with the strengthening process insofar as the reporting relationship is concerned between the Ministry of Health and the various RHA? Maybe the Permanent Secretary can come in here and tell us what is the current status of this particular matter?

Mr. Ali: Sure. Thank you. Through you, Chair, thank you, Sen. Mark. So with regard to the reporting relationship, we do have various mechanisms in place, one of which would be we have quarterly meetings of the Quality Managers of the RHAs together with the Ministry of Health [*Inaudible*] Department. We do have the adverse events reporting mechanism where the adverse events those reports come back to the Ministry. We do also have regular reports coming in through our Health Policy and Planning Department and also our Epidemiology Department where we will get statistics in terms of patient throughput in various areas from the respective RHAs.

In addition to those formal mechanisms, we also meet on a monthly basis with the chairmen of the boards, the respective boards together with the CEOs, Minister, CMO, myself, the DPSs, and there is also a weekly meeting of the CEOs and the Ministry's executive. So there are quite a few different mechanisms in place for reporting between the RHAs and the Ministry.

Mr. Mark: As I have you on the floor, can I ask you to give us an update on the old issue of the c-store or c-stores as they call them. You know there has been this whole question about its over-centralization and their accompanying bureaucracy which causes a lot of confusion in terms of

RHAs accessing medical supplies, pharmaceutical products on a timely basis in many instances, not to mention shortages of supplies in critical pharmaceutical products. Can you advise this Committee whether any attempts are being made to relook at this over-centralization and bureaucracy and move towards a more decentralized approach so that there can be more efficiencies generated if you have a greater level of decentralization rather than the over-centralization that we currently have?

Mr. Ali: Sure. Through you, Chair, so what we have currently would be the decentralization of the procurement function for those medical supplies that we spoke about, and that is in essence what is centralized. The procurement function. The RHAs each have point persons as well as NIPDEC who as we are aware, would be our procurement manager for our pharm and non-pharm supplies. So there is a point person at the level of the RHA as well as NIPDEC and they interact virtually on a daily sometimes with regard to managing that supply chain and logistics between the RHAs and the NIPDEC central stores. There is also a dedicated resource within the Ministry of Health that also works together with that particular network.

So in terms of—and over-centralization, I do not think that is currently the case. What is centralized is the procurement and for obvious reasons in terms of the economies of scale, taking advantage of the supply chain and stuff like that, but beyond that I think the decision-making process and the whole supply chain and logistics function, it is decentralized to a large extent across the sector.

Mr. Mark: So you would say at the present time things are working relatively—well, things are working relatively good you would say at this time?

Mr. Ali: Well, there is always room for improvement. There is no perfect system. So we are continuously looking at ways to improve what we have, but things are working well bearing in mind—

Mr. Mark: Relatively efficient?

Mr. Ali: Relatively well, bearing in mind the current environment within which we operate in terms of global supply chain with COVID. That has affected supply chains globally.

Mr. Mark: All right. Madam Chair, I will pause at this time because I know I have taken up a few moments well. I have a host of other questions, but I know time is running out on us and I will pause at this time, and thank you very much for allowing me to intervene at this time.

Madam Chairman: Okay. So can I call member Bethelmy, please?

Ms. Bethelmy: Good afternoon everyone. Good afternoon, PS, good afternoon CEOs, good afternoon, Madam Chair, I am sorry, good afternoon CEOs, good afternoon heads of departments. Thank you so much for joining us. Madam Chair, through you, I have three questions to ask, but before I continue I just have to say that I disagree with Sen. Mark. Our health care system is not broken. I believe we need or we require improvements, but my father recently suffered complete organ failure in October and he was admitted to the Port of Spain General Hospital, and because of their care he is alive today. So thank you very much.

So my first question goes to PS Ali. Under the pillar, primary care—under the primary health care pillar, item 3, the system for block appointments has been instituted across some specialities and the system is currently being assessed to determine its effectiveness. Can you explain for the members and the wider public what this system does?

Mr. Ali: Thank you. Through you, Chair, member, I know you posed the question to me, but maybe I could pass that question across to one of my technical persons who will be better placed to explain what a block appointment system is. I am not sure CMO if you want to take that?

Dr. Parasram: Sure. Yeah. So basically what used to happen in the past and you would see it a lot in the primary care setting is that people would be asked to come in at a certain time when the clinic begins, sometimes between 7.00 a.m. and 8.00 a.m. in the morning, and all 30 or 50 people that were registered for that particular day will show up at the same time. What it means is that somebody on that list will end up having to wait quite a long period of time to be seen, possibly half of the day. So by way of block appointments what we do is basically schedule the appointments every hour or thereabouts so that persons come in throughout the day, usually those, for example, 8.00 a.m., 9.00 a.m., 10.00 a.m., 11.00 a.m. There is a break for lunch although the patients are continuously seen during the lunchtime period and there is a rotation of staff, and then, of course, resumption at 1.00, 2.00, and 3.00, for example, in a health sector setting.

So that has been used across the board for a long time in the primary care setting. It has begun to be used in North Central and other RHAs in the secondary care setting as well, and it really is meant to decrease the length of time one person will have to stay in the clinic and, of course, get best use of the staff in terms of staff being able to see you in a staggered manner and giving that appropriate length of time for the physician consultation to occur rather than trying to do an ad hoc scenario where the consultation is really disadvantaged and you are rushing through from one patient to the next.

So the block appointment has been doing well and established for quite a number of years, and the expansion into secondary care has started for certain RHAs, for example, North Central, because of constraints with the size of their clinics because central block for example, is down. It has not gone as much as into the block appointment systems as, for example, North Central or South West would be able to in secondary care, but it is a policy that we hope to roll out across the system so that we can see, and redounding really to patients coming in at staggered times and spending less time to be seen by the physician and having a better patient experience at the end of the day.

Ms. Bethelmy: Thank you. Through you, Madam Chair, my second question goes to Mr. Thomas. On page 7, item 3, the NCRHA has been utilizing a system approach to facilitate the positive outcomes for improved service delivery by conducting audits, gap analysis and identifying action plans basically to improve service delivery. Can you elaborate on some of those gaps that you identified; and how has it improved your service delivery?

Mr. Thomas: Through you, Madam Chair, just to explain what this system approach is, is that we are particularly interested in a more holistic sense of how things interact to facilitate the outcomes. So, for example, one of the examples I gave earlier was the relationship between being able to have a lab result available for the consultant when he gets into the emergency department and to be able to do that in a predictable manner so that it would then imply that the patient could then be discharged the very same day. Another gap that we would have had is and this is just another example because we have multiple. One is—and I am just using the emergency department as an example. For a patient who came in with the possibility of a heart attack, chest pains, et cetera, it is important to do a test called troponin. Usually, a troponin test would take about 12 hours in the past. The net impact of that is that you will have to retain that patient in that department for the duration of the 12 hours, and therefore, generate additional congestion.

So you could just imagine in the past if you would have had five, or six, or 10 of those patients with the possibility of heart attacks staying each 12 hours. With the approval of the Ministry and the board, we started from a systems approach, purchasing what we call a high sensitivity troponin machine. That reduced the time that it takes for the test to just about two hours. The net impact of that—and if you multiply that by numerous patients, we were able to tell immediately that in two hours whether you had a heart attack or not. The net impact is that if you did not, then we could send you home. And the implications of that, the outcomes are less

waiting times in the department, less congestion, and certainly the improvement in the patient satisfaction. So those are some of the examples of what we term "systems approach", and one or two of the gaps that may have occurred.

Ms. Bethelmy: Thank you so much. Madam Chair, through you, I have one last question under the core infrastructure and medical devices. This goes to either PS Ali, or Dr. Armour, or possibly Mr. Alleyne. The Ministry will seek to commence construction work for the establishment of a cardiac catheterization lab in the San Fernando General Hospital. What does this mean for the general public?

4.50 p.m.

Mr. Ali: Sure. Thank you. Chair, maybe Dr. Armour can speak to the clinical benefits of having this cath lab at the San Fernando General Hospital.

Dr. Armour: Sure. Thanks for the question. Through you, Chair, I think the Director of Health, that is our content technical expert and he himself is a senior cardiologist, so I would like for him to answer.

Dr. Ramoutar: Thank you, Madam Chair. So a cath lab is designed to rapidly diagnose if someone has blockages of their arteries. Ideally, it should be close to your Accident and Emergency Department. Your patient comes in with chest pains, you suspect a heart attack, you get them into your cath lab, you look at their arteries and diagnose if they have blockages. The standard treatment for heart attacks now—a particular type of heart attack is to go into the artery and open them up and put in a stent and that saves lives. It saves a whole lot of down time for the patient as well as ongoing costs for continuing medical care for the patient.

So the impact of it would be a quicker diagnostic time for your patient, shorter hospital stay and reduced long-term complications. Long term, it saves the Government money if this equipment is close to your Accident and Emergency Department and you have a programme of doing rapid diagnostic work and intervention.

Ms. Bethelmy: Okay. Thank you so much. Thank you, Madam Chair.

Madam Chairman: Okay, thank you. May I now call on member Bodoe?

Dr. Bodoe: Thank you very much, Madam Chair. I just want to tie my next question back to the primary health care system and relate it to the improvements in the triaging system and the ambulance management at the Accident and Emergency Department of the San Fernando General Hospital. I widely recognize it is one of the busiest hospitals in the country and I am

happy to see that we are building and so on.

But if I might direct this question to Dr. Armour, CEO. I just wanted to ask and I ask this in relation to a recent incident that occurred at the Point Fortin Area Hospital where there was an issue with triage and it was reported in the newspaper of Monday 01 February. I do not want to go into details but it is related to a patient, Carol Joseph-Alexander, who died at the institution. There are a couple of issues there that perhaps you may want to address and I am sure that you probably have an investigation already commenced into this. But one is the issue of triage. That came up when the patient was being asked to go through a second triage despite already being admitted and sitting there with chest pain. So perhaps you may want to share some clarity on that.

The other was the issue of the patient having to be transferred to San Fernando hospital because she required intervention of a cardiac nature, transpired to a heart attack eventually, and the absence of an ambulance. I also want to tie this in because I note also in the infrastructure pillar that the Point Fortin hospital is now on stream. So if I can just ask Dr. Armour, CEO, if you can just give us a brief update as to whether the training and the improved system of San Fernando has been shared with those at the Point Fortin Area Hospital?

Dr. Armour: Through you, Madam Chair. Thank you for the question. And I would like to take the opportunity to express condolences on behalf of South-West Regional Health Authority to the family and friends of the deceased patient. Yes, I am aware of the situation. The matter is under investigation. We are due to complete a report based on my last check on Friday the 12th of February, so it is being actively investigated. Through the adverse event policy, it would be determined to be classified as an adverse event. Based on the policy framework, once we have incidents and it is investigated, there is an RHA committee that determines if it is an adverse event and then that, of course, requires, through the policy of the Ministry, certain actions. The triage system, as described, is in place at all five emergency departments in the South-West Regional Health Authority. I am speaking of San Fernando General, our three district health facilities which are at Siparia, Couva and Princes Town and at the Area Hospital, Point Fortin.

So yes, part of the investigation is looking into the triage system that is already enshrined and therefore, any gaps or deficiencies, either in this individual case that may involve particular individual officers or if there is, unearthed, a more systemic issue that was not seen before, then that would be addressed. But in terms of based on the volume throughput that I would have

mentioned earlier, in large measure, it is a pretty standard process so any gaps or any issues that arise, that come in public domain, we promptly investigate.

So that is in terms of the level of expected training and competence as well as the system that is in effect at our five emergency departments. Sorry, through you, Chair, member Bodoe, I believe you are on mute. Sorry, I am not hearing.

Dr. Bodoe: Thank you. CEO, can you hear me?

Dr. Armour: Yes.

Dr. Bodoe: Yes, so I was asking for the benefit of the public, can you indicate what services are currently available at the Point Fortin Hospital? So I am speaking of the new Point Fortin Hospital.

Dr. Armour: Okay. Well, the new Point Fortin Hospital, it was commemoratively opened in July and we started off patient services in August, which are our outpatient clinics. We are working with the Ministry of Health and other stakeholders. We are in the final processes of commissioning all the equipment in order to have a full transition of services. So it would include the services that are currently at the old Area Hospital which are our emergency department services and our general medical and surgical services. As illustrated in the public domain, there are significant and new services at the Point Fortin Hospital that basically are in keeping with the standards of practice for any modern hospital. So there are CT scan services, there are enhanced, new services such as the burns unit and ophthalmology services, and a lot of quite impressive support services as well.

So the range of services—in terms of the next immediate phase, right now we are doing outpatient clinics, then we are going to move across existing services which are the ED, emergency department; labs; basic and advanced radiology services; and our ward and theatre services, and then certainly, shortly thereafter, with the additional equipment, we do intend to fully utilize the hospital in terms of how it has been built on installation.

Dr. Bodoe: Thank you, CEO. Do you have a time frame for the transition of these services from the Area Hospital to the new hospital?

Dr. Armour: We are working with—through the Ministry of Health, our optimistic forecast is at the beginning of March. We can say that we are at the final stages having our own internal process monitoring of the commissioning. It is a complex sequence to ensure that the equipment, quality assurance, staffing, training, everything else is lined up such that when we open our doors

from day zero or day one, however we look at it, patients get the quality care. We are looking at early March.

Dr. Bodoe: Thank you. In terms of staffing, is it the intention to allocate staff from the other hospitals or is it the intention to hire new staff for that facility?

Dr. Armour: Based on the commissioning activities, there has been planning with the Ministry in terms of dedicating an operating budget for which we were already allocated and it is of note, in noting what the CEO of RHA said, we were in the process of hiring persons in the middle of COVID last year in preparation for opening of Point Fortin Hospital. And we are talking here about bringing on board between the existing on or around 272 staff at the Area Hospital, we were in a position to hire on or around, I think, a little over 300, close to 400 persons. So we actually did hires during the midst of COVID, while COVID is going on, through our tele-interview process and therefore, we have the budgets additionally applied for the commissioning of Point Fortin Hospital. So those hires have since been completed and we have done the staff training and on boarding so therefore we have the staff ready to be deployed to offer service.

Dr. Bodoe: Thank you very much, CEO. If I may, Madam Chair, just to move on to a few of the vertical services and these are mainly on pages 12 and 13, and perhaps I can share these questions between the PS and the Chief Medical Officer.

I wanted to just get an update in terms of the National Blood Transfusion Service and I note the goal of trying to achieve 100 per cent voluntary donations, but there are several issues here. I note that there is a terms of reference for the National Blood Transfusion Service and the clinical protocols and the appointment of a medical director. So I do not know, PS or CMO, whether you would want to give us an update and the public as well, as to where we are, blood transfusion being such an important and necessary service in terms of saving lives, if we can have an update as to where we are with the National Blood Transfusion Service.

Mr. Ali: Sure. Through you, Chair, let me just speak to the administrative parts of it quickly and then CMO can speak to the technical parts of it. Member, you mentioned the issue of a director. So we are currently engaged in the recruitment process for a director. I hope to have that completed during this month and to have somebody on board by the end of February. All right? That is in terms of the leadership of the blood transfusion service at our end. I will let CMO speak about what is happening throughout the sector. Thank you.

Dr. Bodoe: Thank you, PS.

Dr. Parasram: So in terms of the blood transfusion service, we currently have no sitting director. However, the consultant haematologist at Port of Spain General Hospital has agreed to provide oversight and she has been at the blood bank before. She is presently there providing oversight by phone round the clock as well as sitting in two days a week to the blood transfusion service and she is very close by as the consultant in the Port of Spain General Hospital.

By way of the systematic issues at the blood bank, we had Dr. Waveney Charles who was in the blood bank, hired as a consultant a couple of years ago, and her purpose was really to develop standard operating procedures to ensure that they were robust and in alignment with international best practice, which she did and she has handed that over to the Ministry of Health. So we are in the process of implementing, countrywide, the standard operating procedures for the blood transfusion services.

There is somewhat a decentralization of the donation sites. So now all the RHAs have their own blood donation centres. We retain the National Blood Transfusion Service for our testing for pathogens, dangerous pathogen screens as well as, in some instances, we do some breaking into constituent parts of the blood, blood process, for example, platelets. We are looking towards—the blood transfusion service has also been overseeing the quality improvement arm of it through a national committee that has been set up to go towards a full voluntary, non-remunerated service. Hopefully, the process is earmarked to take approximately three to five years to go from a chip-based system all the way to a voluntary system and that unit is actually chaired by myself with the blood donation nurses from across the country as well as a corporate communications unit and Dr. Kenneth Charles is also a technical advisor on that particular committee.

The other bit, in terms of quality control across the RHAs, we have reestablishment, a couple years ago as well, of clinical blood units at each RHA. So they now have a clinical committee designated to the use of blood and blood products to decrease the amount of the wastage and to streamline the clinical distribution of blood and blood products throughout the system.

So in terms of our service, I think there was great improvement over the last few years. However, we are still searching to get a director which is a big piece of the puzzle. Once we get the director in, we can have enhanced monitoring of what is happening at the RHAs in terms of the utilization of blood products as well as the donation centres and trying to get that voluntary

blood donation up to 100 per cent in the next three to five years.

Dr. Bodoe: Thank you, CMO. I am happy to hear the PS indicate that perhaps we will have a director by the end of February because I know there is a shortage of local haematologists in the country. Can you indicate whether citizens can donate blood in the RHAs on a Saturday? I know it is convenient and I know there was a practice at the SWRHA some years ago. Can you indicate whether that is still possible just for—

Dr. Parasram: Each of the RHAs have a particular blood donation centre. I know we have expanded the hours in recent times. I do not know if the CEOs can let us know, maybe individually, if—I believe we had gone to half day on a Saturday or up to 2.00 p.m. in some instances. The CEOs can give us an idea of the actual hours of opening of the blood donation sites under their purview.

Dr. Bodoe: That would be useful. Thank you, CMO.

Mr. Thomas: Through you, Madam Chair, it is—for the NCRHA, our blood donation site at Eric Williams is open on Saturdays now until 2.00 p.m. and so it is really just to confirm that.

Madam Chairman: Can we have for the South-West Regional, please?

Dr. Armour: Yes, subject to confirmation of the [*Inaudible*] opening hours, we do open on Saturdays up to half day, as I am advised.

Madam Chairman: Thank you. And what about the North West?

Ms. Baksh: Hi, good afternoon, Madam Chair, again. Yes, we are open on Saturdays as well from 7.00 to 2.00 and we also have our mobile blood clinic that we go to different communities for blood donations as well.

Madam Chairman: Thank you. And East Regional?

Mr. Tsoi-A-Fatt: Yes, Madam. Our blood bank services run on Saturdays until 12.00 noon and we also have to the supplementary blood drives from time to time.

Madam Chairman: Thank you very much. Yes, Dr. Bodoe.

Dr. Bodoe: Thank you. Madam Chair, sorry, if I may? Yeah. I just wanted to raise the issue of dental services, very important, but the public health dental service is really in need of some work, and I see that part of it is spoken about here. CMO, perhaps, could you share with us the plans to decentralize the dental health services and what we can expect when these recommendations are fully implemented?

Dr. Parasram: Yes. So as you know, with the coming of the RHA Act, the intent of and really

the spirit of the Act was to have all clinical services delivered via the RHAs and, of course, the Ministry of Health retain the strategic vision and policies arm of it. So dental service is one of those purely clinical service delivery arms. Of course, the Ministry has a role with regard to policy but with regards to the clinical service delivery, we see and we agree with the recommendations of the report that it should be delivered through the RHAs, as do other services occur and we are in the process of actually doing just that, having that service decentralized so that the clinical service delivery arm will be through the RHAs.

There is a human resource component to that, meaning, and I think the PS may be better suited to answer what is going to happen with regard to the Ministry of Health dentists that are retained with us in terms of going towards the RHAs, but I think that would be the last part of the puzzle where the remaining persons, maybe dentists and other officers, are going across to the RHAs to complete that decentralization process. I do not know, PS, if you want to add anything.

Dr. Bodoe: Madam Chair, through you, yes, I would like the PS to have an input here.

Mr. Ali: Sure. Thank you. Through you, Chair. So member, CMO is correct. In terms of the HR element, what would be happening during the course of this fiscal year, we would be handing over the management of dental services to the respective RHAs. The intention being that the RHAs would come up with their respective structures for the delivery of dental services within the respective RHAs, within the Ministry's overall dental policy.

With regard to the staff that are currently employed by the Ministry, the dentists and the dental nurses and assistants, just like the other public servants when the RHAs started, they will be offered the option to transfer to the RHAs or to accept VSEP, and depending on the option that they exercise, we will then take it from there. In terms of if they choose to transfer to the RHAs, they will move across to the respective RHAs. If they choose VSEP, then the RHAs are free to hire persons in those vacancies. But there are existing vacancies currently and the RHAs are free to hire persons at those vacancies and that is what we are working on right now to hand over to the RHAs.

Dr. Bodoe: Yes, thank you. Can you indicate how many vacancies, if you have that information, are there for dentists in the public health sector?

Mr. Ali: I do not have that with me right now, member, but I can provide that to you in writing.

Dr. Bodoe: Thank you very much. If we can have that in writing, Madam Chair, because I know

one of the challenges that we will face as a country. Because private dental practice is perhaps lucrative and I do not know whether we have a shortage. Are you in a position to indicate whether you might have challenges to fill those positions?

Mr. Ali: Well, I think it will be difficult to say because what would have been happening in the past, those positions would have been filled or sought to be filled through the Public Service Commission. Having handed those positions across to the RHAs, they can then recruit using their recruitment process. So it is not quite the same, so I expect to get better results in terms of filling those vacancies once the RHAs are fully empowered to do so.

Dr. Bodoe: Thank you, PS. Madam Chair, if I may, just one more question and again, this is related to the Ministry of Health administration pillar. And I am looking at the top of page 12 and I just want to read so that, PS, maybe you can comment on this and it says:

> Review, assessment and the improvement of CDAP is being undertaken for more effectiveness and service delivery to patients.

Now, we know that CDAP is a very component of drugs to patients and citizens in the public health sector at subsidized cost—well, in fact, it is free at the point of delivery. Can you indicate what this statement means? What is the intention?

Mr. Ali: Sure. Through you, Chair. So it is exactly what it says, member. We are reviewing CDAP as part of our normal ongoing monitoring of our respective programmes. There is a review currently underway looking in terms of not just the diseases, the actual drugs, but also the whole management of CDAP and once that review is completed, based on the recommendations, we will then act on those recommendations.

Dr. Bodoe: Thank you, PS. Madam Chair, I have a few more questions but I can give way if there is any other member who would want to ask questions.

Madam Chairman: Thank you so much, Dr. Bodoe. Can I call now on member Deonarine?

Ms. Deonarine: Thank you, Madam Chair. Thank you to member Bodoe for giving way. I have several questions for PS Ali, Madam Chair, and I would like to first allude to the fact that in the Welch Report, they made reference to other areas of health care delivery and they did draw reference to cardiac services and they did mention that there is a massive demand and burden where cardiovascular disease is concerned. PS, are you in a position to tell us, on an annual basis, how much it is we usually spend on cardiac care in Trinidad and Tobago?

Mr. Ali: Through you, Chair. Member, I would have to get that for you in writing because that

is a combination of expenditure. We spend both within the public sector and there is some level of outsourcing of services, so I can get you those figures in writing. I do not have that with me right now.

Ms. Deonarine: No, I would appreciate that. But with respect to the outsourcing of services, what exactly in cardiac services you all outsource? Is it the bypass surgeries and so on?

Mr. Ali: Sure. Sure. So we outsource some angiograms, angioplasties and yes, some of the bypass surgeries. Correct.

Ms. Deonarine: Okay. And also, if you could submit to us in writing, are we on par in terms of payments for these outsourced services.

Mr. Ali: Sure, I can do that.

Ms. Deonarine: Okay. Now also in your response, you would have alluded to the fact that you all are working on some clinical guidelines and protocols for chronic diseases. Could you tell us the cost of this and also the status of implementation?

Mr. Ali: Chair, through you, I would let CMO speak to where we are with regard to that particular initiative please.

Dr. Parasram: Okay. So in terms of the guidelines, we are looking at revising our clinical care guidelines for a number of diseases starting with the non-communicable diseases. We are looking at hypertension, diabetes and then a number of others that will follow thereafter. So in terms of our completion, we are looking at the HEARTS initiative which is an initiative to actually change the way we dispense and change the clinical guidelines for hypertension treatment. The phase one of HEARTS has been implemented last year, I believe—the end of last year, meaning that we now have drugs that were different. So we would have to change our formulary to go forward and take us into the new clinical case definitions and the new clinical use of hypertensive drugs under that initiative, and they would be rolled out to the primary care setting in the first instance and then to secondary care.

Similarly, for diabetes as well as other non-communicable diseases, what we did is through the IADB loan, we are in the process of actually having technical advisory groups, formulated with various specialists and we did have a couple of meetings internally in the country where, for example, we would have brought the endocrinologists together, we would have brought those medical internists at the hospitals together and got consensus and this was run by a programme developed through the Pan American Health Organization, so they would have

workshops to actually develop the technical advice from our local specialists. Those would have gone abroad through a PAHO collaborative effort with the McMaster University to put it into a proper guideline form. So we are far way on with regard to cardiac reformulation, diabetes and we have already started the hypertensive reformulation through the HEARTS initiatives.

Ms. Deonarine: Thank you, CMO. Do you have an idea when each one of them is expected to be completed, especially the HEARTS initiative?

Dr. Parasram: Sure. The HEARTS initiative has been started already. There are two phases to the HEARTS initiative, meaning that there is a recommended first phase where we use a certain type of drug and then there is a second phase. So we can provide you with our implementation plan for the revision of the guidelines if you wish. I suppose we can give that in writing as well. Yes.

Ms. Deonarine: Sure, we would appropriate that.

Dr. Parasram: Sure.

Madam Chairman: Can I now go on to member Mark? Member Mark? Okay, so while we—

Mr. Mark: Yeah.

Madam Chairman: Are you hearing?

Mr. Mark: Yeah, very clearly.

Madam Chairman: Yes.

Mr. Mark: Madam Chair, just a few questions to distinguished Acting Permanent Secretary and that has to do with a follow up on my earlier enquiry, and that has to do with this effort by the Ministry of Health to develop a longer contract arrangement between NIPDEC and itself for procurement, storage and distribution of pharmaceuticals and non-pharmaceuticals. So I would like to ask the Permanent Secretary the following: When will the assessment of the contract arrangement between NIPDEC and his Ministry for the procurement, storage and distribution of pharmaceuticals and non-pharmaceuticals be completed? That is the first question. The second question is: What is the current arrangement with regard to the procurement, storage and distribution of pharmaceuticals and non-pharmaceuticals? And finally, who at the Ministry is responsible for monitoring the arrangements for the procurement, storage and distribution of pharmaceuticals and non-pharmaceuticals? These are my three questions, Madam Chair, and that is my final engagement.

Mr. Ali: Thank you. Through you, Chair, let me take it from the top. With regard to the first

question, we expect to complete that review during the course of this fiscal year. Sen. Mark, I expect by the second quarter of 2021, we should be completed with that review. With regard to the procurement of pharm and non-pharm supplies, that is currently still being done by NIPDEC on behalf of the Ministry and the rest of the public health sector.

With regard to your third question in terms of within the Ministry, the responsibility for monitoring that particular function, it is a multi-disciplinary approach. We have within our job inspectorate, within our finance and accounts department and under the Office of the CMO, it is monitored by those three departments based on the various aspects of it: financial, inventory management and the actual pharmaceutical in terms of standards and the regulatory part of it.

Mr. Mark: Yes. Madam Chair, I would like to crave your indulgence to just ask Mr. Tsoi-A-Fatt whether he can share with this Committee the extent of the operations of the Arima hospital. In other words, is that hospital fully operational or not? Could he clarify and give us some up-to-date status report on the Arima General Hospital?

5.20 p.m.

Mr. Tsoi-A-Fatt: Chair, through you, I would be willing to answer if it is the Sangre Grande Hospital, but the Arima Hospital belongs to Mr. Davlin Thomas at the North Central RHA.

Mr. Mark: Oh, sorry, Sir, sorry. Well, Mr. Davlin Thomas please.

Mr. Thomas: Through you, Chair, I would be happy to say the Arima Hospital—I would give a general sense and then the Director of Health for the North Central Regional Health Authority will expatiate that currently we are decanting the Arima Hospital of the COVID-19 suspected cases to be able to operationalize that hospital within the next two weeks to ensure that—to provide categories of services. Namely, initially some inpatient services for patients attached to the department of medicine and then subsequently we are currently providing some minor surgical services.

So the first phase will be inpatient services, then we extend that to some outpatient services meaning that some of the clinics associated with those kinds of services. Minor surgeries, same day surgeries, which are critical and then the emergency department will move across to provide the full service. I do not know if the DOH would like to expound?

Dr. Ojuro: Thank you. Through you, Madam Chair, yes, in addition to what the CO said, after the initial two phases we will now begin expand, begin to introduce further services. Currently, we have support services already working in Arima Hospital, we have the radiology department,

we have the lab in operation. So, subsequent to the two phases the CO talked about, we go into the third phase where we introduce additional services inclusive of now in service surgical services, admission for services and other additional services, including dialysis and subsequent to expanding to include even other sub societies in medicine, for example, in pulmonary medicine and in nephrology and endocrinology. So that is the third phase the last phase of the expansion.

Mr. Mark: When are we expected to complete the entire expansion to make it fully operational? Is it at the end of this year 2021, or maybe in 2022? Is there any deadline for it?

Dr. Parasram: Senator, if I may interject? So, the Arima Hospital was started as they said as a suspect hospital for COVID-19. I do not think any of us can tell what the trajectory of COVID-19 will be over the coming months. So what we are hoping to do is actually use Arima in the near future probably from March or thereabouts to go back to its original function in phases. Having said that, if we do see an increase in the number of cases in COVID-19 in Trinidad and Tobago at some point, then there may be a reversion of services back to COVID-19 whether for positive patients or possibly positive and suspected patients as the need may arise. So I do not think it is fair to ask North Central to put an end date to that. I think we will all have to wait and see a little bit, but I am sure they can guarantee that in the month of March we are looking to at least start services and then we can take it phase to phase once COVID-19 remains a little bit under control.

Mr. Mark: Thank you, thank you.

Madam Chairman: That is it, member Mark? For now?

Mr. Mark: Yes, Ma'am, thank you very much.

Madam Chairman: Okay, I just wanted to ask something. I am not sure to whom to direct this: The installation and operationalization of the linear accelerator St. James Medical Complex which is something that has been completed, what is the benefit of that to the public?

Mr. Ali: Through you, Madam Chair, I would want Dr. Smith maybe to just give us a little update on that please? Thank you.

Madam Chairman: Yes please.

Dr. Smith: Good afternoon, PS, good afternoon, Madam Chair, and the rest of the Committee. The linear accelerator project is a major project that was initiated to really bring oncology care and more specifically external beam radiation therapy into the 21st Century. Before in the public sector all we provided was in fact cobalt therapy which is of course the old technology for treating radiation. It comes with its own risk and limitations. By bringing linear accelerator technology

into the private sector which would allow for IMRT, VMAT and all the high tech issues, we have brought about a more accurate and safe method of treating our cancer patients that require external beam radiation, and it also complements well our other services there including our brachytherapy services.

So it brings our entire cancer care services in terms of treatment up to par and up to scratch with respect to international standards and protocols. We also will continue to use of course the cobalt machine but that would be used more for palliative patients what are doing the spinals and so forth to ensure patients are pain free, but now we have a complete cancer centre that could provide total and comprehensive care.

Madam Chairman: Thank you, Dr. Smith. And maybe you could assist me in terms of this: I understand that, okay, we have some state-of-the-art technology, in terms of your recurrent expenditure are you sufficiently funded to ensure that this system continues to function? Is there built-in preventive maintenance with adequate funding and so on?

Dr. Smith: Thank you for that question, Madam Chair. The good thing about it is this is a new machine. It was about an approximate $85 million project, correct me if I am wrong PS, between 80 and $85 million project. The policy of the Ministry of Health with respect to major medical technology within which the linear accelerator will fall, requires that together with the one-year warranty that comes with the equipment, the Ministry requires that we purchase an additional four years of warranty coverage. So right now that machine us under warranty for its first year of operations and then we have purchased additional warranty coverage for service. So, at this point in time we are well covered at that point.

Madam Chairman: Okay, so thank you for that and congratulations for that. What happens though when it breaks down? So we have coverage, but in terms of—is there going to be a time lag? What kicks in because we know the incidence of cancer in this country, what kicks in? Do we go back to cobalt? Do we have alternative equipment or would the contractor then loan us something? Is it readily available here? Those sorts of things, I would be happy if you could address.

Dr. Smith: So let me start with the first question. It is not advisable to switch therapies. So which means if you are on the LINAC treatment we would not switch you to cobalt. So what we will try to do is complete the treatment plan under the LINAC. Because we have only one linear accelerator in the public sector it means therefore, if we need to switch a patient because of the

machine being down and they are currently on treatment and this is treatment four of 15, let us say, we have options in the private sector because the Ministry of Health also has relationships with both the private providers for linear accelerator technology. So we can switch the patient from one machine to another within the system in the larger health system both public and private. So that is not an issue.

With respect to your specific question of what happens with respect to when the machine goes down, the maintenance contract we have is for a specific down time. So we have a 97 per cent up time with respect to ensuring the machine is up at those times. I can say without fear of contradiction the problems that we have had with the machine in recent times with respect to breakdown has not been with the machine itself, i.e. the linear accelerator, but with the UPS system in terms of making sure we have a clean power supply coming to the machine because it is very sensitive.

So, so far we have not had the issue of any major down time that would have affected or having to transfer patients from one system to another, one being the accelerator system, to the other. So the intent is through the preventative maintenance programme, to keep that machine up and therefore patients can be planned accordingly.

Madam Chairman: And just let me just push the envelope a little further. How do we address that power supply issue? Is it a question of backup power, generators, how do we address that?

Dr. Smith: The issue with respect to the UPS was just a function—not because of our power supply. We did some upgrade work as well at the St. James Medical Complex prior to the installation of it. So the project had—because we were bringing in that new machine the power source in terms of the larger electrical framework had to be upgraded, the entire grid. So that has been done.

The actual problems I was describing with respect to the UPS were mechanical problems related to the UPS and not the source of power. So the UPS itself had a problem as opposed to the power coming to the UPS. So at this point in time we are good. So the power supply so far has been good and has been regular and has been secure.

Madam Chairman: Okay, thank you very much. And, Dr. Bodoe, just before I call you, I just want to switch back to—and maybe this goes to the North Central, I wanted to find out a bit about the Arima Rehabilitation Centre. I do not know under whose remit that falls, and particularly I think it is at page 9 of the submission where they say it is a key activity but it has

not yet been restarted, and hopefully this fiscal, dependent on funding availability. So, what I would like to find out is if we could get a little detail about the progress, whether the budgetary allocation has included what is required to be done to restart and complete this project. I know the releases is one question, but I want to know if the allocation that the Ministry has received can satisfy the startup and completion of this rehabilitation centre?

Mr. Thomas: Madam Chair, we are at the stage where we have appointed a small committee to engage the needs associated with the rehabilitation centre and it is really at its embryonic stage. So we should, we anticipate that by the end of February we should be able to articulate with some clarity to the Ministry of Health exactly what it would take to ensure that we could activate, and that is currently the position.

Madam Chairman: You are talking about budgetary and everything like that?

Mr. Thomas: Yes, Madam Chair.

Madam Chairman: All right, so you said the end of February?

Mr. Thomas: Yes.

Madam Chairman: Okay, thank you. So—

Mr. Ali: Madam Chair, sorry, if I may just add a bit to that please?

Madam Chairman: Yes, Mr. Ali.

Mr. Ali: So the Arima rehab centre, that facility is part of our overall mental health programme. So we are currently engaged in finalizing our decentralization plan for mental health services. So that will also inform part of what Mr. Thomas is speaking about. So that is just one part of the puzzle in terms of that overall plan for decentralizing mental health. Thank you.

Madam Chairman: Okay, as you said that Mr. Ali, you just reminded me, in the report they were talking about that the users there were just some very old—senior—let me put it that way—senior persons who could not take the benefit of what the centre was initially established for. So, have we at all migrated other people into it? Or all of that is pending the resuscitation of the centre, and of course the decentralization of mental health facilities?

Mr. Ali: Sure, so I will let the RHAs answer whether they have taken in additional clients because that is directly under their purview in terms of management of the centre, thank you.

Ms. Baksh: Hi, good afternoon. Madam Chair, through you of course, the St. Ann's Hospital would have transferred at least 28 patients to the Arima rehab right now. They were long stay patients so that was part of their decentralizing and reducing the patient population at St. Ann's,

but yes, the patients will not be—what was initially envisioned for the purpose of the Arima Rehabilitation Centre. But there are mental health patients there.

Madam Chairman: And the 28 who were transferred by the St. Ann's Hospital, is that now the total complement of its population or does it service a greater number?

Ms. Baksh: Those 28 in addition to an additional 10 that were transferred from Port of Spain General Hospital. So in total there are 38 patients there.

Madam Chairman: Thank you very much. And might I just ask one question: How does the non-completion or the state of the facility affect the service delivery in this aspect?

Ms. Baksh: Thank you, Madam Chair. As the PS would have mentioned in terms of the overall national plan for mental health, the refurbishment of the Arima rehab is part of that, as well as realigning the services of Arima rehab as part of the national movement towards decentralization of mental health.

Madam Chairman: All right, so as we were told we should expect that you all will complete your report by the end of this month. So then, could I ask that maybe by the middle of March if your findings could be shared with us and a sense of direction be shared with us please?

Ms. Baksh: Yes.

Madam Chairman: Thank you.

Ms. Baksh: Will do, Madam Chair.

Madam Chairman: Member Bodoe.

Dr. Bodoe: Thank you. Thank you, Madam Chair, and this will most likely be my last engagement with the stakeholders. I just want to direct this to PS, and I am looking at the update of the Annual Services Agreement between the Ministry of Health and the RHAs. I know that we still have the purchaser/provider model, PS, where the RHAs, where you have an agreement but I know that that has not worked for a while. Can you give us an update as to how it is working, whether it has been strengthened and whether you are achieving what these agreements are meant to do?

Mr. Ali: Sure. Through you, Chair, member Bodoe, maybe I can let Mr. Jaisingh who is our point person dealing with the ASAs give an update on that matter please. Thank you.

Dr. Bodoe: Sure.

Mr. Jaisingh: Thanks, member, for the question. Yes, indeed I know the service agreement was repurposed in 2019/2020 in alignment with also our strategic framework itself. Right now we

are updating the ASAs as we speak. Because we are new in our fiscal year we are currently issuing and updating our strategic plan, and based on that there would be new purchase intention agreement which will—and the ASA now, would fit into that in terms of the new priority areas but as it is right now we have tailored the ASA to a smaller set of indicators that could be quickly and easily reported on. So we have RHAs reporting on the ASAs right now based on the priority areas but as the case might be, we have put a revision based on our strategic plan but it is almost completed, and we are hoping that by the third/fourth quarter of the fiscal year our ASAs would be ready for signature again.

But right now we are developing the process flow arrangements to make sure that the indicators are aligned as much as possible to the strategic framework for reporting.

Dr. Bodoe: Thank you, Mr. Jaisingh. PS, if I may direct your attention to the Item VIII—VII, the manpower plan is being reviewed and strengthened to identify the possible shortages of staff required for health professionals including the doctors, nurses, and allied health professionals. Can you give us an update on the status of that manpower review?

Mr. Ali: Through you, Chair, thank you. That review is currently under way. We hope to have that completed during the course of this quarter. Of course, because of COVID and the HR requirements there that has added another layer, another factor into the mix, all right? So, we are currently almost complete with that and that would also cater for the new Sangre Grande Hospital as well as the new central block because we want to cater not just for today, but we are looking forward also into our future planning.

Dr. Bodoe: Thank you, PS. I just want to close off with one last question, and you know, I just want to take us back to why we are having this enquiry and it really is to look at the efficiency of the RHAs. And, in view of the fact that, you know, over five, close to $6 billion are expended annually from the public purse and about over $4 billion was spent by the RHAs, as to whether the efficiency—and in fact the Welch Report asked the very question as to whether the RHA model is the best model for delivery of health services to the population. So I just want to ask you—now, this is something that is outstanding and it says "review and assessment of the RHA structure"—it is at the bottom of page 13—it says:

> Review and assessment of the RHA structure and arrangement to determine whether it is effective or should be replaced to ensure efficiency of operations in the provision of health care.

PS, is it the intention to actually undertake this review? And if so, how soon?

Mr. Ali: Through you, Chair, yes we would undertake that review. If I were to be quite honest, I cannot give you a time frame, member. We would like to do it during the course of this fiscal, but at this point I do not have a definitive date when we want to start that, that actual review.

Dr. Bodoe: Thank you very much, PS, and thank you all for your contributions. Thank you, Madam Chair.

Madam Chairman: Thank you very much, and I am reminded of the time but I just wanted to maybe just engage us a little longer, and PS, if I could refer you to page 12 of the submission. And it is just really to do a tick-off list in terms of, we were told that the filling of the positions at the Nutrition and Metabolism Division has been advertised. Could you say what the status is of this?

Mr. Ali: Sure, Chair. We have actually recruited through the service Commission Department our Chief Nutritionist, that is the head of the division. That person has been engaged and we have also been able to recruit some of the lower level positions. There are still some vacancies but that recruitment is ongoing but the header has been recruited.

Madam Chairman: And could you say if at all the filling of the positions that you have done, and also if that has helped in establishing any sort of efficiencies in this service?

Mr. Ali: Definitely, so what it has done—I spoke a bit earlier in the session about—I referred to an IDB loan. That loan is to help the Ministry with its NCD drive, non-communicable diseases. A key part of that is nutrition. So having that director on board has brought that technical expertise to bear, in terms of providing that technical advice as we plan our NCD interventions from a nutrition perspective. So to answer the question, yes, it has definitely assisted us.

Madam Chairman: Okay. And in terms of this I see that you all were doing a review and update of the handbook of policies for the Ministry of Health and the Regional Health Authorities. Could you share with us where this has reached?

Mr. Ali: Sure, so there are many different policies within the Ministry of Health. We have our clinical technical policies and we have our HR policies. With regard to the HR policies we currently are engaging a consultant to review the work that has already been done to finalize those revised HR policies. That should not be a very long consultancy, I expect within a month or two months we should be able to complete that exercise. So ideally, during the course of this fiscal year we would have completed a review of our HR policies. I would let Mr. Jaisingh just

speak to the other policies please, in terms of where we are with those.

Mr. Jaisingh: Hi, Madam Chair. Yes, indeed we have done a template to collect all the policies from the various RHAs. This has been completed since 2018 and it is presently being updated. Last year it was updated as well to make sure that policies—similar policies are compared with the RHAs as well, but also that if one policy is done by one RHA, it could be shared easily and quickly with other RHAs. That is the intention of the handbook so persons can see exactly what are some gaps, what are some challenges in policy development, and also what are some policies from a national perspective that we are actually undertaking in a Ministry itself. So it is being shared across RHAs and it is currently being updated every quarter.

Mr. Chairman: Yeah, so might I ask, do you all do systems audits? And if you all do, how often? Or when last the systems audits would have been done of the—I mean, not just talking about you know, financial audits, system audits in respect of the RHAs and in respect of the Ministry of Health?

Mr. Ali: Sure, thank you, Chair. So with regard to systems audits, yes we do. That is part and parcel of the work plan of our audit department. We would appreciate that based on staffing constraints and the other workload that they have, we may not do as many systems audits as we would like within the Ministry. With regard to the RHAs, that falls under our quality department. We have had some vacancies in our quality department, so we are currently trying to beef up our quality department, once again to really restart doing those system audits in a meaningful way at the level of the RHAs.

Madam Chairman: Okay, so what I would ask, Mr. PS, if you could share with us in writing the last time systems audits were done in each of the entities and the key findings of those systems audits, and any sort of remedial steps which were taken? I will ask you to do that in writing.

Mr. Ali: Sure, no problem.

Madam Chairman: And I am just going to detain us with two more questions, I mean, we have many more but we will, you know, forward them in writing for you all to answer. Now, I think the CMO spoke at length about the transfer of the dental services to the RHAs but that is just only one of the vertical services. And in terms of key activities not yet started, the other vertical services are to be transferred at some time. And what we are told is that there is an analysis being done to determine feasibility and streamlining of service delivery. Could you give us some idea of where you all have reached with this and when you are likely to complete your analysis to

know how you are moving forward with the other vertical services?

Mr. Ali: Sure. Thank you, Chair. I expect by the third quarter of this fiscal we may be completed with that analysis and then will be able to at that point, determine which verticals we do next, and then with the sequencing, because some of them may not be as complex or as detailed as dental and we may be able to do some of them concurrently. So that is actually what we are trying to work out right now, the sequencing and at the timing of that decentralization.

Madam Chairman: Okay, and the elephant in the room, the second report which is to rationalize the system of public sector doctors in private practice. Give us an idea because what we have been told is that you have not started on this. So, could you give us an idea of when these consultations are going to be taken to be held with the Medical Board of Trinidad and Tobago to design a possible way forward? How long do you think this is going to take before you are able to ascertain whether it is feasible?

Mr. Ali: Sure. So what we have done to date, if you recall the report number two as we said, there would have been two options put forward by the committee. One would have been the outright cessation of private practice, the other would have been continuing with some level of private practice, but putting in place performance indicators in terms of managing the output of those physicians.

What we have done at this point would be to focus on that latter option, so at the level of the RHAs—and the CEOs can speak a bit more, and the DOHs can speak a bit more to it after I am finished—we actually started to look at the performance management system with regard to really managing the contracts we have with those physicians at this point. I am not sure which RHA wants to really step in first to speak about what they have been doing and their experience so far in that regard.

Madam Chairman: Okay, so could we start with the North Central?

Mr. Thomas: Through you, Madam Chair, the North Central Regional Health Authority is really focused on the outcomes and the outputs associated with the services that are provided by those practitioners. So for example, we were able to record increases in the numbers of surgeries, particularly, which are being monitored not just at the executive level but by the subcommittees of the Board and the Board itself. So, just as an example we would have engaged the practitioners via the DOH and so on, and the Medical Chief of Staff, to ensure that we increase the number of surgeries that were provided in 2018/2017 to the extent where we would have identified an

increase in 2,000 additional surgeries. And that is what I mean from the approach of outcomes.

5.50 p.m.

The number of patients, for example, that we were able to provide ophthalmology services, the number of orthopedic surgeries would have increased exponentially. So, one of the metrics that we would use to provide us with the monitoring that would be meaningful to the population would be identifying what these outcomes and outputs are that we anticipate and certainly, to ensure that we work toward those outcomes and to exceed the expectations and certainly the outcomes that we had projected in the past.

Madam Chairman: Okay, thank you. Could we then go to Eastern?

Mr. Tsoi-A-Fatt: Thank you very much. Chair, I just want to say that in the short term, we have been addressing this through engaging with the heads of department, the consultants and so on and to ensure that the throughput is increased in terms of all our services and so on. And we have been through this engagement, been able to reduce reporting times, reduce surgical waiting times and that type of thing.

In the long-term what we need to look at and we are looking at, is the performance management system that will kick in, in terms of the long term, been able to monitor the performance of your consultants and link, of course, as my colleague says to the outputs that—[*Inaudible*] But we have been engaging directly, through the, particularly through the Hospital Medical Director, engaging directly with the heads of department and we have been seeing remarkable improvements in terms of waiting times and you know, reporting times and so on.

Madam Chairman: And doctors' presence.

Mr. Tsoi-A-Fatt: Also.

Madam Chairman: Can we now have the North West?

Ms. Baksh: Good afternoon, Madam Chair, again, in addition to the measures that my colleagues would have spoken to, we also have internally started to review of our performance measurement tools. We have rolled out tools at both St. Ann's Hospital as well as St. James, and we are working on revising our tool for Port of Spain hospital. And in addition to which our medical directors are increasing their case reviews, which is a peer-based related initiative where these doctors are entitled to attend and review their performance, their clinical performance. So that increase of case reviews, you know, that is more supervision and in terms of accessing their performance and seeing where the gaps and rooms for improvement, so that is what we have

been doing as well.

Madam Chairman: And you have been seeing some improvement just by that sort of monitoring mechanism?

Ms. Baksh: Yes.

Madam Chairman: Okay thank you very much. And might I then— invite the South West Regional Health Authority.

Mr. Armour: Thank you, Madam Chair, similar to my colleagues in the other RHAs, we also look at performance outcomes measures, and in terms of, there are three, in terms of the medical administrations, you have registrars as the first tier of the senior doctors, then specialist SMOs, heads of departments, medical directors, director of health. So it is pretty—well, relatively tall structure. So underneath those, you have medical, surgical, and their sub-specialties and there is obstetrics. Those are the three big arms for which we have specialist medical officers, so the performance metrics has to be tailored to meet those big sub-areas.

In total, we have 17 heads of department across those three broad areas, so you would find generally the surgical services, yes, our outcome measures are the number of surgeries being done, that can be disaggregated with our increasing automation of performance down to the individual specialist medical officer, as well as, through the quality departments.

We look at customer feedback in terms of outpatient clinics, time to start, complaints and we even do like, time motion studies where indicated. And of course, we have quality, as you asked, we spoke of the systems audit, we look at infection, prevention and control practices. So those are the outcome measures that we measure. And as we like to say in this field, nothing documented nothing done, so therefore we look at quality of documentation. So all of that has a secondary gain as a senior doctor has to be present.

Medical specialties, we find that the performance metrics there relate to a lot of support services for end organ damage, whether it be dialysis, whether it be non-surgical, neurological interventions and gastrointestinal so forth. So it is the similar metrics, not so much surgeries, but more so in terms of the care and the specialist minimally in basic services, so that is what you would see.

So some of these medical services they could do minimally invasive procedures, where they take tubes and look down your throat, look down your ear ways, look down—so that is the sort of performance metrics we have there. And then the obstetrics and gynecology, is well

supported in the country with the Ministry of Health direction that has been stated publicly, led by the director of women's health and because of the nature of that field, the performance metrics are different yet stern. So what you find is that the doctors there, they have improved accountability in terms of registrars must be on site, in terms of doing much more peer reviews, grand round reviews as the CEO of North West said.

So what you find in terms of performance management at the specialist level, it becomes quickly customized and with the policies of the Ministry of Health with the vertical units, with looking back at our customer feedback, our adverse events, we find that we are very attuned to the needs of the doctors. Actually, you would find that the senior doctors' compensation is an issue like everybody else for your basic needs, but senior doctors need to find themselves in an environment where they say, where we say see one, do one, teach one.

So we also have to build a culture of mentoring, supervising and for that there is also a strong component with the University of the West Indies. So we also—some emerging metrics in terms of how you train, supervise, mentor, run your own graduate programmes for the junior doctors. All of that come into play in performance management and what we do.

Madam Chairman: Thank you very much. I think we would continue that conversation with some further questions and in terms of filling positions, Mr. PS might I ask, I noticed that in three of the Regional Health Authorities, we have a CEO, in one we have an Acting CEO. What is the position about filling that post?

Mr. Ali: Thank you, Madam Chair. We are currently in the process of advertising that position and with a view to filling that position.

Madam Chairman: The advertisements have been placed or not, or are they to be placed?

Mr. Ali: To be placed.

Madam Chairman: And could you give me an idea of how soon that would be done?

Mr. Ali: I will have to get back to you because that falls under the purview of the board directors. So I would have to follow up on that for you please.

Madam Chairman: Okay, so if you could give us that in writing. And the last question to you, Mr. PS. Are you satisfied with the rate of implementation of the recommendations?

Mr. Ali: Bearing all the factors that are impacting upon the implementation rate in terms of—I would mention some of the—well I would not say challenges, the factors, finance, HR, systems, the support systems, the pandemic and everything else, I am reasonably satisfied, I would not

say I am satisfied, but I am reasonably satisfied if not with wholly with the rate but at least with the effort and the commitment of all concerned at the level of the Ministry and also particularly at the level of the RHAs, starting at the top and going all the way through.

Madam Chairman: Okay, and therefore, what I would ask you to submit to us in writing, how do you think this Committee could help you with the areas that you feel, those challenges that you feel that are affecting all the good effort and all the good will of all the players in trying to deliver better health to the public of Trinidad and Tobago?

Mr. Ali: Not a problem I am sure my colleagues around the table would be too happy to sit with me and send that to you as soon as we can. Thank you very much.

Madam Chairman: Thank you very much, okay, so that therefore, I want to bring this part of the inquiry to an end, it is almost six o'clock. I know you are all very busy but I want to thank you for the very fruitful conversation. I want to thank you for the patience for the technology and you know, for giving so willingly to the Committee and by extension to the public of Trinidad and Tobago.

I join with the members of my Committee in congratulating you all, with all the gains that we have benefited from in these very trying times. We all watch international television and see what happens in countries that are First World. And we still owe a great debt of gratitude to the public health players, the players in the health service, both administrative and professional, medical, nursing arms.

So, I want to say thank you, I want to wish you all a good evening and a safe journey home. I want to thank the members of the listening public and the members of the media who stayed with us. Thank you very much, pleasant evening. Goodbye.

6.00 p.m.: *Meeting adjourned.*