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

PRESENT

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

ABSENT

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

OFFICIALS OF MINISTRY OF HEALTH

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

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

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

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

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

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

Introductions made.

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

Introductions made.

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

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

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

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

In this regard, the Ministry continues to partner with GMRTT in the

provision of this service. It is envisaged that today's proceedings will be insightful towards promoting a greater monitoring and evaluation and improvement of the service as we seek to continue to provide a quality service to our population.

Thank you, Chair.

10.25 a.m.

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

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

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

that are far above what was foreseen and what either party could have done on their own.

We have received positive feedback on the performance of GMRTT from prominent members of the local medical community. GMRTT has gone about its business quietly but with undeterred focus to bring world-class ambulance service to Trinidad. The patient transport volume has grown, not through promotion, but through building citizen confidence in the service. Nearly daily, GMRTT receives praise from the citizens we serve. GMRTT is a company predominantly comprising—in fact, 99.9 per cent comprising of hardworking Trinbagonians who are devoted to the profession and proud of the service they provide.

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

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

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

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

Ms. Ramdial: Sure.

Mr. Anderson: We have two levels of service which is commonly known as Basic Life Support which is provided by emergency medical technicians, and Advanced

Life Support which is provided by paramedics. The Advanced Live Support is substantially more clinically sophisticated. They will administer pharmaceuticals, do invasive procedures and have the ability to treat people with acute illness much more severely.

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

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

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

Mr. Anderson: Sixteen.

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

Mr. Anderson: Forty.

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

Mr. Anderson: Generally, routine maintenance requires a one day service. There

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

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

Mr. Anderson: Commissioning of the ambulances, it starts with a specification that we collaborate with staff and experts within our parent organization on the American side. We then seek a converter or builder that is either done locally or abroad, and then when they arrive in the country they have to be stocked fully. Any equipment that is not new with the vehicle is then transferred, and then retired vehicles are currently in a yard basically. To this point, we have only retired vehicles that are the Government's assets and so would hope that one day the Government will take control of those so I would not have to house them any further. In the future, the ambulances are our assets under our current agreement. When we retire those we would figure out an appropriate disposal arrangement.

Mr. Chairman: I recognize Mr. De Freitas.

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

Mr. Anderson: The paramedic programme is relatively new. It is a very extensive training process. When we started that, we started with an initial pilot group of four people and then created a curriculum. The American parent company of GMRTT

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

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

Mr. Paul Anderson: I foresee probably a deployment where roughly 75 per cent of employment is the ALS ambulance. We could potentially go to 100 per cent, and that is a little bit excessive because not every case requires a paramedic.

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

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

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

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

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

their response in their reports have been adequate thus far.

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

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

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

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

Mr. Aboud: About 13 years.

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

Mr. Aboud: Yes, Ma'am.

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

Mr. Aboud: From inception.

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

Mr. Aboud: Two.

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

Mr. Aboud: Yes, Ma'am.

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

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

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

Mr. Aboud: But two.

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

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

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

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

Mr. Anderson: Not on my watch.

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

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

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

Mr. Anderson: Probably the most common issue is to lay patient handover at the

receiving facilities. We can predict that based upon prior days and the census of the facilities and available bed space things tend to back up in the casualty, and when it backs up in the casualty it backs up into the EMS system. We monitor 40 operating metrics continuously and there are hourly reporting to operational leaders on those things. So if we see patterns start to develop with respect to unexpected call density in a particular area, we are able to react to that and adjust the deployment plan so that additional ambulances are allocated to that particular area.

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

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

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

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

that particular thing. Is any data sharing going on between the Ministries? Because you guys seem to be collecting a large amount of data that helps you to efficiently run your institution.

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

Mr. De Freitas: To the Ministry: What programmes are you implementing based on the great data that you are getting from the company to help reduce some of the more frequent incidences that may be occurring that require ambulances? Do you all have any programmes that you can point to that you are developing, or have been developed to help reduce some of these mishaps that would require an ambulance service?

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

Another way in terms of policy is we look at the nature of the complaints that they

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

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

I think another gap we had was the adjunct services, like when you are going into an area to let the police services come on board also. I think I saw that in your report. So since you are going into an area and your team may have a difficult situation to manage, and having that difficulty you may need the officers there on board to help you probably apprehend, get that person into that situation because we may be dealing with a patient who may be somehow delirious for any reason, hypoglycaemic—low sugar—getting on erratic. You may a person who had a psychotic break. There was a complaint I actually had—and we would probably

look at this—where a mentally ill person, his relative called the hospital for an ambulance and it was not forthcoming. They actually did not get an ambulance to come and they had to actually hold that person, tie up that person, bring that person into St. Ann's, and again the police service did not come on time.

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

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

Mr. Chairman: So it was not under your—

Mr. Aboud: I want to just make a point that on many occasions when there is a national or someone from the community is dissatisfied with perhaps the response of the ambulance service and I hear about it, we check to see what the chain of information was, the transfer of information; and everything at GMRTT is recorded and logged. This is US standards. So on many occasions you find that people are calling the wrong place.

They call the fire services. Well we call for the ambulance, but that that is not GMRTT. They call the hospital, but that is not the right place because that is not the national ambulance service. They call E99 and part of their function is to relay the information to us, but regrettably many times there is no sense of urgency. So we would get the call, but when we check the time that we get the call in our log, and the time that the person says they called for ambulance service, it is sometimes an half an hour, 45 minutes. But we cannot know that someone—I

mean we are not that good yet. We cannot know that there is a problem, a national outside there is in distress and needs an ambulance service unless we get the call. And so, a lot of the information is not transmitted to us and we have deliberately not—we have had this discussion with almost every board meeting. We have deliberately—forgive me—not promoted ourselves to the national community in any big way because success brings success.

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

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

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

Mr. Smith: That is a key—because I know a lot of people drive themselves. Secondly, does it occur—and is there a percentage that when the ambulance arrives at a location and they deal with the person, is it mandatory that they have to take them to a hospital, or is it that it could be settled there and the person could go back to their home? Is there any data in terms of the paramedics and the people in

the ambulance being able to service the people right there that they do not have to clutter the hospital?

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

10.55 a.m.

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

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

Mr. Anderson: I do not know if that is a decision for me. There is benefit and also counter benefit from promoting the ambulance service and its use. The immediate reaction is you tend to get a lot of misuse when you do that. The people that are having a crisis tend to reach out, either via 811 directly to us or 999 or they ring

911 and then it goes to 999, and those cases are eventually transferred to us. So, in terms of a Trinidadian national having a real problem and being oblivious to how to reach out, I think those cases are pretty rare.

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

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

Mr. Smith: No, no.

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

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

Mr. Chairman: Okay, sure.

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

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

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

take a little more time?

Mr. Anderson: We do prioritize. We use an international standard. In fact, our despatch centre was just internationally accredited to that process. It is not precise, it is based on the information that you obtain and Trinidadians are very clever people and they know what to say to get an ambulance.

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

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

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

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

Mr. De Freitas: Thanks again, Mr. Chairman. So I am just trying to envision the logistics, more specifically at the beginning period where you get the call. So, so far I have heard that there are two ways to contact or get an ambulance through direct call which is the 811 or the emergency service. Now, I know you have said

that with a direct call, it is up to international standards, everything is recorded. I am not sure what the standard is for the emergency service and I guess this is to the Ministry. Do you not think it is better to have one that is put out to the population? So for example, if we are going with 811 so that people can call them directly so that the recordings are there and you can get that data and you leave the emergency numbers alone for now or they use that as a secondary emergency number, do you not think it is better that way? Because in the States, it is 911 and that is it. All right, I guess they could call an ambulance directly but everybody knows 911. In Trinidad, we know it as the emergency numbers that we have. We are now hearing there is an 811 but it seems that with the 811, they can assess better the need for an ambulance at that point.

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

Mr. Chairman: Before Ministry responds, I want to agree with Mr. De Freitas that you know, sometimes you are reaching out for an ambulance, they may call the hospital and they may get one response and you know, sometimes they may call outside St. John's and people go down that list and they do not know which ambulance service to call and I will give a scenario that happened recently. But before I go to that, we actually would need one number that people can call and

that could be despatched to, you know, so this is something, I think, we have to look forward and maybe in our report, that we may want to recommend. Yeah, good.

Mr. Ali: Thank you, Chair. Member, we do advertise the 811 number. I take the point of the Committee, maybe it needs to be improved upon, maybe more widely disseminated but it is available and we do have it advertised. But yes, there is definitely a need to consider having the population more aware of the 811 number. Just to say that just to come back to Mr. Anderson's point, even though they have the 811 number, that does not necessarily reduce the likelihood that those who do not need the ambulance service will not still access it.

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

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

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

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

It is a globally recognized standard and it includes the process for triaging and prioritizing incident priority based upon the presumptive level of severity from the interrogation of the caller. And so, it is a fairly elaborate process but it is all computer-driven and so there is not a lot of freelancing that goes on. So when the despatcher hears, you know, the first person, the first question they ask is: "Is the

person breathing?", and if not, it stops there and they start giving what is called despatch life instruction. And so they will walk somebody through mouth to mouth resuscitation, CPR, emergency child birth and it is all scripted for them so they do not have to make up anything. And so a layperson can be trained to be an emergency medical despatcher and we have brought people in with no medical experience whatsoever and they have gone through the training and they function very competently as an emergency medical despatcher.

Mr. Chairman: I commend your company for introducing the despatchers and that level of competence here, and I know the gold standard, you have set the gold standard into this and this is very commendable. I have seen some of your services offered and it is first class, it is world class, you have that standard there. I am saying if I collapsed, I would rather one of your paramedics see me than an intern now graduating because the level of training they get—and I am sure Dr. Parasram would realize, we will forget some of those basic trainings. And I have actually seen one of your persons who had that level of training give magnesium sulphate to a child with asthma and this is something I would hesitate to do as a physician, so I commend you for that.

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

Dr. Parasram: Well, I do not think at the hospital there are despatchers trained, we are really—we have operators, more telephone operators so they are telecommunications background. They would be aware of the requisite numbers to send persons on to, but the function at the hospital is completely different from the

function of an ambulance service. So we have to, again, look at the calls that we have been receiving, look at the frequency, and we can review it and see if there is a need in particular areas. But as of now, the RHAs have not indicated to the Ministry that there is a need in that particular area. But of course, seeing that there is a programme in place with GMRTT, if there is a need, we can liaise with them to actually fill that gap.

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

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

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

Dr. Parasram: Yes.

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

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Staying with the Ministry of Health, this question is directed to the Permanent Secretary, Mr. Ali. If you feel you do not possess the information, I guess you will pass it on to a member of your team. The questions that were sent, the responses that this Committee got with particular reference to section 15 of the Act where the Minister of Health has the authority to appoint inspectors or an inspection team to visit and inspect the facilities of GMRTT, the response was that the inspection team has not been appointed to date. Could you share with this Committee what may be the reason or reasons for the non-appointment of inspectors or the inspection team? I refer to page 35 of your response.

Mr. Ali: Thank you. Chair, through you, member, so we have not invoked the

licensing process at this point. We are in the process of licensing the providers. What we do have in place at this point would be our Internal Audit Department. They do visit the facilities of GMRTT and they do provide some level of audit at the provider's facility.

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

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

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

Mr. Anderson: Sure. Purchasing ambulances starts with the purchase of the panel van, the chassis, and so we have requirements for that. Our preference is an automatic transmission right-hand drive with sufficient engine displacement to handle the load. That whittles it down pretty severely. We will then choose a fabricator. In the past, we have locally converted vehicles that we have sourced through a local auto-dealer and that was successful. Our most recent procurement, I attended, as I do every year, a conference called Arab Health which happens to have the largest medical—

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

Mr. Anderson: Arab Health, it is in Dubai every January. The reason why I go, in

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

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

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

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

Mr. Anderson: They are all new.

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

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

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

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

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

Mr. Ali: Maybe I can answer. GMRTT is not in possession of a licence, member, through the Chair. As I mentioned earlier, we are in the process of licensing

providers. So what currently exists, GMRTT is managed through the contractual arrangement, that is what governs the relationship between the Ministry and GMRTT at this point.

Mrs. Baptiste-Primus: Through you, Mr. Chairman, and Chairman of GMRTT, from where I sit, that is a gap in the operation of this company. I mean the company is well-run, delivers a good service but this issue is one I want to strongly recommend that urgent attention be paid and that the necessary licence be granted to GMRTT. They are providing a national service, the law requires it and therefore, Ministry of Health, you all need to step up to the plate.

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

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

Mr. Anderson: Thank you.

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

Mrs. Baptiste-Primus: That is a secondary—

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

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

Dr. Parasram: Yes.

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

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

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

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

Ms. Roopchand: Chair, we recognize that we have not been licensing the service providers and we do take your point and we have started the process. We needed to put the regulatory committee in place, we have gotten nominations from the RHAs and the Minister has his reps, we are only waiting on one which is National Security, and as soon as we get that, the committee has do to the recommendation with respect to the provider licence. So we expect at least during December. We have also written to all providers indicating that they are to make an application to the Ministry if they are in the business of providing emergency ambulance services.

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

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

Ms. Ramdial: Eight?

Ms. Roopchand: Yes.

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

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

Mr. Chairman: Red Cross also would—

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

scale.

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

Mr. Anderson: A million dollars.

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

Mr. Anderson: Yeah.

Mr. De Freitas: TT?

Mr. Anderson: TT.

Mr. Chairman: Well, I would hate if some patients, you know, who may get in there, aggressive and violent, and gets loose there, so I mean, you have to have some way of restraining and protecting. Yes, question?

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

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

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

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

11.25 a.m.

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

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

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

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

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

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

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

Mr. Chairman: So, part of the gap I mentioned was the accessibility of mentally ill patients trying to get to the hospital. Is there any level of having mental health officers or persons trained in mental health? I think part of our challenge now, we know mental illness is increasing in the country. One in four persons may have it and you may have more calls to apprehend certain persons—persons who may be

on drugs, persons who are having a meltdown out there, psychotic patients. What sort of training would your staff have in apprehending those persons? And again, that is one question. And the other question is the Ministry. Is there anything you could suggest that we can help that situation, in terms of joint effort with mental health officers in the area to apprehend those persons?

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

Mental health emergencies and behavioural emergencies are a challenge for every EMS system in the world. I know of a few projects that our company in the United States is involved with, of specialty ambulances, that are staffed with a mental health professional that handle those cases. That is very costly. But it is probably something to think about. In Trinidad, there are half dozen or so of those. One of the big challenges we have with mental health cases is when they occur after hours, and they tend to occur after hours.

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

when they are called out, to assist your services, in case they are called out.

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

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

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

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

Mrs. Baptiste-Primus: Mr. Director of policy planning, I do not understand what

you just told me. What does it mean? The audit is ongoing. That is public service language that I am very familiar with. What does that mean? Is it that the audit is 50 per cent completed, 60 per cent, 25 per cent? So the Committee can get a feel.

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

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

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

Mr. Ali: The Chief Medical Officer.

Mrs. Baptiste-Primus: Yes.

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

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

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

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

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

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

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

Mr. Chairman: So, I think we have clarified a bit that we may have the greater collaboration for the Ministry of Health, in terms of when they enter the hospital

setting, the handover time, as well as the collaboration with the police. We will have to look at the police officers and mental health officers.

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

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

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

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

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

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

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

Mr. Anderson: Right.

Mr. Chairman: But when I reached to the end there, I would say it is about half hour. I was there at that function and she was there. Now, two numbers they called there, right? So what I am looking at, if they are not getting through to you, is there any backup services that they could have called? I mean, there are the other ambulance services. Because there is another number there. So we have to have, in my opinion, a backup service, a second line. You know, if you are not getting through to you, there is an emergency. I would hate if there is an emergency and they are making various calls and not getting a response. So I can, you know, any sort of comments?

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

Mr. Chairman: For the officials on the Ministry, is there a system where if their ambulance calls the Casualty Department, there is a prep team waiting, a response team waiting, to receive someone from an ambulance setting? Because, I mean, you guys do a tremendous effort of resuscitating the equipment you have. And you

bring them up to a point to Casualty. We are seeing a delay there. So the cost that we are putting out to your company, I think it is like $123.3 million, I think Ministry of Health pays you.

So, let us say you have provided such an excellent service, you have brought somebody up to the hospital level but there is a delay now of 20/30 minutes to get them just on another trolley to go to that Casualty setting where there may be another delay. So I think somehow there is a little gap there we need to know. Is there a call-in system that, you know, you now identify the emergency, you have actually implemented the correct standard of care, but when you reach to the hospital setting now, you may have that care not being up to standard or that level of care not being fast enough, the haste in it? Comment?

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

Mr. Chairman: Yes.

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

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

Mr. Sinanan: Morning, Chair.

Mr. Chairman: Morning.

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

from their trolley to ours, but we will initiate care on that trolley if necessary.

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

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

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

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

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

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

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

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

all rank?

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

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

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

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

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

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

Mr. Chairman: Would you mind naming that member?

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

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

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

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

I need to ask one question: With our input of nationals from Latin America, do you have any sort of—you know, there are the phones now where the apps, if there is a language problem, Spanish or even Chinese. We had a Chinese national who recently collapsed and the doctors could not make head or tails what was the language, what was being transmitted, how to ascertain what was the problem. Do you have any apps that those officers would have to have that language barrier somehow dealt with?

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

One of the recently added enquiries we do at hiring now is check for Spanish speaking and Spanish language skills. And we have it on our training plan for 2019, for a rudimentary Spanish medical language course. So the paramedics can ask simple questions like: Point to where it hurts. Are you having trouble breathing? That sort of thing. There is no way we will ever get to a point of being

able to handle, in an emergency setting, any language that there is. And again, you may recognize it is an Asian dialect but you do not know which one. And so it is very difficult. And so the paramedic just responds to other cues about patient condition.

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

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

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

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

I must commend you for thinking ahead about the flooding issues and trying to

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

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

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

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

During the floods, probably the biggest problem that we faced was when the north/south highway was closed and the country was bifurcated. We actually had to hire a boat to bring staff from San Fernando to relieve the dispatchers. And then we had to put that dispatch team in a hotel overnight so that they could report to work the next day after adequate rest. I was really worried if that was a prolonged problem because—we were fortunate that by happenstance we had the right number of ambulances on both sides of that divide. But if I started to have vehicle problems or something south, I would not have any way to redeploy ambulances from north. And so, it is good that we have things dispersed around the country to begin with, but that circumstance stressed this entire country, including the

ambulance service, without question.

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

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

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

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

Mr. Chairman: So then there is a flat monthly fee paid out, but if there are any additional, for a certain amount of services offered. But beyond that, if there are additional numbers, you pay by invoice. Is that the way things run?

Mr. Ali: Correct, yes.

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

11.55 a.m.

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

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

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

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

Mr. Chairman: Okay.

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

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

Mrs. Baptiste-Primus: Okay.

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

Mr. Ali: Chair, so I can start the answer and the CMO will take it from there. In terms of the ambulance service, the service provided by the RHAs is not an emergency ambulance service. All right, those are really for inter-facility

transport—

Mr. Chairman: Sorry.

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

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

Mr. Ali: Yes, they are.

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

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

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

Mr. Ali: Yes.

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

They also mentioned that the training—the nurse, the ambulance driver they did not have any sort of basic training. This guy collapsed there, a heart patient, when they were trying to—they said the resuscitation efforts were minimal. Nothing was

really done and when they tried to say, listen, we want to go to Mt. Hope Hospital where there are the facilities, they were told by that ambulance service no, we can only take you to Arima.

So, two things come up there. One, the service provider there was probably not up to mark. Two, the other thing is, when you are now having to make a decision which is the best hospital to go to—now I do not know if that person would have lived if they had gone to Mt. Hope which offers excellent services in cardiac resuscitation. And it brings up a third point, if there is an international person here traveling and collapses at the airport that will be a major embarrassment for our country. So could you give an input into that?

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

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

is not complete.

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

So, we have recognized the gap as well.

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

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

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

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

Mr. Ali: Thank you, Chair and Members. Thank you Committee for the rich discussion. We have taken on board at the Ministry of Health some of the recommendations with regard to the greater public awareness of the 811 number. I think what came out definitely, and we have recognized that, is a greater

collaboration between the agencies. You mentioned the police, the medical officers, Airports Authority. We have recognized that and we have started to work on that. There is always room for improvement and we will be working on those and just to reassure the Member that the licensing will be sorted out before we meet again. Thank you.

Mr. Chairman: Mr. John Aboud.

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

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

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

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

Mr. Smith: Not in the ambulance.

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

12.04 p.m.: *Meeting adjourned.*