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Third Report of the

JOINT SELECT COMMITTEE ON

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

On an

Inquiry into the Administration and Operations of the South-West Regional Health Authority (SWRHA) in Relation to the Adequacy of Medical Staff and Equipment at the San Fernando General Hospital (SFGH)

Second Session (2016/2017), 11th Parliament

Third Report

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

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Inquiry into the Administration and Operations of the South-West Regional Health Authority (SWRHA) in Relation to the Adequacy of Medical Staff and Equipment at the San Fernando General Hospital

Second Session (2016/2017), Eleventh Parliament

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ACRONYMS AND ABBREVIATIONS

Abbreviation	Term
HAI	Hospital Acquired Infections
MOH	Ministry of Health
PCC	Patient Care Coordinators
PSIP Report	Public Sector Investment Programme
RHA	Regional Health Authority
SFGH	San Fernando General Hospital
SFTH	San Fernando Teaching Hospital
SWRHA	South-West Regional Health Authority

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EXECUTIVE SUMMARY

1.1. At its Sixth meeting held on Wednesday 27th April, 2016, the Committee resolved to inquire into the Administration and Operations of the South-West Regional Health Authority (SWRHA) in relation to the adequacy of medical staff and equipment at the San Fernando General Hospital and agreed that the following 3 objectives would guide the inquiry:

i. **To evaluate the effectiveness of the SWRHA in executing its mandate, in relation to the San Fernando General Hospital;**

ii. **To determine whether the human resources and equipment at the San Fernando General Hospital are sufficient to allow it to operate efficiently;**

iii. **To determine what are the shortcomings in the services offered to patients at the hospital, the root causes of these operational shortcomings and potential solutions to alleviate these shortcomings.**

1.2. The Committee agreed to meet in public with officials of the SWRHA and the Ministry of Health (MOH) on Wednesday 22 June, 2016.

1.3. The Committee obtained both oral and written evidence based on the objectives listed above. Some of the significant issues which were highlighted during the course of the inquiry included:

a) ***The issue of overcrowding at the SFGH***[1]

The Committee was informed that the issue of overcrowding still exists at the SFGH and an extra 100 beds are required to alleviate the problem of overcrowding at the hospital.

[1] Page 5, Verbatim Notes of the 8th Meeting of the Joint Select Committee appointed to inquire into and report on Local Authorities, Service Commissions Statutory Authorities (including the THA),

b) The Shortage of junior doctors at the SFGH

The committee was informed of the vacancies in junior medical positions that were created when non-nationals who were hired to fill the posts were promoted, whilst there are a number of unemployed nationals who are medical school graduates;

c) *The impact of the shortage of senior medical specialists and nurses on the day-to-day operations of the SFGH*;

It was noted that in such a facility, middle managers and Heads of Departments perform critical roles in ensuring quality and consistency in the delivery of services.

d) The High Cost of Maintaining Hospital Equipment

The Committee observed that a significant amount of funds were allocated to equipment repairs and maintenance during the period 2010-2015;

e) The Shortage of Pharmaceuticals and Non- pharmaceuticals at the SFGH

Based on observations made during this inquiry, the Committee has proffered recommendations which we believe will appropriately address the issues highlighted. A summary of these recommendations is Executive Summary.

We anticipate that the Parliament, the Ministry of Health and other stakeholders would give due consideration to the findings and recommendations contained in this Report with a view to improving the delivery of health care services at the SFGH. The Committee looks forward to reviewing the Minster's response to this Report, which becomes due, sixty (60) days after it is presented to the Houses of Parliament.

SUMMARY OF RECOMMENDATIONS

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

The Committee recommended the following:

i. that the data gathered from the Public Health Observatory be used to assist the management of the hospital to determine which departments or clinical areas should be prioritized and properly streamlined so as to meet the demands of the public.

ii. Given the financial constraints of the state, the elimination of wastage and duplication must be a priority for the SWRHA and other RHAs.

iii. that the MOH work with alacrity to complete its ten year human resource plan. This planning exercise must take into consideration existing financial constraints and current realities of the labour market.

iv. that the Ministry of Health collaborate with the Ministry of Foreign and CARICOM Affairs with a view to negotiating further Technical Assistance Agreements with the People's Republic of China and with other countries who may be amenable to such an agreement.

v. that immediate attention is required to filling existing vacancies for medical and nursing personnel at the SFGH.

vi. that training of staff in the proper use of equipment should be mandatory.

vii. that the SWRHA explore the range of technical assistance offered by International Organisations with a view to determining whether such organisation provide technical aide in the area of equipment maintenance and repair.

viii. that the SWRHA mandate the management of the SFGH to develop effective strategies for assisting health care providers at the institution to understand and adhere to expected standards of conduct.

ix. The Patient's Bill of Rights and Patients Charter should be displayed in prominent public spaces of all Health Care Institutions.

x. Health providers must be encouraged to exercise more care when handling patient records. A zero tolerance approach should be adopted for this and other forms of unprofessional conduct.

xi. The management of the SFGH must ensure that all persons who are required to access, update or scrutinise hospital/patient records are trained to properly operate computer programmes.

xii. that particular attention be paid to estimating the quantity and type of drugs required for the SFGH as accurately as possible so as to eliminate wastage.

xiii. that Board of the SWRHA mandate all health facilities under it purview to conduct regular monitoring of their drug inventory. This would assist in predicting potential drug shortages or overstocking.

xiv. that the Board of the SWRHA take into consideration implementing a Drug Inventory Management Model, for example, the open-to-buy (OTB) budget method.

xv. Stricter adherence to existing standards and protocols which aim to prevent HAIs must be encouraged.

INTRODUCTION

Background

2.1. The South-West Regional Health Authority (SWRHA) was established along with other RHA's by Act No. 5 of 1994, as part of the Government's Health Sector Reform Programme. The primary aim of these reform efforts was to decentralize the management and provision of health care in Trinidad and Tobago. Presently there are 5 RHAs; North- West, North-Central, South-West, Eastern and Tobago.

2.2. The South-West Regional Authority (SWRHA) is the largest of the Five RHA's, with a catchment area of one-third of country's population or approximately 650,000. The SWRHA faces challenges in balancing the provision of quality, consistent and reliable health care services. Currently the SWRHA oversees 700 inpatient beds and deliver care to approximately 2400 persons daily.

2.3. The operation of the Authority are supported by approximately 4600 staff, including physicians, approximately 58 volunteers, 250 On-the-Job Trainees and 210 nursing aids.

Principal Responsibilities

2.4. The SWRHA is responsible for the management of the following health care facilities:

1. San Fernando General Hospital;
2. San Fernando Teaching Hospital;
3. Area Hospital Point Fortin;
4. Princes Town District Health Facility;
5. Couva District Health Facility;
6. Siparia District Health Facility;
7. 31 Health Centres; and
8. 2 Outreach and Extended Care Centres.

Please refer to Appendix III for some of the major services provided at the San Fernando General Hospital.

Organizational Structure

2.5. The Minister of Health and the Permanent Secretary exercise a supervisory role over the SWRHA. Section 5(1) states that:

Subject to subsection (2), a Board of an RHA shall exercise its powers and functions in accordance with such specific or general directions as may be given to it by the Minister.

2.6. A new Board of Directors was appointed on Thursday March 03, 2016. The follow persons comprise the Board of the SWRHA:

1. Chairman- Dr. Alexander Sinanan
2. Deputy Chairman- Mrs. Valerie Alleyne-Rawlins
3. Mr. Anil Bhagowtee
4. Ms. Jennifer Marryshaw
5. Dr. Harry Smith
6. Mr. Colin Kangaloo
7. Ms. Jayselle McFarlane
8. Dr. Shalini Pooransingh

The Chief Executive Officer is Dr. Anil Gosine.

Please refer to Appendix IV for the Organisational Structure of the SWRHA Hospital Administration Department

Fiscal Expenditure

2.7. The actual and estimated expenditure of the SWRHA for the period 2012 – 2016[2] is outlined in Table 1 below:

Table 1:

The Actual and Estimated Expenditure of the SWRHA for the period 2012 – 2016

2012 (Actual)	2013 (Actual)	2014 (Actual)	2015 (Actual)	2016 (Estimate)
$638, 146, 047	$805, 083, 081	$823, 078, 900	$810, 000, 000	$936, 342, 000

Objectives of the Inquiry

2.8. The Committee agreed that the objectives of the inquiry will be as follows:

i. **To evaluate the effectiveness of the SWRHA in executing its mandate, in relation to the San Fernando General Hospital;**

ii. **To determine whether the human resources and equipment at the San Fernando General Hospital are sufficient to allow it to operate efficiently;**

iii. **To determine what are the shortcomings in the services offered to patients at the hospital, the root causes of these operational shortcomings and potential solutions to alleviate these shortcomings.**

Conduct of the Inquiry

2.9. A public hearing was held with representatives of the SWRHA and the Ministry of Health on Wednesday 22 June, 2016 at which time the Committee interviewed the officials on issues relevant to the inquiry objectives. Prior to the public hearing, the Committee wrote to the Authority requesting written responses to certain preliminary questions. The written responses submitted by the SWRHA and the Ministry of Health provided a frame of reference for the questions pursued at the hearing.

[2] Draft Estimates – Details of Estimates of Recurrent Expenditure for the Financial Years 2015 and 2016

2.10. The SWRHA was represented by the following officials:

i. Mr. Anil Gosine - Chief Executive Officer
ii. Dr. Alexander Sinanan- Chairman
iii. Mrs. Valerie Alleyne-Rawlins -Deputy Chairman
iv. Mrs. Gail Miller-Meade - General Manager Finance
v. Mrs. Debra Singh -Khan – General Manager Human Resources
vi. Dr. Anand Chatoorgoon -Medical Director - Secondary Care Service & Director of Health (Ag.)

2.11. The Ministry of Health was represented by the following officials:

i. Ms. Donna Ferraz - Permanent Secretary
ii. Dr. Akenath Misir - Chief Medical Officer
iii. Mr. Lawrence Jaisingh - Director Health Policy Research and Planning

2.12. The Committee also noted the contents of the *Report (No. 1) of the Committee to Review the levels of Health Care Delivery by the Regional Health Authorities and to Rationalise the System of Public Sector Doctors in Private Practice (Dated August 29 2016)*. The Committee acknowledges that the mandate of the Welch Committee included reviewing the level of health care delivery by the RHAs. This was much broader than this Committee's objectives as set out above. Notwithstanding, the Committee took note of certain findings and recommendations contained in the report of the Welch Committee which if implemented may assist in improving the operations of the RHAs.

2.13. **The Minutes and Verbatim Notes are attached as Appendix I and Appendix II respectively.**

Summary of Evidence, Findings and Recommendations

Objective 1: To Evaluate the Effectiveness of the SWRHA in Executing its Mandate, in Relation to the San Fernando General Hospital

3.1.1 The SWRHA provides health care services through two (2) hospitals at San Fernando and Point Fortin, three (3) District Health Facilities (DHFs) and thirty-one (31) health and outreach centers. The San Fernando Teaching Hospital and two (2) Extended Care Centers (ECCS) are also under the remit of the Authority.

The MOH's Role in Overseeing the Management of the SWRHA

3.1.2 The Ministry of Health provides oversight in the management of SWRHA through the following key instruments:

- The Regional Health Authorities Act;
- The Purchasing Services Intention Agreement;
- The Annual Services Agreement;
- The Minutes of the Board Meetings of the RHAs; and
- The RHA Annual Reports.

3.1.3 Various reporting tools are used to track and monitor the operations of SWRHA including:

- project portfolio matrix for updating the status of infrastructure projects under the PSIP;
- hospital utilisation reports on the delivery of health services,
- financial reports for reconciliation of funds released and spent;
- human resources management reports;
- quality control and clinical audit reports; and
- client satisfaction reports.

3.1.4 Additionally, the Minister of Health meets with the RHAs on a monthly basis to discuss the status of key strategic priorities and emerging challenges and solutions. The Committee was informed that the following measures were adopted to assist the Ministry in monitoring the performance of the SWRHA:

- the periodical examination of financials and HR policies;
- monthly meetings involving the Minister of Health, the Chairman, Deputy Chairman and CEO of all the Regional Health Authorities;
- monitoring by the Health Policy Division; and
- the Quality Council, chaired by the PS was re-established.

The Reporting Relationship between the Ministry and the Board of the SWRHA

3.1.5 The Permanent Secretary in the Ministry of Health informed the Committee that there is a reporting mechanism between the Board and the Ministry. The Board of the RHA is required to:

- provide the Ministry with a copy of the Minutes of Board Meetings within two weeks of being confirmed;
- communicate all decisions of the Board to the Minister within 72 hours; and
- additionally a weekly strategic meeting is chaired by the Minister and Board Members.

The SWRHA's Annual Business Plan

3.1.6 The SWRHA's Annual Business Plan comprises department plans which are aligned to the SWRHA's Strategic Plan 2013-2016. The objective of this business planning process is to provide a focused and measurable method of healthcare Management at the regional, departmental and individual level. Annual Business Plans are developed, based on the strategic objectives set out in SWRHA's Strategic Plan 2013-2016 and SWRHA's Annual Services Agreement 2012-2013

and 2013-2014. These documents provide a framework for the Authority to develop a set of expected output/outcomes and performance indicators which the SWRHA will use to facilitate the improvement of healthcare services in the South-West region.

3.1.7 For the year 2015/2016, the SWRHA has identified key initiatives and actions aligned to the nine (9) core strategic priorities which are outlined in the Strategic Plan 2013-2016:

1. Prevention, Care and Treatment of Chronic Non-Communicable Diseases;
2. Prevention, Care and Treatment of Communicable Diseases;
3. Maternal and Child Health;
4. Mental Health and Wellness;
5. Health Human Resource Planning and Development;
6. ICT Integration in the Health Sector;
7. Continuous Improvement of the Management of the Health Sector;
8. Continuous Improvement of Health Services Delivery;
9. Health Infrastructure Development and Facilities Management.

3.1.8 These areas are crucial for the SWRHA to effectively uphold its mission and vision to the community.

Data Driven Approach to Decision-Making at the SWRHA

3.1.9 The Committee was informed that a *Manager of Policy Planning and Research* was hired in 2012. The Committee was also informed that SWRHA has created a Public Health Observatory[3] which will be managed by hired epidemiologists. Data collection would not only be done at SFGH but through the region. The observatory will focus on collecting data on predominant health issues and

[3] http://www.apho.org.uk/resource/view.aspx?QN=ABOUT_DEFAULT

diseases e.g. non- communicable and communicable diseases. Data collected will be analysed to guide policy formulation.

Financial Overview of the SWRHA

3.1.10 The Estimated Recurrent Expenditure for 2015-2016 was $936,342,000. However, the Authority's planned/projected expenditure for 2015-2016 was $2.027 Billion. This is quite a notable shortfall. The table below outlines the details of budgetary allocations relative to the SWRHA for the period 2012 to 2016.

Table 2

Details of the Budgetary Allocations made to the SWRHA for the period 2012 to 2016

Fiscal Year	Original Budget Requested	Budget Received/Allocated	Actual Expenditure
2012-2013	TT$977,000,000	TT$879,000,000	TT$873,000,000
2013-2014	TT$1,000,000,000	TT$879,000,000	TT$905,000,000
2014-2015	TT$1,100,000,000	TT$810,000,000	TT$1,024,000,000
2015-2016	TT$2, 027, 000, 000	TT$936,342,000.	-

Mechanisms for Releasing Funds to the SWRHA and for Monitoring the Use of Funds

3.1.11 Funds are released to the SWRHA by the Ministry of Health under sub-item *Current Transfer and Subsidies* in Estimates of Recurrent Expenditure 2016 and 2017[4]. Based on the details of the Estimates of Recurrent Expenditure, funds are to be transferred to the SWRHA for the purpose of:

- Salaries and Recurrent Expenditure;
- Debt servicing;
- Community HIV Programme;

[4] Estimates – Details of Estimates of Recurrent Expenditure for the Financial Years 2016 and 2017

- Aides to Nursing Programme;
- Gynaecological Cancer Screening and Surgery;
- Vacant posts;
- School Nursing Programme;
- Private institutions;
- Other; and
- Legal settlements.

3.1.12 Funds are also allocated to finance the following development projects for the period 2016/2017: [5]

i. 004 Social Infrastructure Item A001-Medical Equipment Upgrade Programme,
ii. 005 Multi-Sectoral and Other Services 005 Item C 234- Hospital Refurbishments Programme; and
iii. 004 Social Infrastructure F 001- Physical Investments.

3.1.13 The table below outlines the MoH's estimated allocation of funds to the RHA for developmental projects for fiscal 2016-2017.

Table 3

Allocation to the RHAs for Development Projects for Fiscal 2016/2017

SUB-HEAD/ ITEM DESCRIPTION	2016 Estimates	2016 Revised Estimates	2017 Estimates
004 Social Infrastructure Item A001-Medical Equipment Upgrade Programme	30,000,000	30,000,000	45,000,000
005 Multi-Sectoral and Other Services Item C 234- Hospital Refurbishments Programme	31,000,000	31,000,000	40,000,000
004 Social Infrastructure F 001- Physical Investments	80,000,000	91,000,000	60,000,000

[5] Estimates of Development Programme for the Financial Year 2017

3.1.14 With respect to Development Projects, funds are released and monitored through cash flow/project schedule; verified invoices and certification by the Ministry's Project Management Unit. Under the Infrastructure Development Fund (IDF), funds are released based on the submission of supporting documents including contractor invoices and payment certificates for validation for payment.

3.1.15 These funds are monitored through a series reporting and control mechanisms including:

i. Submission of monthly expenditure statements from SWRHA to the Ministry of Health for reconciliation of funds released and spent;
ii. Monthly PSIP reports are submitted outlining the status of projects with follow up meetings to address possible constraints and issues;
iii. Site visits are conducted by the Project Management Unit of the Ministry of Health to validate the status reports submitted and to ensure accountability;
iv The Ministry of Health has a representative Board Member on each RHA to provide oversight to ensure accountability and to monitor that the strategic priorities are being implemented;
v On projects exceeding $1.5Mn, each RHA is required to submit the project for review through the Ministry's Internal Contract Committee for final approval by the Minister of Health; and
vi The Internal Audit Department of the Ministry of Health provides the requisite audit oversight.

The San Fernando General Hospital

3.1.16 The SFGH, the flagship of the SWRHA, has evolved to become one of the major providers of health care nationally and regionally. It is considered as the main trauma unit for the Southern region of Trinidad. The hospital provides its

patients with many essential health services, some of which are rarely available in the country. The SFGH provides 750 beds.

The San Fernando Teaching Hospital

3.1.17 The retrofitted San Fernando Teaching Hospital has 216 beds to assist in alleviating the chronic bed shortage problem faced at the San Fernando General Hospital and includes; paediatric and adult wards and outpatient clinics; mother and child facilities, as well as administrative and teaching rooms to support the objectives of the teaching hospital and the overall management of the facility.

3.1.18 The Committee noted that in July 2015, the Ministry of Health, through the SWRHA allocated two Floors in the Teaching Hospital to UWI. As at June 2016, a Memorandum of Understanding was being drawn up between UWI and the SWRHA. However at that time the University had not occupied the allotted space.

The SWHRA's Role in Overseeing the Management of the SFGH

3.1.19 The Board and Chief Executive Officer of the SWRHA are mandated to oversee the operations of the SFGH. The systems and mechanisms employed by the CEO to oversee the operations of the SFGH includes monthly meetings with the Ministry and the management team of the SFGH. The meetings chaired by the CEO include:

a. Bi- Monthly meetings with the Executive Management team of the Hospital;
b. Quarterly meetings with all Technical Heads;
c. Monthly meetings – Quality Improvement Implementation Steering Committee; Accreditation Oversight Committee; Regional Health and Safety Committee; Project Board Meeting- Patient Information System;

- At the hospital Management Professionals and Health care Providers collaborate to coordinate, manage, deliver, allocate funds and evaluate Health promotion in south-west region Clinical Departments. There are 15 Clinical departments at the SFGH that are under the purview of the Director of Health and Medical Director SFGH.
- **Nursing** –The Nursing Manager and her team provide direction and control, through Patient Care Coordinators; (PCCs); who in turn are responsible for coordinating, monitoring and controlling specific wards and units.
- **Allied Health Services**- the General Manager, Allied Health Services provide specialized support to the operations of the hospital in the areas of :
  a. Pharmacology;
  b. Physiotherapy;
  c. Dietetics;
  d. Medical Social Works; and
  e. Medical Records.

3.1.20 The efforts of these units are streamlined towards achieving clearly defined departmental goals, while measuring and controlling budgetary expenditures. However, the relatively high turnover of staff at the executive management level of the SWRHA has impacted on the continuity in the management of projects and policy initiatives.

Budget Allocations to the SFGH and SFTH

3.1.21 The following table shows the budget allocations to the SFGH and the Teaching Hospital for the years 2012-2015

Table 4

Budget allocations to the SFGH and the Teaching Hospital for the years 2012-2015

Total allocation	**2012/2013** 879,099,953.00	100%	**2013/2014** 854,486,333.72	**100%**	**2014/2015** 889,404,189.15	**100%**	**2015/2016** 961,072,596.91 100%	**100%**
SFGH	604,838,953.18	69%	577,305,307.99	68%	572,142,867.73	64%	534,579,993.60	56%
SFTH	-	0%	-	0%	44,658,601.19	5%	132,435,909.73	14%
Total	**604,838,953.18**	**69%**	**577,305,307.99**	**68%**	**616,801,468.93**	**69%**	**667,051,903.34**	**69%**
SFGH Personnel Emoluments	466,089,675	77%	454,028,492.16	79%	499,592,216.18	87%	469,799,134.37	88%
SFGH Goods & Services	138,748,887.88	23%	123,276,815.83	21%	72,550,615.55	13%	64,780,859.23	12%
Total Budget SFGH	**604,838,563.18**	**100%**	**577,305,307.99**	**100%**	**572,142,867.73**	**100%**	**534,579,993.60**	**100%**
SFTH Personnel Emoluments	**-**	0%	**-**	0%	-	0%	115,055,707.98	87%
SFTH Goods & Services	**-**	0%	**-**	0%	44,658,601.19	100%	17,380,201.75	13%
Total Budget SFTH	**-**	**0%**	**-**	**0%**	**44,658,601.19**	**100%**	**132,435,909.73**	**100%**

Findings

3.1.22 As the main healthcare facility under the purview of the SWRHA and one of the largest Health facilities in the region, the Committee sought to determine what plans and strategies the SWRHA has implemented to first of all ensure that there

is proper oversight of the operations of the hospital. The information provided to the committee demonstrated that the system of oversight involved some typical methods such as meetings and the submission of reports. We also noted that site visits are also a part of the system of overseeing the operations of the hospital.

3.1.23 Given the institution's relatively large size and that its potential population catchment is approximately 600,000, middle managers such as Technical and Departmental Heads perform a crucial role at the operational level in ensuring that services are delivered effectively and efficiently. Crucial decisions that involve situations of life and death are made on a daily basis, as such persons assigned to these positions must possess suitable qualifications and expertise. The Committee was pleased to learn about the creation of a Public Health Observatory to collect vital data emanating from patients at the SFGH and other health institutions. The data captured should be used to assist the management of the hospital to determine which departments or clinic areas should be prioritized and properly streamlined so as to meet the demands of the public.

3.1.24 With respect to funds allocated to manage the SFGH, we noted that for fiscal 2015/2016 a total of $534,579,993.60 was assigned to the operations of the SFGH and a staggering 88% of this was allocated to personnel emoluments. Health care is a labour intensive and specialised sector as such, the fact that the majority of funds are allocated to salaries and allowances would be typical of all RHAs. Often this leave a small balance of the allocation for development purposes. Therefore, it is incumbent on the managers of these health facilities to ensure that the public/clients receive a high standard care and professional conduct by health care professionals.

3.1.25 The Committee was also interested in understanding how the advent of the Teaching Hospital affected the SWRHA's capacity to manage an additional major health facility. The SWRHA submitted that the construction of the Teaching Hospital has reduced some of the pressure placed on SFGH as the new hospital provide in-patient and out-patient care. However, the Committee was concerned about the impact that the divergence of funds from the SFGH to the SFTH has had on the improvement of the infrastructure and equipment at the SFGH.

Recommendations

A. The Committee recommends that the data gathered from the Public Health Observatory be used to assist the management of the hospital to determine which departments or clinical areas should be prioritized and properly streamlined so as to meet the demands of the public.

Financial Resources for the SWRHA

B. Given the financial constraints of the state, the elimination of wastage and duplication must be a priority for the SWRHA and other RHAs. This would involve:

- **rationalizing goods and services;**
- **capitalizing on in-house expertise for conducting training and development interventions;**
- **fostering a "value for money" culture in all aspects of operations of health facilities under its purview;**
- **Effectively addressing, poor performance by employees;**
- **Strategically streamlining the resources of the SFGH and the SFTH to optimize the efficiency of both facilities;**

- **Establishing a fee-structure for non-nationals to pay for certain specialized services.**

Objective 2: To Determine whether the Human Resources and Equipment at the San Fernando General Hospital are Sufficient to Allow it Operate Efficiently

Human Resource Management

3.2.1 There are currently five thousand and forty-three (5043) persons employed on the establishment of the SWRHA, these persons include medical and administrative staff. Approximately four thousand two hundred and ninety eight (4,298) of the total person employed under the SWRHA are employed at the SFGH and SFTH.

3.2.2. Currently approximately Fifty-Five (55) employees out of four thousand two hundred and ninety eight (4,298) employed at the SFGH/SFTH are non-nationals. The table below shows the country of origin of the 55 non-nationals and their respective positions at the SFGH/SFTH.

Table 5

Non-nationals employed at the SFGH/SFTH as at September 2016

POSITIONS	PLACE OF ORIGIN – NON-NATIONALS									TOTAL
	Nigeria	India	Cuba	Jamaica	Guyana	Australia	Pakistan	America	Italy	
Specialist Medical Officer			**2**						**1**	**3**
Registrar		**1**	**1**							**2**
House Officer	**7**	**12**					**2**	**1**		**22**
Physiotherapist II		**2**								**2**
Psychiatric Social Worker II						**1**				**1**
Medical Laboratory Technician I	**1**									**1**
Registered Nurse	**1**	**3**	**18**	**1**						**23**
Enrolled Nursing Assistant					**1**					**1**
TOTAL NON-NATIONALS	**9**	**18**	**21**	**1**	**1**	**1**	**2**	**1**	**1**	**55**

3.2.3 The Committee was informed by the Chief Executive Officer of SWRHA that most of the non-nationals were operating at the House Officer level or below. The Authority was planning to ensure that the vacancies created when the periods of service of foreign doctors expires are filled by local Doctors. The SWRHA have recently notified the foreign Doctors of this decision and have given them an extra six to transition out intended to permit them.

The recruitment and retention of staff

3.2.4 Attracting and retaining staff with the required skills and competencies is one of the major challenges within the SWRHA. This has affected the standard of service delivered at the health care facilities under its purview including the SFGH. The table below outlines the vacancies by category at the SFGH/ Regional Administrative Centre.

Table 6

Vacancies at the SFGH/ Regional Administrative Centre by Category

SAN FERNANDO GENERAL HOSPITAL/ REGIONAL ADMINISTRATIVE CENTRE	
Medical	170
Nursing	601
Allied Health Service Professionals	361
Administrative/Other Support Staff	510
Sub-Total	**1642**

3.2.5 Information submitted to the Committee by the SWRHA indicated that currently there are approximately thirty-two (32) vacancies in the posts of specialist Medical Officers. The Committee learned of the difficulties experienced by the SWRHA in attracting and recruiting Specialist Medical Officers. Some factors that contribute to low recruitment include:

a. Low compensation packages;
b. More attractive remuneration earned from private practice; and
c. Some applicants lack sufficient years of experience to be eligible for promotion.

3.2.6 The Chief Executive Officer of SWRHA advised that the SWRHA was working with the Ministry to address the staffing issues. The PS, Ministry of Health further advised that the Ministry is reviewing its *10 Year Human Resource Manpower* Plan for the Health Sector. The Plan would involve the standardization of certain positions throughout the RHAs and based on the specialized service offered by a particular RHA, overseas recruitment would be conducted. It was estimated that the review exercise should be completed by the end of the first quarter of 2017.

3.2.7 Additional strategies being explored to boost the human resource capacity within the SWRHA include partnering with foreign universities to establish a specialist training programme whereby foreign medical professionals can come to Trinidad to train local doctors in a particular field. Another method to address the shortages would be to create 'Centres of Excellence' in different regional hospitals. In this regard, each hospital would specialize in a specific service as opposed to every hospital attempting to offer the same specialized services.

Doctor-to-Patient Ratio

3.2.8 The SFGH's Departmental Business Plan 2015-2016, states that the staff to patient ratio at the hospital is inadequate. The following table illustrates the doctor to patient ratio for the SFGH/SFTH as at June 12, 2016.

Table 7

Doctor-To-Patient Ratio at the SFGH/SFTH

	Department	Doctor to Patient Ratio
1.	Medicine	1:3
2.	Cardiac	1:1
3.	ICU Including HDU	4:1
4.	Pediatrics including Pediatrics Surgery	1:1
5.	General Surgery	1:2
6.	Surgical Sub- Specialties (Neurosurgery, Plastics and Burns)	1:1
7.	Urology	1:1
8.	Orthopedics	3:1
9.	Eyes/ENT	1:1
10.	Psychiatry	1:1
11.	Obstetrics and Gynecology	1:1

Needs Assessments

3.2.9 The SWRHA submitted that Needs Assessments are ongoing for health facilities/departments under the purview of the SWRHA. Assessments were conducted on five (5) areas in the previous fiscal year: Nursing, Medical, Supply Chain, Hospital Administration, Nutrition & Dietetics and Pharmacy Departments. In 2015/2016, six (6) additional areas were earmarked to be assessed as follows:

1. Security Services
2. Quality improvement
3. Policy Planning & Research
4. Health Records
5. Operations Departments
6. Medical Records

3.2.10 A Needs Assessment of the Infrastructure and Equipment was done in 2013 and has been reviewed annually as part of the Development Project and Recurrent Expenditure budgeting process.

Maintenance of Equipment

3.2.11 Every RHA is responsible for the maintenance of its equipment installed within the various facilities under its purview. As such, each RHA has a Biomedical Department and an Engineering Department with the responsibility for maintenance of both medical and plant equipment. RHAs are provided with a budget to cover maintenance costs. However, major equipment costs are dealt with at the level of the Permanent Secretary, MoH. The MoH provides funding through its capital development allocation for equipment replacement. As part of the RHA's reporting, the MoH also requires that they be informed of any major equipment downtime and/or requests for additional funding for equipment maintenance.

3.2.12 Lack of equipment for executing basic and specialized diagnostics and surgical procedures, outdated and frequent breakdown of medical equipment such as radiology and Laparoscopic equipment were highlighted as major issues current affecting the operations of the SFGH. In addition, the frequent breakdown of Monitors and ECG machines was also reported as adversely affecting the operations of not only the SFGH but other medical institutions under the SWRHA. The Authority indicated that there is an urgent need for the modernization of surgical instruments and related equipment as a means of improving the standard of care at the SFGH and other medical institutions under the SWRHA.

3.2.13 The lack of adequate equipment at the SFGH has made the work environment more challenging for staff as they attempt to execute daily functions. Frequent equipment breakdowns have led to low equipment availability and a consequential adverse impact on clinical services and patient care. Examples of adverse impacts include:

a. Long waiting time at clinics;
b. Long waiting times in accessing critical services e.g. Radiography (CT-Scan, MRI. X-rays);
c. Negative Publicity;
d. Idle equipment;
e. Low employee productivity levels;
f. Rescheduling of surgeries due to equipment failure;
g. Consistent customer complaints- loss of trust; and
h. Challenges in meeting Accreditation standards.

3.2.14 The following table provides information on the responsibility of the RHA with respect to the maintenance of equipment and the reasons why some equipment remain in a state of disrepair at the SWRHA.

Table 8

Maintenance of Equipment and the Reasons the Equipment is in a State of Disrepair at the SWRHA

RHA	RHA AND EQUIPMENT MAINTENANCE	REASONS FOR BROKEN-DOWN EQUIPMENT
SWRHA	➢ There are two maintenance systems to maintain and repair equipment: 1. Service Contracts-Several Service contracts for maintenance of elevators, imaging equipment, large air conditioning equipment and so on with the Supplier/ Agents of equipment. In addition the RHA purchases extended warranty (3-5) years for some new equipment **2.** In-house maintenance- In-house engineering staff conduct scheduled preventative and corrective programmes for the equipment with the facilities of the RHA.	➢ Equipment remain broken down because:- • Some obsolete equipment remain in operation for a prolonged period, as the replacement cost is beyond the available funding. Acquiring spare parts for these pieces of equipment is difficult and results in an increase in downtime. • Local suppliers do not stock spares, as they should, and most spares have to be imported with consequential delays • The procurement process of the Regional Health Authority has a built-in delay, which adds to the total delays. • Some of the in-house end users are not careful and cause damage to equipment. • The RHA is challenged by the private sector to keep and retain skilled and experienced maintenance personnel (Biomedical Engineering)

3.2.15 Most of the equipment required for the SFGH are large equipment and are either purchased on extended warranty, or on extended maintenance contracts. A number of factors account for the downtime of equipment at the hospital. They include:

- Age of equipment, particularly plant equipment at various facilities that require upgrade/ replacement. This also impacts on the availability of spare parts;
- Shortage of trained Biomedical Engineers and Technicians;
- Suppliers of some equipment do not have the necessary technical service staff to adequately maintain equipment they sell.

3.2.16 A Computerized Maintenance Management System was installed in certain RHAs to aid in the tracking, planning and monitoring of equipment maintenance. Also, Standard Operating Policies and Procedures for the maintenance of medical equipment have been developed.

Estimated Cost for Equipment and Maintenance

3.2.17 The SWRHA indicated that in fiscal 2015/2016 $103,962,847.000 was allocated to the SFGH for the acquisition of the required equipment for the period 2015/2016. Those funds covered the following:

i. Property
ii. Plant Equipment Maintenance
iii. Medical Equipment Repairs & Maintenance
iv. Equipment request (no allocation made due to lack of funding)

3.2.18 The table below details the annual cost of equipment maintenance at the SFGH & for the years 2013-2015.[6]

[6] Submission form the SWRHA

Table 9

Annual Cost of Equipment Maintenance at the SFGH & SFTH for the years 2013-2015

SOUTH-WEST REGIONAL HEALTH AUTHORITY				
Annual Cost of Equipment Maintenance - SFGH & SFTH				
Income Years 2013, 2014, 2015				
Description	***2012/2013***	***2013/2014***	***2014/2015***	**Remarks**
San Fernando General Hospital				
Property, Plant Equipment Maintenance	1,104,825.45	1,314,031.95	1,592,736.93	
Medical Equipment Repairs & Maintenance	3,604,715.00	2,115,422.00	6,186,323.83	
Equipment Purchased	393,062.00	5,989,169.00	443,800.33	
	5,102,602.45	**9,418,622.95**	**8,222,861.09**	
San Fernando Teaching Hospital				
Property, Plant Equipment Maintenance	-	-	118,315.01	
Medical Equipment Repairs & Maintenance	-	-	49,092.00	
Equipment Purchased	-	-	346,073.46	
	-	**-**	**513,480.47**	
	2015/2016 - Equipment Request			
SFGH Request (no Allocation made due to lack of funding)	**103,962,847.00**			
SFTH Request (no Allocation made due to lack of funding)	5,035,490.00			
	108,998,337.00			

Procurement Practices at the SFGH

3.2.19 The SWRHA is guided by the Procurement and Contracts Policy aligned to the RHA Act 1994[7]. The standard procurement regime adhered to by the SWRHA is

[7] Subsection 29 (5) *"Contracting of Goods and Services"*.

contained in *Purchasing and contracting of Goods and Services Policy*, which prescribes that:

a. An Open Tendering process be used for purchases in excess of TT 100,000.00 as outlined in Section 9.6, pages 15-18 of the Policy;

b. For purchases less than equal to TT 100,000.00- *see* Section 9.2-3, pages 6-12**.**

Departments of Concern at the SFGH

3.2.20 Given the large number of clinical departments at the SFGH, the Committee decided to place particular focus on scrutinizing the current status of the human resource and equipment needs of selected departments including:

1. Emergency Department;
2. General Surgery;
3. Obstetrics and Gynecology;
4. Oncology; and
5. Pediatric Medicine.

Human Resources in Selected Departments

3.2.21 The table below shows the number of House Officers and Registers positions in the five (5) departments highlighted above that are established, filled and vacant at the SFGH.

Table 10

House Officers and Registers Assigned to the SFGH

Department	Post	No. of Post established	No. of Post Filled	No. of Vacancies
Emergency Department		12	3	9
General Surgery		8	4	4
Obstetrics and Gynecology		5	3	2
Oncology		1	1	0
Pediatric Medicine	**Register**	6	2	4
Total		**32**	**13**	**19**
Emergency Department		48	47	1
General surgery		29	29	0
Obstetrics and Gynecology		23	19	4
Oncology		12	11	1
Pediatric Medicine	**House Officer**	15	14	1
Total		**127**	**120**	**7**

3.2.22 The breakdown of the Nursing Department at the SFGH is as follows:

- No. of post established – 1, 895;
- No. of post filled – 1, 356;
- No. of vacancies - 539.

Emergency Department

3.2.23 The Accident and Emergency Department at the SFGH provides a 24 hour service. The department is presently operating with 75%-80% of its complement of House Officers and Registrars (non-specialist House-Officers now function in

these posts). There is still a need for at least 25 additional nurses. With regards to doctors, it was reported that the department has been functioning with approximately 50% of the required number of doctors.

3.2.24 The committee noted that the remedial plans in place to resolve the human resource shortages and challenges with equipment at the SFGH include:

a. the identification of current vacancies and the creation of new positions, and liaising with HR to update the establishment and fill approved positions.

b. the generation of an equipment listing for both the current and new equipment, as well as the development of a preventative maintenance schedule for each equipment.

General Surgery

3.2.25 There are ten functioning Operating Theatres at the SFGH. On-call service for acute surgical admissions via wards 3 and 6 (male and female) is available on a rotating basis. There are five (5) surgical units, each lead by a Consultant, supported by a Registrar (with post-graduate qualifications or near completion), 3 Residents and 2 Interns. It was reported that this department has a staff shortfall and there is an urgent need for additional Theatre Nurses and an Anesthetic Assistant. Another major challenges that is confronting the General Surgery Department is the need to acquire the latest surgical instruments and related equipment.

Obstetrics and Gynecology

3.2.26 The Obstetrics and Gynecology Department currently has 42 Obstetric beds and 28 Gynecology beds. There is a 24 hour Obstetrics and Gynecology theatre for minor surgeries such as Dilatation & Curettage and Extraction of Retained Products of conception.

3.2.27 The complement of staff assigned to this department include:

- 19 House Officers,
- 4 Registrars; and
- 4 Consultants.

3.2.28 The department is still in need of 4 House Officers as leave reliefs. The department however has a shortage of midwives and there is the need for 1 Secretary. The department is encountering difficulties in procuring equipment.

Oncology

3.2.29 The role of this department is to supervise and manage the care of cancer patients and administer chemotherapy for appropriate patients. The complement of staff assigned to this department include:

- 1 Specialist Medical Officer
- 1 Registrar
- 2 House Officers
- 1 Registered Nurse
- 1 Enrolled Nursing Assistant
- 1 Clerk

3.2.30 There are staffing needs that include a DM of Oncology, oncology trained nurses, house officers and additional chemotherapy compounding pharmacist/technicians. Currently the SFGH intends to review the organizational structure of the department with a view to introducing the position of General Manager, DM of Oncology, administrative staff, House Officers and specialist nurses.

3.2.31 It was reported that the Laparoscopic equipment is not functional although it is physically located in the department.

Pediatric Medicine

3.2.32 The Pediatric Department provides diagnostic services and treatment to children up to the age of 12. There has been over 5, 736 admissions for the period 2015/2016. The current staff assignments to this department include:

i. 28 Pediatric and Neonatal House Officers
ii. 9 Pediatric and Neonatal Registrars
iii. 1 Secretary
iv. 2 Ward Clerks
v. Nurses: Ward 14 A
   - 20 Registered Nurses
   - 7 Enrolled Nursing Assistants
   - 3 Aide to Nurses
vi. Nurses: Ward 14 B
   - 25 Registered Nurses
   - 6 Enrolled Nursing Assistants
   - 3 Aide to Nurses

3.2.33 The written submission of the SWRHA stated that the Pediatrics Department was in need of Registrars and a SMO Neonatology. It has also been a challenge to attract new clinical staff for Pediatrics sub specialties since the Hospital is not an approved site for University training in this area.

Findings

The Effect of the Shortage of Human Resources at the SFGH

3.2.34 The shortage of specialist medical doctors within several departments at the SFGH, though a cause of concern, may well be indicative of the general shortage of specialist doctors in the country. The Committee also noted the effect the shortage of Registered Nurses has on the hospital's operations, particularly with respect to the performing of elective surgeries. The efforts of the Ministry of Health which lead to the execution of the bi-lateral agreement with China must be commended. The Committee trusts that negotiations are in motion for the extension or renewal of such an arrangement as it is an essential measure for supplementing the shortage of specialist medical services available to the SWRHA.

3.2.35 We noted with concern the fact that there are no incentive programmes tailored to attract and retain the "best and the brightest" and, as a result, doctors, in particular senior specialists and nurses seek alternative options for acquiring greater earnings for their services.

3.2.36 The significant number of vacancies in administrative positions was also noted with concern. Hospital Administrators, particularly in a large facility such as the SFGH, play a crucial role in managing the day-to-day operations of the institution and therefore stability among this class of employees is also important. Although some of the responsibilities associated with the vacant positions are being executed by contract employees, by making permanent appointments to some of these positions it may assist with enhancing the institutional capacity of the SFGH.

High Cost of Maintenance at the SFGH

3.2.37 The Committee was not surprised to learn of the significant amount of money required for the maintenance of equipment at the SFGH given the size of the facility and the number of departments in operation. However, we are cognizant that the purchasing and replacement of equipment in the short-term may be stymied by the lack of state funds. As such, until the Ministry is in a position to transfer additional funds to the SWRHA for maintenance expenses, internal repairs and technical aid (though international partnerships) should be seriously pursued.

3.2.38 Equipment and specialist practitioners that are not available at SFGH or the SFTH may be available within other RHAs. This does allow some flexibility in terms of ensuring that patients can be treated at one hospital or another. In this regard, the Committee took note of the recommendation which emanated from the SWRHA for the creation of 'Centres of Excellence' in different RHAs. This suggestion was primarily aimed at eliminating the duplication of resources.

3.2.39 The committee noted that the SWRHA has engaged in projects to improve the maintenance and replacement of equipment at the SFGH, these include:

- the replacement of the UPS for Obstetrics theatre; and
- acquiring advance equipment to improve minor surgeries

Recommendations

Human Resources at the SFGH

a. **The Committee recommends that the MOH work with alacrity to complete its ten year human resource plan. This planning exercise must take into consideration existing financial constraints and current realities of the labour market. The development and effective management of existing staff to achieve optimum output and value for money should be included in the objectives of this plan.**

b. **The Committee recommends that the Ministry of Health collaborate with the Ministry of Foreign and CARICOM Affairs with a view to negotiating further Technical Assistance Agreements with the People's Republic of China and with other countries who may be amenable to such an agreement. We suggest that negotiation include a request for technical assistance for equipment repair and maintenance.**

c. **The Committee recommends that immediate attention is required to filling existing vacancies for medical and nursing personnel at the SFGH. Accordingly, the MoH and SWRHA should:**
   i. **Arrange for the timely recruitment of qualified/eligible returning scholars to fill vacant positions at the SFGH and other health facilities falling under the SWRHA;**
   ii. **Proceed urgently with the review of the nursing establishment.**

d. **A Performance Appraisal System should be applied by the SWRHA (and by extension other RHAs) and modified to address the low level of productivity by implementing a reward system. Negotiations for increased salary should be linked to productivity bargaining.**

e. **The Committee recommends that discussions be advanced regarding the feasibility of 'Centres of Excellence' within the RHA system. These discussions should take place in the context of general RHA Reform measures.**

f. **The Committee recommends that MOH expand their current partnership with United Nation Volunteers (UNV) Programme on the Health Care Initiative, to allow international and local doctors to fill vacant posts at the SFGH.** [8]

<u>Equipment Maintenance at the SFGH</u>

g. **The Committee recommends that training of staff in the proper use of equipment should be mandatory. This will contribute to reducing the rate of damage/depreciation of equipment as well as the repair time**

h. **The Committee recommends that the SWRHA explore the range of technical assistance offered by International Organisations with a view to determining whether such organisations provide technical aide in the area of equipment maintenance and repair. Should such assistance be available, the SWRHA should seek to benefit from it.**

Objective 3: To determine what are the shortcomings in the services Offered to Patients at the Hospital, the Root Causes of these Operational Shortcomings and Potential Solutions to Alleviate these Shortcomings

The Quality Standards at SFGH

3.3.1 The Committee was informed that in relation to quality standards, the Ministry adopted an evidence-based policy approach to restructure its Annual Service Agreement to be more in line with the CTAS format. The Committee was also informed that the operations of the local Health Sector adheres to international

[8] http://www.tt.undp.org/content/trinidad_tobago/en/home/operations/projects/poverty_reduction/primaryhealthcare.html

standards set by the World Health Assembly, PAHO and the Joint Commission International (an arm of the Joint Commission of the U.S.) which have been adapted; Regional Standards established by the Caribbean Cooperation in Health (CCH); and local standards.

3.3.2 The Ministry of Health is accountable for the oversight of the quality of service delivered to citizens of Trinidad and Tobago in the public health care system. The Ministry is able to influence public health care standards through the Directorates of Quality Management and Health Policy, Research and Planning. Some of the initiatives aimed at improving the standard of services at the San Fernando General Hospital are as follows:

1. **Re-introduction of the Health Sector Quality Council**. This Council provides guidance and oversight on regulating, planning and implementing health care quality throughout the RHAs. The Chief Executive Officer at the South-West Regional Health Authority is a member of the Council and provides direct oversight for the implementation of all quality initiatives. The Sub-Committees of the Quality Council are:
    a) The Clinical Governance Sub-Committee. This Committee is chaired by the Chief Medical Officer of Health and the Medical Chief of Staff of the South West Regional Health Authority is a member. One of the key objectives of the Committee is to allow for early identification and intervention, system review, and analysis of any adverse event cases.
    b) The Quality Sub-Committee. This Committee implements the Quality Improvement Programme at the RHAs. The Quality Manager of the South West Regional Health Authority is a member of the Committee charged with the key responsibility of implementing the health quality strategies and work plan of the Council.

c) The Statistics Sub-Committee. This Committee reviews the operational flow process in the collation, analyzing and reporting of health related data. In the RHAs.

2. The Directorate of Health Policy, Research and Planning to monitor and track the performance of the health care service.

Other Initiatives

3.3.3 The Client feedback system- this system provides a mechanism for management to handle complaints from internal and external clients, and in so doing improve the quality of service delivered to its clientele. It measures patients' satisfaction and is an avenue for quality improvement of the services at the SWRHA.

3.3.4 Ongoing work for the development of the Health Services Accreditation Bill to create the legal framework for the establishment of the Health Sector Accreditation Council. The purpose of this council will be to regulate, monitor, improve and maintain quality of care and to ensure that Trinidad and Tobago develops a modern and responsive health care system.

Client Feedback System

3.3.5 The Client Feedback System was developed by MOH for implementation by the RHAs. The Client Feedback System manual has been revised on several occasions the last being in 2013. This system provides a mechanism for management to handle complaints from internal and external customers, and in so doing improve the quality of services delivered to its clientele. The Client Feedback System assesses the quality of services based on 5 Dimensions of Service Quality-Reliability, Responsiveness, Empathy, Assurance, Tangibles. The table below outlines the number of complaints by the service, ranked from 1-5, with 1 representing the most number of complaints received.

Table 11

Types of Complaints

Year	Types of complaints
2012	1. Misplaced medical records 2. Postponement of surgeries 3. Staff attitude 4. Delays in obtaining medical records 5. Not satisfied with clinic appointment
2013-2014- the ranking remained unchanged	1. Staff attitude 2. Delays in accessing services 3. Dissatisfied with service 4. Misplaced medical records 5. Unavailability of medical supplies
2015	1. Waiting time for appointments 2. Misplaced medical records 3. Long wait times in ECHO and stress test to be done 4. Long wait times for surgeries
2016: as at March 30, 2016	1. Medical care 2. Safety and security of patients 3. Nursing care 4. Staff attitude 5. Ineffective communication

3.3.6 The Manager Quality Improvement is charged with overall responsibility of overseeing the Complaints Process. This process entails three levels:

I. **Level 1: Complaints are Received-**

Complaints are received by the SWRHA, acknowledged and an inquiry is conducted.

II. **Level 2: Complaints are Investigated**-

a) The Complainant is written with a full explanation/apology/action take. If the Complainant is satisfied no further action is taken.

b) If the Complainant is unsatisfied, the matter is referred to the Quality Manager who will investigate the matter.

c) The matter is usually referred to a relevant Head of Department/Manager/General Manager to discuss and determine the most suitable method of rectification.

d) The complaint is then provided with a full explanation/apology and action taken. If he/she is satisfied, no further action is taken.

III. **Level 3: Matter Referred to the MoH-** if the complainant is still unsatisfied, the matter is referred to the MoH where it is referred to the Complaints Authority. The Complainant is provided with an explanation/apology and notified of the recommendations made to the MoH.

3.3.7 All complaints forwarded to the Human Resource Department are addressed through the grievance procedure in accordance with the RHA Conduct Regulations.

Complaints at SFGH

3.3.8 Information submitted to the committee indicated that the total number of complaints received by the SFGH via the Client Feedback System for the period 2011 to May, 2016 was one thousand seven hundred and fifty-two (1, 752).

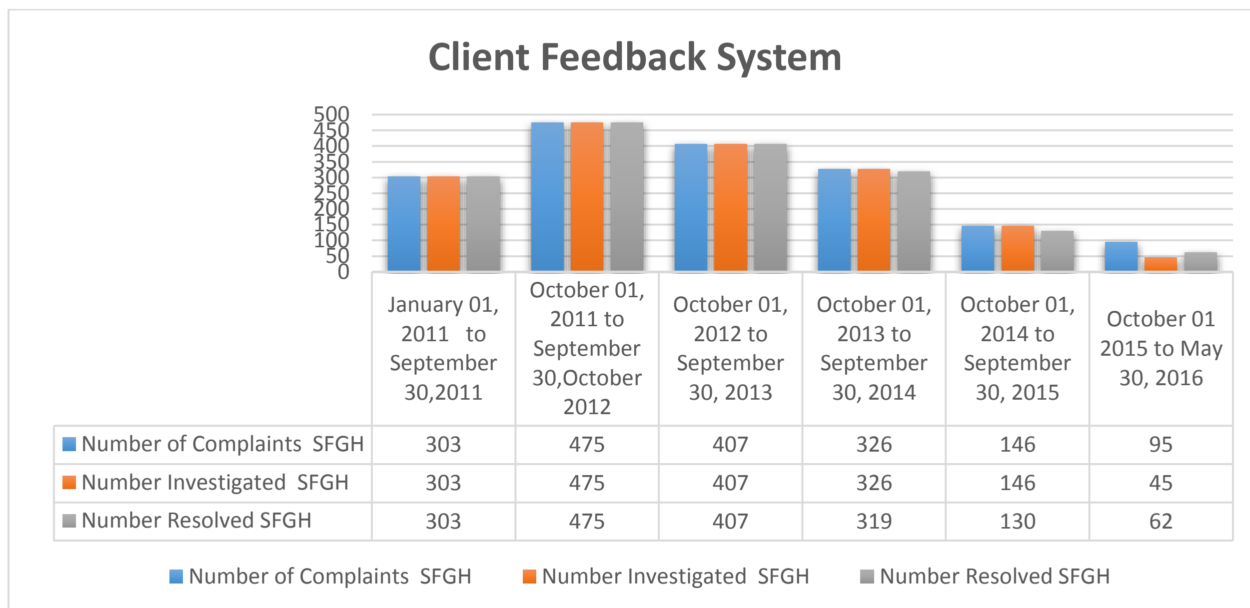
Table 12

Statistics on complaints lodged by the patients of the SFGH from 2011 to 2016

Timeframe	Number of Complaints	Number Investigated	Number Resolved
	SFGH	SFGH	SFGH
January 01, 2011 to September 30,2011	303	303	303
October 01, 2011 to September 30,October 2012	475	475	475
October 01, 2012 to September 30, 2013	407	407	407
October 01, 2013 to September 30, 2014	326	326	319
October 01, 2014 to September 30, 2015	146	146	130
October 01 2015 to May 30, 2016	95	45	62
TOTAL	**1,752**	**1,752**	**1,696**

Chart 1

Statistics on complaints lodged by the patients of the SFGH from 2011 to 2016



	January 01, 2011 to September 30,2011	October 01, 2011 to September 30,October 2012	October 01, 2012 to September 30, 2013	October 01, 2013 to September 30, 2014	October 01, 2014 to September 30, 2015	October 01 2015 to May 30, 2016
Number of Complaints SFGH	303	475	407	326	146	95
Number Investigated SFGH	303	475	407	326	146	45
Number Resolved SFGH	303	475	407	319	130	62

3.3.9 It was reported to the Committee that all complaints were investigated with a total **of one thousand six hundred and ninety-six (1,696)** being resolved.

SFGH's Emergency Department

3.3.10 The Accident and Emergency Department (A&E) at the SFGH offers a 24- hour service providing initial treatment for a broad spectrum of illnesses and injuries, which may be life threatening and require immediate attention. The A&E serves as a definitive specialist care facility, equipped and staffed to provide rapid and varied emergency care to all people with life threatening conditions. A trained nurse will assess the patient's condition upon arrival and decide on further action using the Clinical Triage Protocol.

3.3.11 The Committee was informed that in all Emergency Departments in Trinidad and Tobago, the Canadian Triage Acuity Scale (CTAS) is applied. This system outlines

standards for patient care including procedures and timeframes to be observed. In the Emergency Room there are also flowcharts on display that describe the standard that is supposed to be achieved and there are Customer Service Representatives that interface with patients to advise them of their rights and obligations.

Waiting time at the SFGH Emergency Room

3.3.12 The average time a patient is required to wait from arrival to time of Triage at the SFGH is approximately 7-15 minutes and the average time from Triage to registration is said to be approximately 15-20 minutes.The average time from arrival to assessment of care –patients are categorized based on their acuity level (there are 5 levels of acuity) and assessed by a Medical Practitioner as follow:

- **Level 1- Resuscitation Patients are seen immediately-** patients with conditions that are threats to life or limb (or imminent of deterioration) requiring immediate aggressive interventions e.g. cardiac /respiratory arrest, major trauma;
- **Level 2- Emergent Patients are seen immediately-** patients with conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts viz MI, Overdose, and CVA;
- **Level 3- Urgent Patients (average waiting time 1-2 hours)** – patients with conditions that could potentially progress to a serious problem requiring emergency intervention. It may be associated with significant discomfort or affecting one's ability to function at work or activities of living viz- moderate trauma, asthmas, GI bleed;
- **Level 4- Less Urgent Patients (average waiting time up to 3 hours)** – patients with conditions that are related to patient age, distress or potential for deterioration or complications viz- headaches, chronic back pain;
- **Level 5 - Non Urgent Patients (average waiting time up to 3 hours)** – patients with conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem viz- sore throat, mild abdominal pain.

Patients with more serious condition (level 1-2) are treated before patients with minor complaints (level 4-5)

Persons Awaiting Surgical Procedures at SFGH

3.3.13 At the SFGH there is a backlog of surgeries. The table below shows the current number of persons awaiting surgical procedures as at June, 2016.

Table 13

Persons awaiting Surgical Procedures as at June, 2016

Type of Surgery	No. of Surgical Doctors in the Department	No. of Cases
General Surgery	4	428
Orthopedics	4	262
Eyes	5	1126
Ear , Nose and Throat	3	311
Pediatric	1	182
Endoscopy	1	201
Vascular	1	6
Plastics	1	206
Urology	4	321
Gynecology	3	91
Neurosurgery	1	50

3.3.14 Due to the shortage of theatre nurses, the hospital is unable to perform elective surgeries on weekends.

High Infant Mortality

3.3.15 During the public hearing the issue of the infant mortality rate at the SFGH which increased from 25 in 2010 to 64 in 2015 was raised. The Administrators of the hospital were unable to provide specific reasons for the increase. However, it was vaguely stated that certain procedures were put in place by SFGH to ensure that there was improved maternal care at the health centres and the hospitals

under the remit of the SWRHA. The officials of the SFGH also claimed that efforts were also made to address critical issues including maternal mortality and morbidity at the hospital. Improvements were also made to the Neonatal Intensive Care Unit.

3.3.16 The Committee took note of the commencement of an Early Pregnancy Unit at the gynaecology wards where by doctors in the Field of Obstetrics and Gynaecology used the ultrasound machines to diagnose problems in early pregnancy.

Hospital Acquired Infection (HAI)

3.3.17 The Committee sought to determine to what extent Hospital Acquired Infections (HAI) were prevalent at the SFGH. The Committee was advised that there is a comprehensive infection, prevention and control management system which is applied throughout the public health care system.

3.3.18 There is a manual (Infection Prevention and Control manuals) that is implemented by a specialized team that is headed by a microbiologist and Infection Control Officers and nurses. The infection rates are monitored daily.

3.3.19 The infection Prevention and Control Unit collected data on the number of HAIs at the Adult ICU during the period 2011-2015. With the addition of an epidemiologist, the HAI is now being calculated per speciality

Table 14

Number of HAI for the Fiscal years 2011-2016 (Quarters)

Please note that information is compiled up to 3rd quarter (April-June) of 2016

Quarter	October-December	January-March	April-June	July-September	Total for Fiscal Year
Number of HAI for 2010-2011	0	2	5	3	**10**
Number of HAI for 2011-2012	1	1	2	0	**4**
Number of HAI for 2012-2013	0	5	5	7	**17**
Number of HAI for 2013-2014	3	2	1	0	**6**
Number of HAI for 2014-2015	1	2	2	6	**11**
Number of HAI for 2015-2016	14	7	7	-	**28 to date**
Grand Totals	**19**	**19**	**22**	**16**	**76**

Malpractice Registry

3.3.20 All malpractice matters are referred to the Court and are dealt with by the Legal Department. The SWRHA is planning to create a Malpractice Registry but these records will be for internal use only.

Management of Drugs

3.3.21 Following the public hearing, the Committee sought to acquire some insight regarding the consumption of drugs within the SWRHA. To this end, the committee was advised by the Ministry of Health that shortages of medicines may be caused by: international shortages; supplier issues and prohibitive costs.

There are also some drugs which must be stocked consistently in case of emergency. These include anti-venom, counter-overdose drugs and Tamiflu.

3.3.22 The PS, MoH further advised that the Ministry has a contract with the National Insurance Property Development Company Limited (NIPDEC) for the procurement, storage and management of pharmaceuticals for the RHAs/public health sector. The purchase of pharmaceuticals and non-pharmaceuticals by NIPDEC is based on the estimation of needs and the annual allocation from the Ministry of Health. NIPDEC's Tender Policies and Procedures are utilized. A more scientific approach is required to meet the needs of the public.

3.3.23 All drugs used in the public sector must be registered with the MoH's Chemistry, Food and Drugs Division and must be listed on the National Drug Formulary which is periodically updated by a National Advisory Committee (chaired by the Chief Medical Officer) and advised by a Formulary Committee. Estimated quantities for each item on the Formulary for the next fiscal year are required to be supplied by each RHA to NIPDEC before the end of March. NIPDEC aggregates the estimated needs, prepares a Tender Package and invites pre-qualified suppliers to bid for these items. After consultation with the RHAs and ratification from the MoH, NIPDEC awards contracts to successful tenders.

Expired Drugs disposed by the SWRHA

3.3.24 Information submitted to the committee indicated that the value of expired drugs disposed in 2015 at the SFGH was $39,083.00.

Findings

Standard of Care and Patients Complaints

3.3.25 The Committee found it commendable that the SWRHA and other RHAs were mandated by the Ministry of Health to adhere to the CTAS format as well as a number of other International and regional guidelines. However, while these standards exist on paper, little evidence was presented to demonstrate the measures in place to ensure that these standards are adhered to at all levels of the hospital's operations. According to statistics received, in 2014 there were 448 complaints concerning service at SFGH and in the first quarter of 2016 alone there were 198 complaints. This relatively high number of complaints suggests that there is a major disconnect between:

i. The patients' understanding of criteria used to prioritize the treatment of patients; and
ii. The written standards which are to be adhered to and the actual performance of health care professionals while on duty at the hospital.

3.3.26 While having a Patient's Bill of Rights and the Patient's Charter are laudable measures to encourage a higher standard of customer service at public health care facilities, translating policy into action require health care professionals to accept and abide by these standards in their daily activities. As such, Heads of Departments, managers and supervisors must play a significant role in assisting their staff in understanding and implementing these standards. We noted that "staff attitude" and "the misplacement of medicals" were the most frequent complaint during the period 2012-2016. No doubt these two problems can be alleviated in the short to medium-term if appropriate interventions are undertaken.

The Digitizing of Patient Records

3.3.27 The Committee sought to determine whether the SFGH has implemented a computerised system to address the issue of the loss of the medical records of patient. In this regard, the Committee was advised that two databases are used at the hospital; 'SELMA' to automate records in the Emergency Department and the Lab Information System (LIS). Even though these systems are in place the Committee recognized that patients entering the SFGH for medical care are still complaining about the misplacement of medical records.

The High Infant Mortality Rate at the SFGH

3.3.28 The Committee was dissatisfied with the inability of the officials of the SFGH to provide a more comprehensive explanation for the increase in the infant mortality rate over the period 2010 to 2015. The fact that the SWRHA has recorded the second highest rate of infant mortality amongst the RHAs over the last 4 years suggests that this is an area which requires closer attention.

Hospital Acquired Infection (HAI)

3.3.29 The evidence received in this regard confirmed that there was an increase in HAI at the SFGH during the period 2015-2016, which was also the highest occurrence of HAI during the time period of 2010-2016.

Drug consumption and Expired Drugs disposed by the SWRHA

3.3.30 The Committee also probed the issue of the shortage of drugs at SWRHA facilities. The Committee took note of the externalities which impacted the availability of pharmaceuticals at the SWRHA and other RHAs. During a public hearing held on 11th November 2016, NIPDEC confirmed that the release of funds by central government for the purchase of drugs and supplier issues were among

the main factors impacting the reliable supply of drugs in the public health system.

3.3.31 Health institutions demand a high amount of public funding to operate, therefore, given prevailing financial constraints, every area of wastage must be assessed and or eliminated. As such, every effort must be made to reduce the amount of drugs which become expired. This would require a re-examination of the quantity valuations and drug inventory processes within the RHA system.

Recommendations

Patient Complaints

a. **We recommend that the SWRHA mandate the management of the SFGH to develop effective strategies for assisting health care providers at the institution to understand and adhere to expected standards of conduct. We also expect that the administration of the SFGH would continue to sensitise members of the public about the hospital's triage system and criteria for prioritising the provision of patient care.**

b. **The Patient's Bill of Rights and Patients Charter should be displayed in prominent public spaces of all Health Care Institutions. In addition, the necessary management strategies should be applied to ensure a higher level of adherence to the principles and standards stated in these documents.**

c. **Health providers must be encouraged to exercise more care when handling patient records. A zero tolerance approach should be adopted for this and other forms of unprofessional conduct. In instances where an employee of the**

SWRHA is identified to be liable for the lost or misplacement of patients' records, this should be reflected in the employee's performance appraisal.

d. **The management of the SFGH must ensure that all persons who are required to access, update or scrutinise hospital/patient records are trained to properly operate computer programmes. Restricting the management of these records to a defined team of individuals would also assist in safeguarding the integrity of the records.**

Drug Shortage and Expired Drugs Disposed by the SWRHA

e. **The Committee recommends that particular attention be paid to estimating the quantity and type of drugs required for the SFGH as accurately as possible so as to eliminate wastage. Drugs which are redundant or under-prescribed by physicians should be removed from the requisition.**

f. **The Committee recommends that Board of the SWRHA mandate all health facilities under it purview to conduct regular monitoring of their drug inventory. This would assist in predicting potential drug shortages or overstocking. Additionally, excess drugs held by one RHA can be transfer to RHA's with a commensurate shortage of the same.**

g. **The Committee recommends that the Board of the SWRHA take into consideration implementing a Drug Inventory Management Model, for example, the open-to-buy (OTB) budget method. This method limits purchases to a specific amount of funds available for purchasing pharmaceuticals during a specified period. The emphasis of the OTB method is financial control of the pharmacy inventory. Although it is useful in monitoring and adjusting the dollar value of the inventory, it should be however combined with other methods for a total inventory control system.**

Hospital Acquired Infection (HAI)

h. **Stricter adherence to existing standards and protocols which aim to prevent HAIs must be encouraged. As was noted previously, what appears to be lacking is the implementation of rules and standards which are already well documented.**

i. **Patients also need to be sensitised about the potential dangers of HAIs and as such, posters should be placed in each ward which contain information on:**
   - **Sources/ causes of such infections;**
   - **What health care providers should do to prevent these infections; and**
   - **What patients and relatives can do to prevent these types of infections**

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

H.R. Ian Roach
Chairman

Updated March 7, 2017

Appendices

Appendix I

Minutes of the proceedings

MINUTES OF THE 8TH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS, STATUTORY AUTHORITIES (INCLUDING THE THA) HELD IN THE ANR ROBINSON ROOM (EAST), LEVEL 9, OFFICE OF THE PARLIAMENT, TOWER D, 1A WRIGHTSON ROAD, PORT OF SPAIN HELD ON WEDNESDAY 22 JUNE, 2016

PRESENT

Members

Mr. H. R. Ian Roach	Chairman
Ms. Ramona Ramdial, MP	Vice-Chairman
Mrs. Jennifer Baptiste-Primus	Member
Mr. Daniel Solomon	Member
Mr. Darryl Smith, MP	Member
Mr. Nigel De Freitas	Member
Mr. Faris Al-Rawi, MP	Member

Secretariat

Mr. Julien Ogilvie	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Mr. Desell Austin	Research Assistant

ABSENT

Mr. Stuart Young, MP	Member (Excused)

Also present were:

OFFICIALS OF THE SOUTH-WEST REGIONAL AUTHORITY (SWRHA)

Mr. Anil Gosine	Chief Executive Officer
Dr. Alexander Sinanan	Chairman
Mrs. Valerie Alleyne Rawlins	Deputy Chairman
Mrs. Gail Miller-Meade	General Manager Finance
Mrs. Debra Singh Khan	GM Human Resources
Dr. Anand Chatoorgoon	Medical Director - Secondary Care Service & Director of Health (Ag.)

OFFICIALS OF THE MINISTRY OF HEALTH

Ms. Donna Ferraz	Permanent Secretary
Dr. Akenath Misir	Chief Medical Officer
Mr. Lawrence Jaisingh	Director Health Policy Research and Planning

COMMENCEMENT

1.1 The Chairman called the meeting to order *(in camera)* at 9:35 am.

1.2 The Chairman informed Members that Mr. Young requested to be excused from the meeting.

CONSIDERATION OF THE MINUTES OF THE 7th MEETING HELD ON JUNE 03, 2016

2.1 The Chairman asked Members to examine, page by page, the Minutes of the Meeting held on Friday June 03, 2016.

2.2 There being no corrections or omissions, the Minutes were confirmed on a motion moved by Ms. Ramdial and seconded by Mr. Solomon.

MATTERS ARISING FROM THE MINUTES

3.1 The Chairman referred the Committee to Item 3.1 on page 3 of the Minutes:

- In reference to the proposed change in the Work Schedule, the Chairman advised that this matter would be discussed later in the proceedings under another agenda item.

CONSIDERATION OF THE WORK SCHEDULE

4.1 The Chairman reminded Members that during the last meeting, members present agreed to amend the Work Schedule to include an inquiry into the Strategic Services Agency (SSA) immediately following the inquiry into the SWRHA.

4.2 The Chairman advised the Committee that the Secretary took the initiative to consult the Clerk of the House (who is also Secretary to the Committee on National Security) on the proposed inquiry with a view to avoiding duplication between both Committees. In turn, the Clerk of the House referred the matter to the Speaker to determine whether such an inquiry should be conducted by this Committee or JSC on National Security.

4.3 During discussion on this matter Mr. Solomon expressed his concern with decisions of the Committee being influenced by other authorities and questioned whether this was a practice.

4.4 At the conclusion of the discussion, the Chairman surmised that he did not believe the Secretary intended to perverse or undermine the Committee's authority but rather acted out of an abundance of caution.

4.5 It was agreed that in the future scenarios of this nature, the Secretary should consult with the Chairman prior to initiating any action.

4.6 It was also agreed that the Committee will inquire into the Medical Board following its examination of the SWRHA and thereafter will examine the Strategic Services Agency, whether or not an opinion is received from the Secretariat.

PRE-HEARING DISCUSSIONS, RE: The Administration and Operations of the SWRHA in Relation to the Adequacy of Medical Staff and Equipment at the SFGH

5.1 The Chairman informed the Committee that six officials from the SWRHA and three officials from the Ministry of Health were expected to appear before the Committee. He also advised that a list comprising the names of these officials was circulated to Members.

5.2 The Chairman confirmed that members were in receipt of the Issues Paper prepared by the Secretariat based on the written submission of the SWRHA.

5.3 The Chairman inquired whether Members were in agreement with conducting a site visit to the San Fernando General Hospital further to its ongoing inquiry. Members agreed with the proposed site visit and a tentative date of July 13th was suggested.

5.4 The Chairman suggested that the Secretariat could propose a date via round-robin.

CONSIDERATION AND APPROVAL OF DRAFT REPORT ON AN INQUIRY INTO THE LAND SETTLEMENT AGENCY

6.1 The Chairman directed Members attention to the report.

6.2 It was agreed that Members will be granted seven (7) additional days to consider and comment on the report.

Suspension

7.1 There being no further business for discussion the Chairman suspended the meeting at 10:09 a.m.

PUBLIC HEARING WITH OFFICIALS OF THE SOUTH-WEST REGIONAL HEALTH AUTHORITY AND MINISTRY OF HEALTH

8.1 The Chairman reconvened the meeting *(in public)* at 10:17 a.m.

8.2 Introductions were made.

8.3 The Chairman highlighted the objectives of the inquiry for the benefit of witnesses and the public.

Discussions with the SWRHA & the Ministry of Health

9.1 The Chairman noted that the committee received written submissions from the:

- South-West Regional Health Authority (SWRHA); and the
- Ministry of Health

Opening Statements

9.2 The Chairman invited Dr. Alexander Sinanan, Chairman of the Board of the SWRHA to make a brief opening statement. Dr. Sinanan highlighted the following points:

i. the Board was appointed in January, 2016;
ii. the SWRHA is the largest Regional Health Authority in the country; and
iii. the RHA offer primary, secondary and tertiary level medical services to the to public.

9.3 The Chairman then invited the Permanent Secretary, Ministry of Health to make a brief opening statement as well. The Permanent Secretary gave an overview of the Ministry's role and responsibility in relation to the Regional Health Authority.

9.4 The following issues arose from the discussions held with the officials of the SWRHA and the Ministry of Health:

i. **The Reasons for the Reduction in the Budgetary Allocation to the SFGH**
Although the SWRHA received an increase in funding from the Ministry, monies were reallocated to improve services at the other health facilities under the ambit of the SWRHA. The monies was used to renovate and construct larger Emergency Health facilities in Princes Town, Siparia and Couva. The improved facilities would thereby reduce the number of patients that seek medical attention at SFGH.

ii. **The Impact of the San Fernando Teaching Hospital on Patient Care at SFGH**

a. The Teaching Hospital has helped reduced the overcrowding at the SFGH which has been a perennial problem. The Teaching Hospital has a capacity of 215 beds. Dr. Chatoorgoon informed the Committee that the issue of overcrowding still exists and an extra 100 beds are required to fully address the problem of overcrowding at the hospital.

b. The Committee enquired about the filling of vacant positions at the Teaching Hospital. Dr. Chatoorgoon advised that other than nurses, SWRHA was able to fill other medical positions at the hospital. He also advised Members that the hospital is well staffed at the two tiers of doctors, there are only vacancies for house officers. He also advised that the shortage of nurses is not only at the SFGH or SFTH, it is throughout Trinidad and Tobago.

iii. **The Shortage of junior doctors at the SFGH**

The Chairman sought an explanation for the vacancies in junior medical positions whilst there are a number of unemployed medical school graduates. The Chairman-SWRHA advised that those vacancies were created when non-nationals who were hired to fill the posts were promoted. Arrangements are being made to replace non-nationals employed as House Officers with locals.

iv. **The Responsibility of the Ministry of Health in relation to the SWRHA**

a. The Chairman enquired whether the PS had the necessary support at the Ministry to properly execute her obligations. The PS advised that there is another PS at the Ministry and two Deputy PSs and the work load is divided accordingly. There is also a Director of Health Policy, Research and Planning.

b. The Chairman enquired further about the PS's knowledge on the quality of health care services at the SWRHA. Ms. Ferraz informed the Committee that the following measures were adopted to assist the Ministry in monitoring the performance of the SWRHA:
- the periodical examination of financials and HR policies;
- monthly meetings involving the Minister of Health, the Chairman, Deputy Chairman and CEO of all the Regional Health Authorities;
- monitoring by the Health Policy Division; and

- the Quality Council, chaired by the PS was re-established.

v. **The Reporting Relationship between the Ministry and the Board of the SWRHA**

The PS informed the Committee that there is a reporting mechanism between the Board and the Ministry. The Board of the RHA is required to:

- provide the Ministry with a copy of the Minutes of Board Meetings within two weeks of being confirmed;
- communicate all decisions of the Board to the Minister within 72 hours; and
- additionally a weekly strategic meeting is chaired by the Minister and Board Members.

vi. **Measures that have been implemented to create a Data Driven approach to Decision-Making at the SWRHA**

The Chairman informed the Committee that a Manager of Policy Planning and Research was hired in 2012 and a Public Observatory was implemented for data to be collected and stored in one place. The data will be analysed to guide policy formulation.

vii. **The High Infant Mortality Rate at the SFGH**

a. The Committee raised the issue of the high infant mortality rate at the SFGH which increased from 25 in 2010 to 64 in 2015. The Chairman of the Committee requested information on the causes of same, however, the officials were unable to state what they were. Dr. Chatoorgoon advised that certain procedures were put in place to ensure that there was improved maternal care at the health centres and the hospitals under the remit of the SWRHA.

b. Efforts were also made to address critical issues including maternal mortality and morbidity at the hospital. Improvements were also made to the Neonatal Intensive Care Unit. It is believed that these interventions would improve the health of the babies and reduce the number of fatalities.

viii. **What accounts for the High cost of Maintenance at the SFGH?**

a. The $103 Million cited in the submission made to the Committee was the total cost over a period of approximately seven years. Other factors that contributed to the

substantive figure were: the shortfall in the budgetary allocation has forced the SWRHA to repair equipment rather than purchase; the long timeframe for repairs to be done on the equipment; and the difficulty to source replacement parts for outdated equipment.

b. The Committee enquired whether there was a Maintenance Programme at the SFGH. In response, Dr. Gosine advised that there is a Biomedical Engineering Department that is responsible for repairs to smaller pieces of equipment. The Larger equipment is purchased with an extended warranty or extended maintenance. Although this is paid for, the local service providers have to be constantly reminded that the equipment has to be fixed which further lengthens the amount of time taken for the equipment to return to operation.

c. The long periods without functional medical equipment affects the number of surgeries that can be done at the SFGH. The SWRHA has to incur an additional cost for the surgery to be done at a private medical institution.

ix. **The Impact of the Cost of Construction of the SFTH on the SFGH**

The Committee enquired whether the construction of the SFTH has diverted funding from the SFGH which has negatively affected its operations. The Chairman-SWRHA stated that 80% of the budgetary allocation to the SWRHA is spent on personnel emoluments and 12% to 14% on supplies and other items.

x. **The Use of the SFTH by the University of West Indies**

In July 2015, the Ministry of Health, through the SWRHA allocated two Floors in the Teaching Hospital to UWI. A Memorandum of Understanding is currently being drawn up between UWI and the SWRHA, however to date the Floors remain unoccupied. Dr. Alexander advised the Committee that the University would have to provide an explanation for its delay in occupying the space.

xi. **The Impact of the shortage of Human Resources at the SFGH**

a. The Committee sought to determine the main factor that impedes the SWRHA from providing efficient and quality health care to the public. Dr. Gosine indicated that the main factor that impacts the standard of care provided was the lack of human resources. He indicated that there are 10 Operating Theatres at the SFGH, but due to the shortage of nurses, especially theatre nurses, it was difficult to perform the desired number of procedures.

b. When probed on plans to address the staff shortages at the SFGH, Dr. Gosine advised that the SWRHA was working with the Ministry to address the staffing issues. The PS, Ministry of Health further advised that currently the Ministry is reviewing its 10 Year Human Resource Manpower Plan for the Health Sector. The review exercise should be completed by the end of the first quarter of 2017. The Plan would involve the standardization of certain positions throughout the RHAs and based on the specialized service offered by a particular RHA, overseas recruitment would be conducted.

c. The Ministry of Health's Plan involves the recruitment of students from Tertiary Level institutions such as COSTATT and UWI. The Ministry has also entered into agreements with international bodies such as the People's Republic of China.

d. Other options being explored to boost the human resource capacity within the SWRHA include partnering with foreign universities to establish a specialist training programme whereby foreign medical professionals can come to Trinidad to train local doctors in a particular field. Another method to address the shortages would be to create 'Centres of Excellence' in different regional hospitals. In this regard, each hospital will specialize in a specific service as opposed to every hospital attempting to offer the same specialised services.

xii. **What is the Expected Standard of Care a Person should receive at any Health Institution?**

a. The Permanent Secretary advised the Committee that she was unable to state the exact standards the RHAs are currently using. However, Ms. Ferraz advised that in 2015, 18 International accredited health standards under the Accreditation Canada International (ACI) were implemented in all RHAs. ACI Training was provided to approximately 2, 000 persons in governance, management, clinical and operational services.

b. The Chief Medical Officer informed the Committee that in all Emergency Departments, the Canadian Triage Acuity Scale (CTAS) is applied. This system outlines standards for patient care including procedures and timeframes to be observed. The Chairman enquired whether these guidelines were made available to the public. In reply, the CMO advised that it was not marketed on social media but the information is at the back of each patient's file. In the Emergency Room there are also flowcharts on display that describe the standard that is supposed to be achieved and there are Customer Service Representatives that interface with patients to advise them of their rights and obligations.

c. Mr. Jaisingh informed the Committee that in relation to quality standards, the Ministry adopted an evidence-based policy approach to restructure it's Annual Service Agreement to be more in line with the CTAS format. The Committee was also informed that in Trinidad and Tobago our Health sector adheres to international standards set by the World Health Assembly, PAHO and the Joint Commission International (an arm of the Joint Commission of the U.S.) which have been adapted; Regional Standards established by the Caribbean Cooperation in Health (CCH); and local standards.

d. Dr. Chatoorgoon in his response claimed that patients who seek medical attention at the SFGH and throughout southern Trinidad receive the best health care because the RHA adheres to international best practices and are 'customer obsessed' meaning the patient's needs are a priority.

xiii. **The International Benchmark for Health Care**

a. The Deputy Chairman responded to a question from the Committee on the country that is considered to be the international benchmark, she indicated that it was Denmark and in the western hemisphere, Canada. Cuba was recognized as one of the best in the world in relation to primary health care.

b. The Committee also sought to determine which country was at the same level in terms of health care as T&T but have made advancements over the last few years, Mrs. Rawlins suggested South Africa.

xiv. **The Bilateral Arrangement between China and Trinidad and Tobago**

a. The bilateral arrangement between China and T&T involved a team of specialist surgeons from China being stationed in Trinidad for two years to assist with surgical operations. However due to the shortage of theatre nurses the hospital is unable to perform elective surgeries on weekends. The Chairman of the Board indicated that he was able to arrange staff to work on weekends to do critical operations.

b. The Committee questioned what was being done to address the backlog of surgeries and the mechanisms used by the Board to better manage the hospital. The Deputy Chairman advised that the Quality Management Committee of the Board has evaluated the bilateral arrangement with the Chinese and it was determined that systems must be implemented to maximize the benefits of having a team of foreign experts at the hospital. One aspect of this approach would be to assign a dedicated team of local doctors and nurses to work with the foreign team so that knowledge and skills transfer can occur.

xv. **The digitizing of Patient Records**

The Committee sought to determine whether the SFGH has implemented a computerised system to address the issue of the loss of patient records. In this regard, the Committee was advised that two databases are used at the hospital; SELMA to automate records in the Emergency Department and the Lab Information System (LIS).

xvi. **The Issue of the Shortage of Drugs at the Health Facility**

a. The Committee enquired about the authority's strategy for managing the shortage of drugs at the SFGH. Dr. Gosine advised that the shortage is not only at SWRHA but throughout the country. At the SWRHA they have to purchase drugs for certain critical surgeries but the drugs are usually sourced through the Ministry.

b. The PS, MoH indicated that the Ministry has a contract with NIPDEC for the procurement, storage and management of pharmaceuticals for the RHAs/public health sector. There is also an issue with the timely release of funds by the State

to purchase these drugs but discussions are ongoing with the Ministry of Finance to resolve this critical issue.

c. The CMO was asked to share his views on this matter. In response, he informed the Committee that the initiatives were developed to address these issues including standardised protocols for different illnesses / ailments and a rationalization of the vital, essential and necessary drugs list in order to reduce the number of drugs on the list which is currently 300 items.

xvii. Hospital Acquired Infections (HAI)

With respect to the rate/level of HAI at SFGH, the Deputy Chairman, SWRHA submitted that there is a comprehensive infection, prevention and control management system in the entire health sector. There is also a manual that is implemented by a specialized team that is headed by a microbiologist and Infection Control Officers and nurses. The infection rates are monitored daily but the officials were unable to provide this information and agreed to submit it in writing.

xix A Malpractice Registry

The Committee enquired whether the SWRHA had a registry with a list of doctors who have been sued for malpractice which was readily available to the public. Dr. Gosine informed the Committee that all malpractice matters that are referred to Court are dealt with the Legal Department. He also indicated that the Authority is moving towards the implementation of a Registry but not a public database. The Medical Board of Trinidad and Tobago is responsible for granting licenses to doctors, both local and foreign; and any disciplinary issues are referred to the Medical Council. Although licences to practice medicine are issued by the MBTT, each RHA is responsible for the hiring of medical officers.

xx The Impact of Non-nationals Accessing Free Health Care in Trinidad and Tobago

a. The Committee questioned whether non-nationals can receive free health care at public health institutions. The Chairman, SWRHA informed the Committee that once a person has an Emergency case he or she cannot be refused treatment.

However, with the new programme SELMA, national identification is required and if you are unable to produce it you will not be served.

b. The SWRHA has begun to curb the access of non-nationals to oncology facilities and drugs because they are very expensive. The CMO also suggested that a policy on the service offered to non-nationals is required to guide medical officers.

9.5 The Chairman invited the PS of the Ministry of Health and the Chairman of the SWRHA to make closing remarks.

9.6 The Chairman thanked the officials of the SWRHA and the Ministry of Health for their contributions and attendance.

REQUESTED INFORMATION

10.1 Based on the Committee's deliberations, the Ministry of Health was requested to provide the following additional information:

i. In respect of each Regional Health Authority, please confirm what is the estimated cost of the drugs in storage that have expired?

ii. How much money was allocated to NIPDEC to replenish/replace expired drugs over the past three (3) years?

iii. Is the rate of consumption or demand for each drug listed on the formulary monitored? If so, which categories of drugs (by illness/condition treated) are among the highest consumed and which drugs are among the lowest consumed?

iv. What measures will the Ministry of Health be implementing to reduce the significant cost of fulfilling the national formulary?

10.2 The SWRHA was asked to provide the following additional information:

i. With regard to the number of complaints received through the Client Feedback System at the SFGH, provide the:

a. total number of complaints received from January , 2011 to May, 2016;
b. the number of complaints that were investigated; and
c. the number of complaints that were resolved.

ii. With respect to the number of persons awaiting surgical procedures at the San Fernando General Hospital, please indicate:

a. the number of patients awaiting surgery in each department/specialty; and
b. the average waiting time patients in each department would normally endure.

iii. What is the Hospital Acquired Infection (HAI) rate at the SFGH?

iv. What was the estimated value of expired drugs disposed by the SWRHA during the period 2013-2015?

v. Provide a copy of the following health care policy documents that the SFGH adheres to:

a. standards/guidelines associated with the Canadian Triage Acuity Scale (CTAS), Accreditation Canadian International (ACI) and the World Health Organisation (WHO);
b. regional standards/guidelines of the Caribbean Cooperation in Health (CCH); and
c. standards/guidelines issued or developed locally.

ADJOURNMENT

11.1 The Chairman thanked all present and adjourned the meeting.

11.2 The meeting was adjourned at 12:24p.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

July 27, 2016

Appendix II

Verbatim Notes

EXTRACT OF VERBATIM NOTES OF THE 8TH MEETING OF THE JOINT SELECT COMMITTEE APPOINTED TO INQUIRE INTO AND REPORT ON LOCAL AUTHORITIES, SERVICE COMMISSIONS STATUTORY AUTHORITIES (INCLUDING THE THA), HELD AT THE INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, JUNE 22, 2016

10.17 a.m.: *Meeting resumed.*

SOUTH WEST REGIONAL HEALTH AUTHORITY

Mr. Anil Gosine	Chief Executive Officer
Dr. Alexander Sinanan	Chairman Board of Directors
Mrs. Valerie Alleyne Rawlins	Deputy Chairman Board of Directors
Mrs. Gail Miller-Meade	General Manager Finance
Mrs. Debra Singh Khan	GM Human Resources
Dr. Anand Chatoorgoon	Medical Director Secondary Care Service. Director of Health (Ag)
Ms. Donna Ferraz	Permanent Secretary
Dr. Akenath Misir	Chief Medical Officer
Mr. Lawrence Jaisingh	Director Health Policy Research and Planning

Mr. Chairman: Good morning, ladies and gentlemen. I would like to welcome you to this the first public hearing on the Joint Select Committee on Local Authorities, Service Commissions and Statutory Authorities (Including the Tobago House of Assembly) on the administration and operation of the South West Regional Health

Authority in relation to the adequacy of human resources and equipment at the San Fernando General Hospital. I would like to introduce myself. My name is Ian Roach and I would ask the other members to introduce themselves starting from my right.

[*Introductions made*]

Mr. Chairman: Thank you very much. I would like to welcome the members of the South West Regional Health Authority and the Ministry of Health. I would ask you all to introduce yourselves as well to the committee.

[*Introductions made*]

Mr. Chairman: Thank you very much, ladies and gentlemen. The objective of this enquiry, just to reiterate, is to evaluate the effectiveness of the SWRHA in executing its mandate in relation to the San Fernando General Hospital to determine whether the human resources and equipment at the San Fernando General Hospital are sufficient for allowing it to operate efficiently and, thirdly, to determine what are the shortcomings in the services offered to patients at the hospital, the root causes of these operational shortcomings and potential solutions for alleviating these shortcomings.

Submissions were received from the SWRHA on the 16th of June, for which we are very grateful. We also received submissions from the Ministry of Health on June 17th, and again we are also very grateful for this. I will invite the chairman, Mr. Sinanan, to make a brief opening statement to the Committee. You may.

10.20a.m.

Dr. Sinanan: Good morning. Thank you for having us here today. As part of our mandate, as the chairman of the board of the South-West Regional Health Authority we assumed our instruments in—we received our instruments in January of 2016. Since then we have been basically meeting and trying get to grips with the operations of the south-west region. As will be discussed, you know, we have frequent statutory

board meetings, below which we have various subcommittees which are set up to oversee the operations of the running of the hospital. The South-West Regional Health Authority, in addition to the San Fernando General Hospital, also oversees the San Fernando Teaching Hospital, but I believe this mandate here today is really concerning the San Fernando General Hospital.

As you will go on to hear, you know, we have a wide gamut—we offer a wide gamut of services to approximately half of the population of Trinidad and Tobago, and the geographic area that we cover also extends to roughly 50 per cent of the area of Trinidad. I think, you know, basically we are the largest regional health authority in the country, and as we will discuss we offer—our services expand the full gamut of medical services, both from a primary care and secondary care to tertiary level medical services.

Mr. Chairman: Thank you very much. I will like to invite Ms. Donna Ferraz, Permanent Secretary, Ministry of Health, to make an opening statement as well.

Ms. Ferraz: Thank you, Chair, and good morning again to all. The Ministry of Health is responsible for the management of the public health system in Trinidad and Tobago, and we undertake this mandate by providing leadership and direction for the sector, focusing on policymaking, monitoring and evaluation, regulation of the sector, and delivery. Delivery of personal health services is done through the regional health authority system, and you would be aware that they would have been set up by an Act of Parliament in 1994. This was for the decentralization and the management of the delivery of those services.

The RHAs are contracted; for RHAs in Trinidad by the Ministry of Health and the RHA in Tobago by the Tobago House of Assembly. They are contracted through the annual service agreements and purchasing service intentions agreements. These agreements are underpinned by the public health policies and the

strategic objectives of the Ministry of Health, and are monitored by the Ministry of Health for effectiveness and adherence to prevailing standards and guidelines. The RHA is the partner with the Ministry of Health in the provision of services to the public of Trinidad and Tobago. Thank you.

Mr. Chairman: Thank you very much, Ms.Ferraz. I have been told that you have been before Joint Select Committees about the fourth time for the year.

Ms. Ferraz: Four times in the last five weeks, Chair.

Mr. Chairman: Wow, so you are a veteran, I dare say. [*Laughter*] Well, thank you very much.

Ms. Ferraz: We will see. Thank you.

Mr. Chairman: For those who are not familiar with the procedure, members from this side of the Committee would ask you questions through the Chair, you are expected in your response to put on your mikes when answering in order to be recorded. This is being televised, not live at this point in time but for subsequent telecasting on a later time since there is another Joint Select Committee which is being simultaneously in session at this point in time. So quite a bit of work is being undertaken by the Joint Select Committees in this Eleventh Parliament. Mr.Smith would like to ask the first question. Mr. Smith.

Mr. Smith: Thank you, Chairman, and again welcome to everyone here this morning, through you, Mr. Chair. Thank you for a very, very, very in-depth submission. Let me get straight into it. When we went through the submission we saw that your budgetary allocation for the SWRHA increased over the period 2010 to '16. We saw an increase of 8 per cent over that period, but yet, however, the San Fernando General Hospital had a decrease of 6.5. It is a two-point question,Chairman; what accounted for those increase in allocations for the SWRHA? But more so, what was the factors that contributed to the reduction of the

San Fernando General Hospital's allocation?

Mr. Gosine: Good morning, Anil Gosine. The allocation increased in the last five years. Yes, while the allocation was increasing it does not necessarily mean that we would have increased services. It is just that what was budgeted to us would have been less than what we really require for the South-West Regional Health Authority. What also is that we increase our services out in the community. We have what we call three district health facilities which are at Princes Town, Siparia, Couva, and what you found there is that we have 24 hours emergency services. What you would have found is that some of the patients that would have been coming directly to the San Fernando General Hospital would have now been going to the district health facilities. So you would find reallocation of funding to the district health facilities. We also increased and we built some of our health centres and that is where we have quite a lot of patients going to the larger health centres. That is the reason why you had a shift in budgetary allocation.

Mr. Chairman: Thank you. Miss Ramdial.

Miss Ramdial: Good morning, again, everyone, and this of course is to the Medical Director, Dr. Chatoorgoon, good morning. Can you tell me, or us, how has the new Sando Teaching Hospital impacted on patient care?

Dr. Chatoorgoon: Thank you, Ma'am, you mean the San Fernando Teaching Hospital?

Miss Ramdial: Yes.

Dr. Chatoorgoon: The San Fernando Teaching Hospital brought with it 216 beds, and that made a great difference to us when it came to this problem of overcrowding at the San Fernando General Hospital which has been a problem that has plagued us for many, many years. So with the coming on stream of the Teaching Hospital it brought with it those extra beds and, therefore, made a great difference to the

overcrowding situation. It is not that the overcrowding situation still does not exist, but it certainly does not exist to the same degree as it did before. And, therefore, the Teaching Hospital brought that help to us by giving us the extra beds and alleviating the situation of overcrowding at the San Fernando General Hospital.

Miss Ramdial: Just a follow-up question, since we understand that the overcrowding issue has not be solved in total, how many extra beds, in terms of number of beds, would be needed to really deal with that overcrowding situation?

Dr. Chatoorgoon: Well, I think, Ma'am, if you gave us the Couva Hospital that would be—[*Laughter*]—that would certainly relieve our situation of overcrowding. I would say, to be honest with you, Ma'am, that perhaps another extra 100 beds would go a long way to helping us address the situation of overcrowding, which still does exist, but, as I said before, it is a lot better. Yes, maybe about 100 extra beds would certainly make a difference.

Miss Ramdial: So you do agree that we should open the Couva Children's Hospital soon?

Dr. Chatoorgoon: Oh, I would love to have the Couva Hospital. I would love to—

Miss Ramdial: Thank you.

Dr. Chatoorgoon:—all other things being equal.

Mr. Chairman: Mrs. Primus.

Mrs. Baptiste-Primus: Chairman, thank you very much, and good morning to the personnel from the South-West RHA and Ministry of Health. I just want to follow up that line of questioning to Dr.Chatoorgoon; it is good to see you. With regard to the Teaching Hospital that is under reference, what about the staffing needs?—because it is all well and good to say open this hospital and open that hospital. The current hospitals in this country have been severely understaffed over the years, so how did you all deal with the staffing for the San Fernando Teaching Hospital? And

since you would love the Couva Hospital to be opened where will the staff come from, from your vast experience?

Dr. Chatoorgoon: Thank you, Ma'am, it is good to see you again. It has been a long time. The staffing for the San Fernando Teaching Hospital, we did have the staffing—we do have the staffing for the San Fernando Teaching Hospital. It is true to say that we are short of nurses. We have been short of nurses for quite some time, but notwithstanding the shortage of nurses we did make the opening of the Teaching Hospital a reality with the current nursing situation. So that is—again to background, yes, I agree with you, there is a shortage of nurses and we do need to have more nurses and we would like to have more, but the San Fernando Teaching Hospital is running at the moment, and we do have nurses to look after the patients there.

With respect to your question about the Couva Hospital, yes, that is also true. Naturally, since we are already short of nurses at the San Fernando General Hospital, and we are, if the Couva Hospital were to be open, yes, you would need more nurses there, but we did have a plan for that with respect to moving certain specialties from the San Fernando General Hospital with the nursing staff. So that say, for example, the paediatric wards which have their own nursing staff, own doctors and patients, we could have moved that en masse, as a block, to the Couva Hospital, and thereby not necessitating any need for any more nurses for that particular specialty.

Mrs. Baptiste-Primus: Mr. Chairman, permit me. What about medical doctors? We know the shortage of nursing personnel does not apply to only San Fernando Hospital, it is a national issue, it has been for many, many years. We both know I have been intimately involved with those issues, but in terms of the medical aspect, with the medical doctors, I know we have been—the collaboration with Cuba, has the issue of the shortage of medical officers been resolved at the San Fernando Hospital?

Dr. Chatoorgoon: No. We are pretty well-staffed at the level of consultants, specialists. There are three tiers of doctors, consultants, registrars and house officers. We are really short more at the house officer level, but we have a pretty good cadre of consultants and registrars. So the shortage of doctors is not really across the board at all levels it is really at the level of house officers.

Mr. Chairman: Dr.Chatoorgoon, if I could just piggyback on that as well, you said that the shortages exist at the higher tier, right, or the lower tier?

Dr. Chatoorgoon: Lower tier.

Mr. Chairman: Which are doctors who are now coming out?

Dr. Chatoorgoon: Yes.

Mr. Chairman: But it is my understanding that there are quite a number, a large number of doctors, probably who recently qualified within the last seven months or so, and they are unemployed, and they are significant, what accounts for that then? I mean, this is a significant investment in the human resource by our Government, so why would you all have such large number of persons unemployed?

Mr. Gosine: Sorry, if I could answer it instead of Dr. Chatoorgoon because I deal with the human resources.

Mr. Chairman: Sure.

Mr. Gosine: We do have a lot of interns coming out now at the lower level. If you were to look through our charts though, they are at the higher level, at the SMO and registrar level, which is the higher level above. It goes from house officer, registrar, specialist medical officers. We do have a shortage of specialist medical officers and registrars in this country. If you look at the chart here, what you asked for, the non-national, you would have seen most of them would have been at the house officer, the lower level. We are in the process now of not taking non-nationals again because there are a lot of house officers that are coming out now of the university that we

can supply to the country.

Mr. Chairman: So how are you going to deal with that? How are they going to be phased out?—at the end of their contracts? You are going to terminate their contracts?

Mr. Gosine: Yeah. What we have done recently is that we have notified them and we have given them an extra six months so that they can phase out. A lot of them would have been settling here, their children would have been in school, but these are non-nationals. The longer serving non-nationals would have then gotten their residency so they would have been okay. So they are now being told, within six months you need to leave because we need to make sure that our nationals are given the house officer jobs. At the higher level, at the registrar and specialist medical officers, they are okay because we have a shortage in those areas.

Mr. Chairman: A question for Ms. Ferraz, Permanent Secretary. The San Fernando Regional Health Authority, I am seeing has 39 health institutions which it oversees, right. It probably oversees almost half the population of Trinidad and Tobago. You have a significant number, you have the hospitals, you have a number of health institutions and district hospitals, and so forth; that is quite a large portfolio for one Permanent Sec to deal with in the Ministry of Health. Is it that you will say that you require—the Ministry of Health should have at least two or three other Permanent Secs to assist in this significant remit that you are undertaking?

Ms. Ferraz: Chair, you will be pleased to know that we do have a second Permanent Secretary in the Ministry of Health. And, as well, we have, while understaffed, a very competent directorate for health policy, Research and Planning Division. What we are also seeking to do at this time is to review our staff and the staffing structure for the Monitoring and Evaluation Unit of the health policy directorate, because that is where the main body of work for monitoring the work of the RHAs under the

service agreements where that work takes place. So we are trying to build out that aspect of our structure for monitoring and evaluation, but, as I assured you, currently we have two permanent secretaries.

Mr. Chairman: So, in other words, you are not overburdened with your portfolio?

Ms. Ferraz: Well, maybe the four times in the last five weeks has caused a bit of pressure, but I would like to say that I highly commend the support of the staff and the teams. The Ministry also has two Deputy Permanent Secretaries, and we have tried to assign the workload so that everybody carries a fair part of it. Additionally, we work very cross-functionally so that allows for optimization of resources.

Mr. Chairman: Now how intimately connected you are with the RHAs? I mean, today, before us is the South-West Regional Health Authority, in terms of the product that is being between the delivery of service and the quality of service, how intimately involved you are at the end product? I know you make policies, you inform policies, but the actual delivery and the quality of delivery, how connected you all are with that?

Ms. Ferraz: The Ministry has recently re-established—I will go through a number of mechanisms that we have. So we have the—we do the monitoring in terms of the financials, in terms of the HR policies, and so, through reports that come in periodically, whether monthly or quarterly, those are established. We have also started under the chairmanship of the Minister of Health meeting once a month with all the RHAs, the chairs, the deputy chair, and the CEOs. That is, as I said, monthly. As well, we have the regular monitoring by the Health Policy Division.

We have also re-established the quality council within the Ministry. That is chaired by the Permanent Secretary, and that, I think, is the mechanism that would give life to what you are asking for. How do we really have that close touch with the actual quality? Under the quality council we have established three subcommittees,

one would be the adverse events governance committee, the quality managers forum is another; the health policy research and planning subcommittee is another. The committee has met once, thus far, and the subcommittees are currently rolling out their—producing—sorry—developing their terms of reference and their work plans, and then we will develop an overall work plan for the quality council. But his is where I think closes touch will be.

Mr. Chairman: Mrs. Primus, you would like to ask a question.

Mrs. Baptiste-Primus: Thank you, Mr.Chair. Madam PS, good morning, good to see you too. The document that we have informs us that the Ministry of Health has a representative board member on each RHA to provide oversight, to ensure accountability, and to monitor that the strategic priorities are being implemented. I simple would like to be advised, Madam Permanent Secretary, what is the reporting mechanism between that board member and the Ministry of Health? Or perhaps I should ask, is there a reporting mechanism?—because if a person sits on the board representing the Ministry I would imagine that that person will have to report to the Ministry and be given some kind of directive. We would need some assistance in this regard.

Ms. Ferraz: I will advise that the board minutes are required to be presented to the Ministry within two weeks of they having been confirmed. Additionally, all decisions of the board are required to be presented to the Minister within 72 hours of those decisions being taken at board meetings. In response to your specific question, the Ministry hosts, under the chairmanship of the Minister, a strategic committee meeting once a week. That would be one mechanism through which policies, as well as implementation of policies, would be discussed and the board members who may not be in attendance of that at that meeting we would be in constant touch with those members.

Mrs. Baptiste-Primus: Thank you very much. Mr.Chairman, as I am on my verbal feet I will go into the other questions, and this is directed to perhaps either the Chairman or the CEO. The submissions that you all made clearly states that more data analysis is required to inform decision-making, because we all known that, essentially, this is at the heart of good governance. The question I would like to ask, what measures have been implemented to create a more data-driven approach to decision-making at the South-West RHA?

Mr. Gosine: I will take that question. In 2012 we started. We got a General Manager, Policy Planning and Research. Coming with that afterwards we implemented what we call a public observatory where we will have epidemiologists working there. They are collecting data, not only at San Fernando General Hospital but all over the region. So this is where we can look at areas where we do have problems, where we do have different diseases, non-communicable diseases; we are picking up the data, tabulating it so we are now making more informed decisions, based on having the public observatory in the Policy Planning and Research Department.

Miss Ramdial: In 2011 certain district health facilities were opened for 24 hours, a 24-hour period, I make reference to the Couva District Health Facility, the Siparia Health Facility, is this still ongoing?

Mr. Gosine: All district health facilities open 24 hours.

Miss Ramdial: Okay.

Mr. Gosine: They have what we call an Emergency Department, and ever since its inception those emergency departments are open 24 hours, and they will always continue.

Miss Ramdial: Thank you.

Mr. Chairman: Mr. De. Freitas.

Mr. De. Freitas: Good morning, again, members. My question is, in your

submission you indicated that the San Fernando General Hospital has a client feedback system responsible for receiving, recording and investigating client complaints; I have three questions, the first is, in relation to client complaints received over the last, or the past four years, how many complaints were investigated and resolved? That is the first one. Are reports prepared on the action taken based on reports made by internal and external clients and stakeholders? And the last question is, if so, how many reports were prepared by the manager, quality improvement?

Mr. Gosine: That data I can find out for you, but I will tell you it is a high percentage that has been resolved over the last four years. You would have seen the process flow where it would escalate to the Ministry, and I do not think there are many that get to the Ministry, so we tend to solve them. In most cases if they are not solved and then go through the Ministry we would then have litigation, and we did not have much as a percentage. In fact, last night I was checking the data that was submitted to you all and when we consider at the San Fernando General Hospital you have over 300,000 visits going through that hospital on a yearly basis, the complaints are less than 1 per cent. But that data that you did ask for we will submit it to you.

Mr. Chairman: All the questions were answered? All the questions were answered, Mr. De. Freitas?

Mr. De. Freitas: All questions answered, thank you.

Mr. Chairman: Okay, just now, Mr. Al-Rawi. San Fernando General Hospital is said to have the highest rate of mortality, infant mortality. It went from 25 in 2010 to 64 in 2015, that is quite an alarming figure, do you agree? Anybody.

Dr. Chatoorgoon: Yes, Sir.

Mr. Chairman: It is. What accounts for that? Or what accounted for that high level or increase, as opposed to a decrease?

Dr. Chatoorgoon: I have to be honest with you, Sir, I am not quite so sure exactly all the reasons that brought that about. What I can tell you is that we have implemented certain—we have put procedures in place to ensure that there is better maternal care because the business with children starts from looking after the mother, and ensuring that there are good services for the mother. So what we have done is to put systems in place to ensure that there is better maternal care starting from the health centres and also at the hospital. And we think that should certainly make a difference with the quality of babies that we see. Also, with respect to the Neonatal Intensive Care Unit, and so on, we have got a Neonatal Intensive Care Unit. We have staffed it better with more neonatologists, and we are hoping that these measures, it should get better.

Mr. Chairman: Mr. Al-Rawi.

Mr. Al-Rawi: Thank you, Mr.Chairman, and may I say a warm welcome to the members of the San Fernando General Hospital team, the Ministry of Health, all of whom I have had the pleasure of working with, in particular in San Fernando West. Mr.Chairman, if you would permit me just two opening remarks. I wish to pay an open compliment to San Fernando General Hospital. It is the largest hospital in the Caribbean in terms of the patient flow management that there is in Trinidad and Tobago. Perhaps Dr. Chatoorgoon may reflect upon in relation to the infant mortality rate, the fact that there was a re-pegging of infant mortality over time, as explained, and the mortality rate may be a little bit skewed as a result of the manner in which it is calculated. Just putting that on the record from a litigation perspective, as I understand.

If I could dive to the questions, I wish to thank you for your responses in relation to the enquiries of the Committee. I am interested, in particular, with the fact that the San Fernando General Hospital property plant equipment, maintenance,

medical equipment repairs, maintenance equipment purchased, 2015/2016, equipment requests, there is an estimated sum of $103,962,847 to put San Fernando General, from your information, to where it ought to be. That is on the back of San Fernando General Hospital, 2012, 2013, 2014, spending in terms of maintenance, $5.1 million, $9.4 million, $8.2 million, an increase in costs. My question to you, in the background of a request for $103 million for which there is no stated funding, an average increase maintenance cost of rounding it upwards to $10 million per year, how has all of this been managed in the context of what is referred to as a teaching hospital which has been provided to the San Fernando General Hospital? Secondly, if you could also explain to us exactly what is meant for the population by a teaching hospital? Is there a teaching hospital there? What is being taught? What is the patient ratio at that teaching hospital? And how has that provision of a teaching hospital allowed San Fernando General to improve its condition?

Mr. Gosine: Okay, MP, first of all I will dwell into the maintenance cost increasing. At the San Fernando General Hospital because of the amount of patients that is turned over there you will find that we have a lot of use of equipment. You would realize this $103 million would have gone back to about five, six, seven years where we were always short of equipment, and as we started to purchase equipment you would have found that the maintenance would have increased. What we are finding now is that because in the last two to three years, if you look back at the budget, there has been quite a shortfall in the budget for the last two to three years, because of that we could not purchase new equipment so that we increased our maintenance cost.

What we have to take into consideration though is that with equipment, apart from its useful life, manufacturers would only have certain models for a certain period of time and then after when it goes off at the market you would not get parts.

So we are in the process now of looking again of purchasing equipment. We have been going to the Ministry for funding. In fact, I will give you an example, we have a lithotripter which is the only one in the public system that shatters stones in the kidney, and it is being used nationally, but that has been on and off for quite a while. But the purchase of that equipment alone is $6 million; it is the capital. If we can get the capital to replace it we will do it. In the meantime we keep slowly fixing these machines.

The other thing with equipment, medical equipment in is this country, because we are a small country there are only a few persons who supply medical equipment, and you have to wait for them to come and fix your equipment. They handle all the equipment in Trinidad. Because Trinidad is a small place it takes a while sometimes for these vendors to bring in parts, so our equipment is down. So, yes, as we get back to it we need to purchase equipment. We have a lot of large equipment at end of life. The second part of it, I will ask Dr. Chatoorgoon to speak on the Teaching Hospital, on the part about the teaching and Teaching Hospital.

Dr. Chatoorgoon: Good morning, Sir. Yes, you are right, Teaching Hospital, the San Fernando General Hospital was opened in 1955. The truth be told, the hospital has always been a Teaching Hospital. Teaching has always taken place at the San Fernando General Hospital, and, therefore, calling the new structure a Teaching Hospital is perhaps not truly reflective of the fact that teaching really has always existed. It is true to say that there is no more teaching at the designated San Fernando Teaching Hospital than there has been really throughout the years. Teaching has always existed at the San Fernando General Hospital. I hope that answers your question.

Mr. Al-Rawi: Thank you. Just the one remaining question on the table is, how has that Teaching Hospital impacted positively upon your end-of-life situation? I mean,

I have just heard five to seven years of underfunding. I have just heard $103 million required to deal with critical replacement. I understand, if you take it on a cost-per-bed ratio, that the San Fernando Teaching Hospital costs approximately—I think it was close to $20 million a bed when you divide the number of beds over the overall structure. That is the highest cost per bed in the system in the Caribbean. So what I am trying to understand, has that provision of several hundred millions of dollars, if not a billion dollars, of plant and equipment in that Teaching Hospital, how has that impacted upon your need for $103 million to save lives?

Mr. Gosine: While we talk about the budgetary requirements you would find that in the health sector, and at San Fernando on the south-west you would find about 86 per cent of the budget goes into salaries and remuneration, and just about 12 to 14 per cent on supplies and items, and that is the problem in the health sector. You have a high percentage on personnel emoluments.

Mr. Chairman: Ms. Ferraz, you wanted to say something?

Ms. Ferraz: Thank you, Chair, but it was in relation to the previous question about maternal care, and I would invite Dr.Misir, our CMO, to add to the comment.

Mr. Chairman: Sure.

Dr. Misir: Just to elaborate on the rates that we were discussing earlier on, and it was mentioned before that in our setting what we call the gestational age, or, in other words, how old the infant is or the baby is. Our system of counting these is a little bit different from other jurisdictions in that 28 weeks, historically, has been the cut-off point, but we have been counting babies or infants even before that. So that we have, over the years, been looking at these statistics critically in terms of doing a proper root cause analysis to determine what are the real causes of these relatively high rates that we are discussing.

So that in addition to as Dr.Chatoorgoon mentioned in terms of the

neonatologists and setting up, what we call the neonatal intensive care units for these young babies, and so on, we have been also looking at the women and our efforts at the maternal care and maternal mortality, maternal morbidity, looking at how chronic diseases would affect the pregnancy, diabetes in pregnancy, hypertension in pregnancy. When we look at our data and when we did your analysis, for example, the most common cause of the mortality would have been postpartum haemorrhage, which is bleeding after you deliver a baby.

So a number of interventions have been undertaken in conjunction with PAHO and other international bodies. We have been training our doctors, our obstetricians, and so on, in new techniques and modern techniques in dealing with these women who have these complications. So, all of these have been done. We have been looking at our protocols. We have been looking at standardizing the care throughout all the hospitals in Trinidad and Tobago, not only in San Fernando. So, all of these efforts are being undertaken with a few in the effort to reduce these statistics that we are referring to.

And if I may just go on a little bit to talk about what Mr. Gosine discussed, the public health observatory. Now, the rationale behind the public health observatory is to put all our operational data into one place so that we can do the churning of the data, or the analysis of the data, so that we could go from data to information, to intelligence, and so on, that would guide our policy intervention. So the rationale behind setting up these observatories, and not only in South-West but in all the RHAs, it is a mandate from the Ministry of Health to set up these public health observatories to look at the data of our utilization, look at the data in terms of our rates, look at the data into other prevailing conditions, look at the data with respect to environmental issues, like Aedes indices. So all of these things would be put together in one observatory that will help us to drive policy and will help us to

determine what our efforts will be in terms of future endeavours in the health sector.

Now, the other point that was being made, technology is always advancing and in an effort to keep up with the technology we have to buy more medical equipment which entails more maintenance costs. So, all of these will help collectively to drive the cost to deliver health care in the country. Thank you, Chair.

Mr. Chairman: Miss Ramdial.

Miss Ramdial: Thank you very much. Going back to the San Fernando Teaching Hospital, it was widely reported last July that the Ministry of Health had handed over the teaching floors, floor two and three last July, and up to date they have not been opened, can you give some explanation?—San Fernando Teaching Hospital. Can you give some explanation with respect to that?

Mr. Gosine: Yes, floors two and three would have been to the University of the West Indies. The Ministry handed it over South-West who in turn would be working with the UWI. We have been meeting with UWI for quite a while, and at this point in time a memorandum of understanding is being drawn up with UWI.

Miss Ramdial: Just one follow-up to that. So how soon, in your estimation, before the teaching levels of the San Fernando Teaching Hospital is open?

Mr. Gosine: That question would have been better answered by UWI, because we are awaiting UWI on that matter.

Mr. Chairman: Mrs. Primus.

Mrs. Baptiste-Primus: Thank you very much, Chairman, and I just want, as a follow-up to the statement made by Dr.Misir where he stated that as the institution buy more medical equipment there would be need for—that is locked into what was referred to earlier regarding the public health observatory. I would like to ask a couple of questions with regard to the medical equipment, because medical equipment is an important tool in saving lives. What percentage of equipment at the

hospital is non-functional?—one. What departments or services at the hospital are most significantly impacted upon by the shortage of equipment? What is the estimated amount of money reported to either repair or restore and/or purchase new equipment? And, finally, is there a maintenance programme in place at the institution? Thank you.

Mr. Gosine: Yes, I can start with the last question. There is some maintenance programme in place. We have a biomedical department, a biomedical engineering department that deals with equipment, but they will just do really the smaller equipment. Most of our equipment that we purchase, larger equipment, we will purchase it with what we call an extended warranty, or an extended maintenance. So if we have a one-year warranty we will tend to, within when we are tendering, we will ask for a five-year period for it to be covered. So the prices we would get would be over five years. But what we have found, again, with the existing vendors in Trinidad, is that even though you have that warranty you have to be behind them all the time to get your equipment fixed. And they will tell you that the parts, basically we do not make the parts here, they have to fly them in. That is one of the reasons why we do have equipment down.

We spoke, and the Member for San Fernando West also spoke about the cost of $103 million, that is required to replace some of our medical equipment at San Fernando General Hospital. As I said, medical equipment is very expensive. And I will give you an example, our Siemens, when those Siemens are down, it means that patients in the urology department, or anywhere, they cannot have their services, they cannot have their surgeries. So we need to have the equipment up and running at all times. That impacts on surgeries, impacts on many other areas.

11.05 a.m.

Mrs. Baptiste-Primus: Sorry, Mr. Chairman, and Mr. CEO. Just to continue the

train of thought there. When these expensive pieces of equipment are down it incurs additional cost for the institution because you have to seek those services externally. Yes?

Mr. Gosine: Yes. Yes. It increases the cost to the institution.

Mrs. Baptiste-Primus: So it is a double cost really.

Mr. Gosine: It is a double cost. But, you know, as we go ahead to—with medical equipment what we have seen with shortages is staffing in the biomedical department. When they do enter our realm, when they come to work at the south-west, they are there for three or four years, when they are trained they get three and four times the salary in the private sector, the same people who complete with us, they go across there. So then we pay for their services on the outside.

Mr. Chairman: Wow. Mr. Solomon.

Mr. Solomon: Thank you, Chair. I am hearing about equipment, I am hearing about human resources, I just wanted to ask you: what is the number one issue that impedes you from providing a proper, efficient, quality health care to the public?

Mr. Gosine: Well, I would say it is a mix of both. Yes. Human resources—having the human resources available. And I will give you an example. We have 10 operating theatres at the San Fernando General Hospital. If we were to have theatres nurses that we can do a double shift, it would increase the number of surgeries. So human resources, we need to look at human resources and specialized human resources also.

Mr. Solomon: If I may, Chair? Given that it is human resources, what is your plan to increase the amount of human resources and to tackle that problem?

Mr. Gosine: Yes. We do have a lot of what we call Cabinet-approved and board-approved positions. We are working with the Ministry of Health to increase our staff shortages at this point in time.

Mr. Chairman: I do not know how best you will answer this question—sorry. CMO.

Ms. Ferraz: Thank you, Chair. I also wanted to add that currently the Ministry is completing the review of a 10-year HR plan, manpower plan, for the health sector. We expect to have that completed, I would say by the end of the first quarter of next year. We are also looking at working with the RHAs and looking at standardizing, as far as possible, some of the positions in the structure. There will be some positions for which we can do that, and because of the services that the different RHAs offer, there will be some specialties. So those are two areas that we are looking at as well to deal with the HR, along with, at this time, still some recruitment from overseas.

Dr. Misir: In addition to that, as was mentioned by the CEO, the Ministry of Health and the RHAs, we are looking at a number of ways of addressing the HR shortages. So, of course, we have been in discussion with the University of the West Indies. We have been in discussion with COSTAATT. We have been looking at all the tertiary level training institutions in terms of how they will fill the need that we have now, the gaps now and also to plan for the future and that is what PS is alluding to with respect to the 10-year HR manpower plan for health.

In addition to that, we have been, not only the universities locally, but we are looking at agreements with other jurisdictions. For example, we have currently in San Fernando, we have an arrangement with the Chinese, the Republic of China to deal with one area that we have a shortage, but we are also looking at other countries and other areas where we can have exchanges. We are also looking at a different modalities or different modes on how we deliver specialist training.

So that sometimes it is difficult or costly to send one individual to get specialist training in another jurisdiction, so we are looking at working arrangements with other universities to maybe bring their personnel from time to time and maybe

they will be able to train a cadre of local professionals rather than train one person. Because we have the shortage with the human resources and the specialists so on, what we are also looking at currently is, rather than each RHA trying to set up a plethora of medical services, we are saying to the different RHAs that we are developing what we are calling centres of excellence. And let me use San Fernando General for an example, where as Mr. Gosine indicated, a lot of investment was made into urological services or urology services.

So we are saying that maybe San Fernando should be the centre of excellence for urology. Historically, the first kidney transplant was done in San Fernando for those of you who would remember. So that we are looking at different regional hospitals becoming centres of excellence in a particular speciality area. That way we could more focus and probably better utilize the current level of professionals that we have in the different specialty areas.

Mr. Chairman: Thank you very much. I am going to ask a questions here and I want all of you, in particular the four persons who I would like to answer individually. It is one question, which will be the Permanent Secretary, the Chief Medical Officer, the Director of Health Policy Research and Planning and the Medical Director Secondary Care Service and Director of Health (Ag.), Dr. Chatoorgoon. And the simple question is which I am sure the average Trinidadian and Tobagonian listening to this this morning would very much interested in finding out. What standard of care is to be expected when one goes to any institution, in particular we are dealing with you all this morning, South-West Regional Health Authority, standard of care that is expected. Is it an international standard of care, a local standard of care? What is the standard of care? You all are mentioning all these various things you all are saying, it comes down to, at the end of the day, a standard of care. What standard of care is being delivered or is being adhered to by the

Ministry being in the delivery of health service? We will start with the Permanent Secretary.

Ms. Ferraz: Thank you, Chair. We were actually going to start with the clinical side, but I defer to you. There are certain international standards to which Trinidad and Tobago has signed on and those are the standards that we would seek to roll out to the various RHAs for the delivery of care. Additionally—

Mr. Chairman: Sorry. Bear with me, eh?—because I am very, very interested in what you are saying here. You said that they are about to roll out.

Ms. Ferraz: No. Sorry.

Mr. Chairman: Yeah. Please.

Ms. Ferraz: There are certain standards of care to which there are international standards that the country would have to adhere to and those would be rolled out through our agreements, our service agreements to the—

Mr. Chairman: Yeah. This is my difficulty. You are saying two—

Ms. Ferraz: Okay. Not as in future, but within the context of the service level agreements to the RHAs as to what they need to adhere to, to comply with and to deliver.

Mr. Chairman: So right now what is the standard as far as the Ministry is concerned? What standard are they adhering to right now? There must be agreements in existence. So what is the standard that they are being adhered to after all these years? What is it?

Ms. Ferraz: That, I am afraid, I cannot answer specifically in the terms that I think that you are asking.

Mr. Chairman: Okay.

Ms. Ferraz: I am aware however, that during last year 18 international accredited health standards under the Accreditation Canada International, ACI were

implemented across all of the RHAs. That there was training that was delivered in areas related to governance, clinical services, managerial and operational services that four surveyors, as they were called, were trained from each RHA, and these persons were used as trainers and some 2,000 persons across the RHAs were then trained across multiple disciplines in these standards. That is the information that I have.

Mr. Chairman: Yeah. Now, PS, Ms. Ferraz: is there a policy document that is distributed to all these various health facilities about this standard? Do you have a document that you can share with us as the Committee?

Ms. Ferraz: There would have been a manual related to these. I will have to submit it. As well I know for adverse events, there is a policy that is in use by all the RHAs.

Mr. Chairman: Okay. Thank you very much, eh. I would like ask the Chief Medical Officer now to give me his understanding of what standard of care does he or—?

Dr. Misir: Okay. Let me just by way of, you know, like background information. Now, the standards that we have alluded to, the standards that we are talking about, it would vary in some degree. And now let me start with the emergency departments. Okay?

Mr. Chairman: Very good.

Dr. Misir: Now, in all the emergency departments in Trinidad and Tobago we have adopted what we call the Canadian Triage Acuity Scale, the CTAS. What this does—

Mr. Chairman: Could you repeat for us, please?

Dr. Misir: Canadian Triage Acuity Scale, CTAS. Now what this does, it gives you guidelines in terms of how quickly or how rapidly the patient should receive medical care dependent upon the presenting complaint. So, for example, let me use—now these numbers are not exact, but it will give you an idea. If somebody presents with chest pain in an emergency department, within 15 minutes you should an

intervention, compared to somebody who would present with, let us say, I mean like a skin rash or something like that. So it sets standards, it sets guidelines in terms of how rapidly or how quickly you should deal with this particular presenting complaint or presenting problem. So that that is what we use. So it varies the time that we give you so, for example, if somebody comes in with a severe heart attack as we say, within five minutes you should do your intervention or you may lose that client or that patient. So that that is the standards that we are talking about that we adhere to in the emergency department.

Mr. Chairman: Now, Dr. Misir, is that—where if I walk into an emergency department in Port of Spain or anywhere would see that up as a sign?

Dr. Misir: Well, you would not see it up as a sign, but all the emergency physicians who have been trained in emergency medicine and so on, they will know that that is the standard that they subscribe to or they should subscribe to.

Mr. Chairman: But is the public educated about that? If I go into a facility, I need to know if I go into the Port of Spain General Hospital with a chest pain I need to know well, , that within 15 minutes I ought to be attended to. It is some standards we are trying to set up. You know in the police service, you go and make a report, you are supposed to get a certificate that you made a report?

Dr. Misir: Right.

Mr. Chairman: Is that available right now.

Dr. Misir: What we have been trying to do, for example, the stationery—

Mr. Chairman: No. No. Doctor, please.

Dr. Misir: Hold on. Let me—

Mr. Chairman: Please. Please. No. You are saying what you are trying to do. I want to know what is being done now. What is?

Dr. Misir: Yeah. Okay. Let me finish. What we are trying to do to the patients, to

educate the public as you are saying, the stationery. In other words, the causality or the emergency department stationery. In other words, the file that we would give to the patient would have at the back of it, it would have information to the effect that, everybody will receive medical however, depending on the nature of your problem or your presenting complaint, you may have to wait a little bit because priority has to be given to more acute emergencies. So that we have been trying to disseminate this to the public through that manner.

Now, we have not, as you say, we have not done a big social marketing or a big communication to let the public know that this is the standard that we are adhering to, but gradually and slowly we are trying to let the public know that, yes, we have these standards and yes, you will get your care and attention, but sometimes you may have to wait because other emergencies will, of course, get ahead of you. So, we are trying to educate the public in an indirect way.

Mr. Chairman: Well, I will just suspend that question for now because I want to come back to you based on the emergency example you gave. Right? But the third person to answer was Mr. Lawrence Jaisingh. Yes.

Mr. Jaisingh: All right, Chair, thanks for the question. What we have done so far in terms of the standards, the guidelines and basically was the first thing to look at evidence-based policy, but with the evidence we had, we have restructured our policies and some of the policies that we have restructured adopting what the CMO indicated the triage scale. And we have adopted those policies and guidelines in restructuring and reforming the annual service agreement.

Mr. Chairman: Which agreement, Sir?

Mr. Jaisingh: The annual service agreement.

Mr. Chairman: Yeah. But is the standard that we—

Mr. Jaisingh: This some of the standards that we use as the high-five standards as

well, looking at the clinical side. We have used the—

Mr. Chairman: Are these international standards or are these local standards?

Mr. Jaisingh: Yes. International standards where Ministry officials attended conferences and adopted a sign on to those agreements as well. We also adopted as well the guidelines and certification in terms of the ISO standards as well, and we have adopted as well the interim guidelines for maternal child health.

Mr. Chairman: Is it fair to say, in Trinidad and Tobago public health service the standard that we adhere to are all international-based standards?

Mr. Jaisingh: Yes. Because we had signed on to the World Health Assembly guidelines as well in terms of resolutions. So, we adopt those standards and protocols in our policies as well.

And also, we have translated that further down into the annual service agreement which has been reformed itself totally in consultations with key departments, where before it was really basically 154 indicators, we have condensed this whole document into a border reporting template that is easy to report on to about 13 indicators which aligned to the Sustainable Development Goals as well. So based on those goals and those standards, we have a reporting tool in terms of the annual service agreement which is also aligned to the purchasing attention agreement which is bent on the policy of the Government as well. So if I translated that whole policy arm, that whole development arm into the actual service delivery in terms of the monitoring control through the annual service agreement.

Mr. Chairman: Okay. Thank you very much. Dr. Chatoorgoon.

Dr. Chatoorgoon: I take it that, so the question you are asking me is—

Mr. Chairman: What standard—

Dr. Chatoorgoon: What is the standard of care? And you are asking this from the patients' point of view or from our point of view? From ours?

Mr. Chairman: From both. From the patient point of view to what to expect? When we come to a hospital—

Dr. Chatoorgoon: Mr. Roach, I will say to you in all honesty that I think that the standard of care at the San Fernando General Hospital is an excellent one. I think it is a very good one and I will share with you why. I think—

Mr. Chairman: Doc, before we go further.

Dr. Chatoorgoon: Yes.

Mr. Chairman:—this standard is excellent. Is that the local standard or that the international standards? That is what I am trying get, a cohesive understanding.

Dr. Chatoorgoon: Good. Yes, Sir. We function in accordance with international—what we call international best practice. Most of our doctors, our specialists have been trained abroad in the United Kingdom and Canada and America and so on. So our practice is definitely in accordance with international best practice. And I think it shows we have 15 clinical specialities, and I am not being dishonest when I say to you that in my view, the care given to the patients. And my focus, Sir, has always been on the patients. We in the South-West, we are not just customer focused. We are customer obsessed, and for us the customer comes first. And to that end therefore, we have done everything that we can. There is more to do. There is always a little more to do, but we have tried to provide a very good standard of care for the patients and I think that we do. We had provided a good standard of care, and we are providing a good standard of care. That is not to say that there is not room for improvement, but I think we are.

Mr. Chairman: I am certain that the population in south, your clients in the south would be encouraged to hear that. That you are client obsessed. I mean, that is encouraging for me even though I am in the north.

Dr. Chatoorgoon: We are customer obsessed, Sir. And I can tell you, Sir, without

no uncertain terms, I have been with the RHA ever since it started in 1994 and I think more than ever we have never been as customer focussed as we certainly are now.

So, I think, we really do, we have done lots of things, Sir. I will be honest with you, Sir, if I may say it myself, I have put my numbers as Medical Director in the emergency department so that patients who come there and they are not getting through, there is a sign which says to them, "if you are waiting more two hours and you are not being attended to, please call the Medical Director".

Mr. Chairman: Is that so?

Dr. Chatoorgoon: At 773-7838. That number is there, Sir, in the emergency department. That number is also there in the clinics. So if you come to our clinics and you are waiting to see a doctor, they cannot find your file and you do not know what to do because you are there waiting to see the doctor, there is a sign there that says, you can contact the Medical Director who then says to you, "Hold on". We will get your file for you. And that quality of care is being provided at the San Fernando General Hospital and certainly, Sir, in no other hospital in Trinidad and Tobago.

Mr. Chairman: I think that is one of the best news that came out of this so far. [*Laughter*]

Mrs. Baptiste-Primus: He should switch to the PR department. [*Laughter*]

Mr. Chairman: I think Mr. Smith would like to ask a question.

Mr. Smith: Well with that answer, Chairman, my question changed. How much calls "yuh does" get a day? [*Laughter*]

Dr. Chatoorgoon: Let me answer. Let me answer. Sure. Let me answer that for you. That suggestion, that initiative it started in September of 2014 at the San Fernando General Hospital because I was concerned, Sir, that everybody was saying, "Things

are going well in the emergency department, patients are being seen". But then patients were complaining. I am coming and waiting so long, I am not getting through. I have come to the clinics. Nobody can find my file. Nobody is seeing me. And I said something had to be wrong. Everybody was saying how everything was hunky-dory and I said, I will only know the truth from the patients themselves.

And that is how in September in 2014 with Dr.Lackram Bodoe who was then the chairman, I suggested to him and the CEO: may I put my number? Let me just to it as a pilot project and see what happens. It started in 2014. The answer to your question, Sir, when it started I got no sleep at nights. [*Laughter*]

Mr. Smith: How is it now?

Dr. Chatoorgoon: My phone was ringing nonstop, as people were saying, "I am waiting here for hours. I brought my father. My father cannot pass urine—nobody has seen". I can say to you though, between then and now it has gotten a lot, lot better. I still get calls. Yes. But it is certainly not as I did then. So it has gotten a lot better.

Mr. Smith: "So yuh kinda know what MPs go through with de calls". But nonetheless, my original two questions were—and I always ask the Committees when they come in front the joint select committee these two questions and we always get a—nothing is new under the sun. Who right now internationally is the benchmark? Because we keep talking about international standards, benchmark for medical care worldwide?

And the second part of it is, who was similar to Trinidad and Tobago a few years ago and was able to make that leap to where we want to go in terms of what did they do and if we are emulating them? Two countries I am asking for.

Dr. Chatoorgoon: Your first question?

Mr. Smith: Right now, internationally who is the best practice that everybody tries

to emulate? And two: who was closest to Trinidad, in the situation before, was able to leapfrog to becoming one of the best, if not better?

Mrs. Alleyne-Rawlins: Okay. Before I respond the two questions, I just want to take us back a little bit in respect—and add something to the responses before, in that Trinidad and Tobago has been using both international as well as local standards. International, in relation to the World Health Organization and Pan American Health Organization, and the Joint Commission International which is an international arm of Joint Commission of the US. Standards were piloted and adapted to suit Trinidad and Tobago because, Mr. Chairman, as you would realize our situation, in some instances, are different from some of the international, so you had to make the standards relevant to Trinidad and Tobago. So, we have used both international, as well as the adaptation for the local environment.

What has also happened is that we have used regional standards too, the Caribbean Cooperation and Health, CCH which is a subcommittee of Caricom has also set regional standards that the countries have signed up to, and therefore, there is a comparative analysis in terms of where we are in achieving those standards based on the data that is captured in each country using specific instruments in order to do that. So that was to add to what my colleagues were—

Mr. Chairman: I just want to take off from there. Could you make that document available to the Committee? We would be interested in having a copy of that?

Mrs. Alleyne-Rawlins: The Director of Policy Ministry of Health could make the CCH documents and some of the WHO documents available to you. In relation to the question that Minister Smith asked and in terms of benchmarking. When the sector worked on designing a quality system for the health sector in Trinidad and Tobago, 13 countries were looked in terms of benchmarking and we looked at where we were then. I was looking at—like South Africa. We were sort of on par with

South Africa and we, in fact, did a comparison to look at the things they had done. Who was at the top of the line at that time was the Danish. The Danish health system really was achieving better indicators than most of the other countries.

Mr. Chairman: Not Cuba?

Mrs. Alleyne-Rawlins: Cuba, in terms of primary health care. Their standards were among the best in the world and the approach to the primary care system. So that when Trinidad and Tobago actually brought the primary care teams from Cuba into our system, we found that we increased in terms of impact and quality because of the approach of those health professionals who came from Cuba. So attachments to actually the primary care facilities in Cuba will help us considerably because we have not been doing as well as we could do in relation to the primary care system. Most of our resources are being put into the secondary care system all of the time and the emphasis on primary health care needs to be strengthened.

So the Danish was really pretty good and in the western hemisphere the Canadian health system is a good benchmark. And then as I said, we were about South Africa when we started.

Mr. Chairman: Mrs. Alleyne-Rawlins, can I ask you a question based on what you have just given us? The information you have just given us is quite helpful. You said you will be using a mixture of international, regional and local adaptation.

Mrs. Alleyne-Rawlins: Yeah.

Mr. Chairman: So this varies in the various departments? It sounds a bit convoluted now, eh. So there are no specific standard?

Mrs. Alleyne-Rawlins: Right. There are specific standards, for example, for different service delivery. Because remember all of this is informed by our health needs assessment. The health needs assessment data analysis tells us what kinds of services we are supposed to be offering. And for each service there are international

measures of best practice, and therefore, you are definitely going to have your standards written the way the best practice, what is ideally best practice and the indicators from measuring that. So all our quality audits, in fact, the standards are used for the quality auditing to help us to know where we are in respect of each.

For example, the CTAS standard that the Chief Medical Officer spoke about that is being used in our accident and emergency are units not just in South-West, but also in the other RHAs as a national standard because it was adopted for Trinidad and Tobago. The flowcharts that describe that standard are posted in the Accident and Emergency Departments. What is also there in the emergency departments are charter standards. The patients' charter standards that outline patients' rights. You have rights and you have obligations in relation to health care, and there are posters that tell the patients what their rights are, what their obligations are. So it helps them to flow through the system.

And in each accident and emergency, you would also find customer service representatives. They are part of the system so that if there is bottlenecking at any time, they interface with the patients or clients and seek to get some kind of redress for them or explain to them what might be causing the delays. So it is all part of one system, but just different processes in the system.

Mr. Chairman: Doctor—sorry. I always say Dr. Al-Rawi. Mr. Al-Rawi will be next.

Mr. Al-Rawi: It is true I had a flirtation with medicine at one point in high school, but not quite. Thank you, Mr. Chairman. We are talking about coordination of services, et cetera. As the Member of Parliament for San Fernando West I have had the opportunity to spend quite a lot of time walking through the hospital. I worked in the hospital as a young man, volunteer basis. I have known it since then, come forward. I was concerned when I had a conversation with the neurological team from

China, as we are talking about coordinated services.

As I understand it, the neurological team works every Thursday on a scheduled basis and very often the schedules could not be met because the nursing schedule conflicted with when the theatre availability would have be prepped and ready. And the recommendation for coordination by the Chinese medical team was, why not give us one month straight of surgeries booked in a theatre, we will push through the patient load. Because in actuality they have been here for a year and have worked occasionally on the Thursday to do one or two surgeries. So, we have not had the best use of what is an obvious thing, which is scheduling. Scheduling of elective surgeries, scheduling of major surgeries, et cetera.

And they say as volunteers, they would have much rather done 31 days of back-to-back surgeries, four to five to six patients a day, as opposed to 52 weeks less certain holidays where they occasionally get work done. So they spent a year stretched out being inefficient, essentially. What is your take on that?

Mr. Gosine: First of all, they did not have that conversation with me, so I am not aware of that. But the Chinese team comprises of many specialities. And you are right. They did complain. In fact, I will tell you, they left two days ago and I managed to get them to work on a—well I managed to get our staff to work on a Saturday where they did a critical operation and they were prepared to work Saturdays and Sundays. We have to get the staff especially the nursing staff to work along with us with theatres and is where the problem lies. We have six theatres that they can use on weekends. We do have a theatre for emergencies and that is one, but they did indicate to us that they are happy to work on weekends when the theatres were down also.

Secondly, the others who were on the team, they did work well with us, but we provided for them in their surgeries. Fortunately or unfortunately, they have left

us, but that system that you are talking about will work well for Trinidad and Tobago to just get some neurosurgeons to come in over a period of time and clear elective lists. It will work well.

Mr. Al-Rawi: Is there a plan for backlog and elective management of this type? Understand that, for me, the process is, how do I better operationalize that which I have? If there is a scheduling conflict or some degree of work issue between theatre, nursing, surgeon, then we need to dust it off and put it into operation. My question is: Is the board paying attention or is the management of the hospital or is the Ministry in receipt of a, how should I say, and information package post experience. I would assume that the Ministry is asking for reflections of the Chinese Government's wonderful support for Trinidad and Tobago by providing this kind of medical assistance as does Cuba, et cetera. But are we taking the information feedback and now saying, right. We have had one cycle, these are the problems, here is how we are going to better that cycle arrangement. If need be on the basis of importing the nursing support to do it. Because it is cheaper to bring in a theatre nurse than to rent a facility and a private hospital and have to pay surgeons, an anaesthetist care, et cetera, or ICU care external to the San Fernando General.

Mrs. Alleyne-Rawlins: Mr. Chairman, through you, I just want to add to the response from the Chief Executive Officer because our board came in the back end of this arrangement, bilateral arrangement. On the board there is a quality risk management committee and the committee actually paid attention to what has been delivered coming out of this two-year arrangement.

And in reviewing that data, what we noted was that in terms of improvement that was need for identifying up front a local counterpart team of nurses and doctors and the other disciplines that will be required who would be dedicated to working with the Chinese professionals. Then you would have had these people assigned all

the time, and you would have set clear targets that you want to achieve during their period in Trinidad, not only in terms of clearing backlog, but teaching our health professionals new skills. So the transfer of technology would have taken place to empower our professionals so that when they leave, we would also have a cadre of people who are highly trained and highly skilled because we did have the opportunity in neurosurgery, in particular at the neuro-endoscopic surgery, to have our staff empowered. But if you do it in a piecemeal operation therefore, you would not really realized the fullest benefit.

So, we took note of that and in fact have communicated that to the sitting Minister so that in the bilateral exit discussions with the Chinese, we have already tabled that as a way forward.

Mr. Al-Rawi: I am extremely pleased that you have done that. That, if I could be bold enough to say it, is progress and I thank you.

Mrs. Alleyne-Rawlins: You are welcome.

Ms. Ferraz: The Ministry has also been in conversation with the RHA and we are starting to negotiate. We have signalled our intention to the Ministry of Foreign and Caricom Affairs that we would like to renegotiate a new agreement with the Chinese and specifically we have taken on board that issue of the transfer of learning as well.

Mr. Chairman: Before I have member De Freitas ask a question. I just want to ask one question concerning this. In terms of the—one of the complaints I saw coming from your feedback with your client quality control was the loss of patients' records. All right? I have been a patient unfortunately in a United States hospital, as well as in Israel. And one of the things I noticed about patients' records is that it was automated. They were using computers. A team of doctors will look after me and as they are finished they already put in that information. So whoever comes in after or wherever in the hospital in terms of whatever department could put up name once I

go with an ID band and he would have immediately what was done to me, what the last thing I received and everything like that. I saw that in America and I saw it in Israel. Is that available in Trinidad at this point in time?

Mr. Gosine: Yes. We what we have done at south-West, we have started one of the programmes we call SELMA that we are automating records, we are automating emergency department, also, the LIS which is the lab information system. So, yes we have started it and records are being automated now. It will take a period of time, a year or two, but the system has started and training has also started with the medical records staff on the automation.

Mr. Chairman: Are the doctors being trained in that?

Mr. Gosine: The doctors are being trained also. In fact, we have some departments like the rheumatology department that has been computerized. So slowly the other departments will follow suit.

Mr. Chairman: Well that is very encouraging. Mr. De Freitas.

Mr. De Freitas: Yes. Just to reiterate what the Chairman has said, that is very encouraging because I have actually seen something similar in Tobago. Yeah. The hospital in Tobago where an x-ray was taken, at the accident and emergency they took an x-ray, and by the time the patient got back to the accident and emergency, the x-ray of the hand or foot or whatever it was on the screen being looked at by the doctor. So it is very, very commendable if it is also being done in the South-West Regional Health Authority.

I just wanted to piggy-back quickly on the line of questioning from the hon. member, the Attorney General, where he was talking about the Chinese and working with them. And the question I really wanted to ask just for contextual basis is: what is the average wait time for a patient as it is now to get the surgery that you all were talking about and what is the size of the backlog?

Dr. Chatoorgoon: It varies, Sir, from speciality to speciality. So, for example, if a lady came to the clinic today and it was thought that she should have a hysterectomy, for example, she could get her surgery done within two weeks at the San Fernando General Hospital because our waiting list for surgeries in the speciality of gynaecology is very short. So it varies from speciality to speciality.

In some specialities, it is longer and that is because we do not have enough operating time. All our theatres are utilized every single day Monday to Friday not on a weekend because we do not have the nurses to be able to run the elective surgeries on a weekend. So the elective surgeries run Monday to Friday in 13 theatres actually. There are 13 theatres.

So because of the heavy work load that we have where we are servicing a population not just 600,000 as people think, it is a lot more than that because the other hospitals, patients are not fools. They have realized that if you could come to the San Fernando General Hospital, you would probably get your surgery much fastener than in the other RHAs, and they are therefore coming to us from all parts of the country. So it is not just 600,000 we are servicing, it is more than that. And therefore, the work load is very, very heavy.

So even though we are running our theatres every day Monday to Friday, it is still not enough yet, not enough to catch up on the backlog. And we may have to—our board is looking at, can we do it on a weekend as well? Can we run a late shift? But all that also depends on the availability of nurses.

Mr. De Freitas: And also, is there a limitation on how long, for example, a doctor is able to go into surgery for? For example, he would not be allowed to do more than three surgeries in a day. You know how pilots sometimes are not allowed to fly over a particular amount of time and they must have a particular rest period. Is that the same with surgeons?

Dr. Chatoorgoon: Well our surgeons, all the surgical disciplines, for example, let me give you a quick idea. In the department of obstetrics and gynaecology, there are four consultants. Yes? So four units in obstetrics and gynaecology. Each of those units has one operating day per week. Just one. So each consultant just operates for one day. So the question of burnout and so does not really arise because he has really only one elective operating day. So burnout does not really arise there at all. There is enough time for them to rest.

Mr. De Freitas: Could I get in relation to the first two questions the statistics in relation to the amount of people in the backlog and that waiting time period? And maybe if you could break it down by again, some speciality? Because I was really referring to the neuroscience department, but it is good have that information for all the other departments as well.

Mr. Chairman: Do you have that information off hand? If at this point in time the information is not available, you could always make it available to us subsequent to this.

Dr. Chatoorgoon: Yes. We will provide the information to you.

Mr. Chairman: Okay. Thank you. We have Miss Ramdial.

Miss Ramdial: Whilst the SWRHAs is doing a fantastic job with respect to improving on what they have, we do still have challenges within the system. How does the SWRHA manage in recent times with the chronic shortages of drugs and in some instances life-saving drugs for patients?

Dr. Chatoorgoon: That is a real problem.

Mr. Gosine: Yes. The problem with drugs and life-saving drugs is not specific to south-West, it is for the country. And we have been working with it. I know even in some of our surgeries up to yesterday we had to purchase drugs which we could not have gotten from C40 in order to have surgeries on going. We have been working

with it. The problem there and maybe the Ministry might be able to give us a little more information because with the drugs both pharmaceuticals and non-pharmaceuticals, the contract is with the Ministry of Health. So, I will put it to anyone in the Ministry to—

Ms. Ferraz: Thank you very much, Chair. Yes. The problem is known. The Ministry has the contract with NIPDEC for the procurement, storage and management of pharmaceuticals and non-pharmaceuticals for the entire public sector where it is needed. Just to state that NIPDEC through C40 does not only provide pharmaceuticals and none pharmaceuticals for the RHAs. They also provide drugs for, like the protective services, all arms of the public sector that would need medical care.

That having been said though, the Ministry continues to work with NIPDEC in terms of the provision of drugs and we continue to work as well with the Ministry of Finance for the necessary funding to provide the drugs, the pharms and non-pharms. I would like to also ask Dr. Misir to talk about the clinical side of how we try to manage with the supply of pharms and non-pharms.

11.50 a.m.

Dr. Misir: Just a further on this. As we all know we are operating in an environment where resources are "scarce". So, a number of initiatives that we have been doing or undertaking, one in particular is standardized protocols, we have been talking about that before. In that, let us say for example somebody with high blood pressure or hypertension, you may not have available a particular drug that the physician may wish to prescribe, but we have developed a number of protocols or standardized protocols that they can adhere to, so that at the end of the day the patients hypertension does not put them at risk for any complication. And we have been doing this. We have been trying to standardize the protocols for different areas. For

example, cancer treatments and hypertension, cardiac care and so on, we have been working with the specialist in the different areas to standardize the protocols so that we could probably better manage our requirement for different drugs and so on.

In addition to that, we have been working with PAHO/WHO to our list of drugs. What is described as the VEN list, vital, essential and necessary drugs that the public sector is committed to provide, and we are trying to rationalize that list. So that we have over 300 drugs on the list now and we feel that we may not necessarily have to provide all of these without compromising patient care, obviously. So right now we are working on bringing that list to a manageable number, with the view that we should be able to provide these as the need determines over time. So that these are the initiatives that we are doing.

Now, I just wanted to make a comment on an earlier discussion with respect to the medical team from China and so on. Now, we have to understand now, surgery is not just the operation, surgery is what we call "pre-op, intra-op, and post-op. So, for example, if you do a complicated neurosurgical operation, the after care, that patient bed is not freed up maybe for weeks, sometimes months, depending on the nature of the condition. So that one of the things that we have discussed with the Chinese medical team and so on, apart from bringing their dedicated nurses, we have been looking at instruments that they are familiar with, we are looking at the next time we may be able to rotate them rather than they being located in one general hospital, they may be able to go from hospital to hospital and deal with the backlog in cases, and deal with the complicated procedures, and so on. So that a number of initiatives we are looking at, or we are considering for the next time, or the next round of cooperation that we are going to have with these international medical teams.

Miss Ramdial: Just a follow-up to that, going back to the drug situation and lack of

drugs. Whilst doctor, you would have included some other measures that you would have utilized in terms of dealing with the lack of drugs, I want to go back to the PS and ask, so is it a funding issue with respect to the purchasing of these drugs? Is it an operations issue from your perspective with respect to Nipdec in terms of processing the required and doing the paperwork to request these drugs? What in your estimation needs to be done ASAP, especially with respect to saving lives and acquiring life-saving drugs, and saving the lives of our patients out there?

Ms. Ferraz: Thank you for the question. There is the issue at this time of funding, and as I indicated the Ministry of Health is currently and, as we speak, the discussions are ongoing with the Ministry of Finance. I would also like to say that as I have understood the process as well, you would have had to come up with the funding for the drugs. Each RHA and the other agencies that procure drugs from Nipdec, they would send in their list of needs, as they see it based on the services that they provide, near the beginning of the year. That list is considered by representatives of the Ministry of Health, the Hospitals as well, and Nipdec. And then a master list as it were would then be produced. That would be estimated for use during fiscal. We would then get the allocation for the purchase of the drugs. At no time, whether we are talking about the current fiscal, two years ago, 10 years ago, would you ever get the amount that you would have asked for. You then have to be able to manage the supply.

We have also, in addition to what Dr. Misir talked about from more on the clinical side of what we have been trying to do. We also worked with PAHO, and we have been doing some work with Nipdec for supply/chain management. Because as you alluded to, there could also be some things on the operation side. We have also worked with Nipdec and the RHAs, and other agencies to clean up the list of the persons who are actually properly authorized to request drugs from Nipdec. I do

want us to consider, at the end of the day, the key aspect of one of Dr. Misir's points. The issue of the formulary and the VEN list. I think he used the number 300?

Mr. Gosine: Nine hundred.

Ms. Ferraz: It is 900 different drugs that medical officers, consultants, would say I need this or I prefer this. So, according to the jurisdiction within which, as I understand it, they may have trained, they were accustomed using X, Y or Z. So, a key part of managing the drugs list is really cleaning up that formulary and coming to a decision about the VEN list. That is not going to happen for right now. It is continuing, and we are hoping to get that list cleaned up by next fiscal. In the meantime to your specific question, as I said, we are working with the Ministry of Finance to try to alleviate the situation, and it is where we are at this time. But, we do try to manage the stocks that we have, and as well, there is an issue with the cycle of procurement of the drugs as well as our financial cycle.

Mrs. Baptiste-Primus: Thank you kindly, Mr. Chairman. Two questions I wanted to ask. One, is there a shortage of cancer drugs at the hospital to treat cancer patients? I think we all appreciate the need for that list to be rationalized, because there is a direct correlation between the over 300 drugs on the list, and the fact—I would rather ask it as a question. What is the cost of expired unused drugs? Do you know, Madam PS?

Ms. Ferraz: I do not have that information off hand, but I can submit it. We can look for it and submit it.

Mrs. Baptiste-Primus: I would argue that the cost of the expired/unused drugs is sufficient cause for the cleaning up of that list. And some of the problems may just be resolved when that list is cleaned up. Would you agree Dr. Chatoorgoon, as the medical director?

Dr. Chatoorgoon: Yes. Yes, I would agree with that.

Mr. Smith: I know we are going a while now, I saw people getting tired. But it is a silent killer that occurs in the States. I know in the US it is around 1.7 million people that get HAIs every year, Hospital Acquired Infections. Around 100,000 people actually die from that annually. So, it is a 5 per cent chance in the US that you could get that. Do we have any data? I have friends who have gone in for one ailment and come out with a next.

Mr. Chairman: If they come out.

Mr. Smith: If they come out. Do you all have any data and anything to prevent HAI's? I know there are a number of mechanisms in North America of ensuring that people wash their hands, and in term of sterilizing equipment, but do you all have any data on that? It is something that is not really mentioned or talk about, they call it the silent killer, but do you all have any data or info on that?

Mrs. Alleyne-Rawlins: There is a comprehensive system of infection, prevention and control management in the health sector, not just at SWRHA. We have a comprehensive manual that is implemented by teams headed by microbiologists, and infection control officers, and infection control nurses. The infection rates are monitored on a daily basis, and the analysis informs decision-making and changes in procedures to prevent what happens in the US. So we really have a very good infection, prevention and control management system.

Mr. Smith: Do you all have data like how the US have data in terms of how many deaths?

Mrs. Alleyne Rawlins: We have that data which could be provided for you. Yes.

Mr. Chairman: We are drawing to a close, eh. So, there would not be many more questions. But, I mean, the health industry, as you all agree, is quite important to all of Trinidad and Tobago, and at some point in time if we personally have not had an encounter, somebody close to us must have had some sort of encounter with it. And

there is a growing concern of the quality of health that is being delivered both private and public. We pay a health surcharge and people expect to get something, quid pro quo, of value for it.

Having said all of that, earlier on Dr. Chatoorgoon, I think, was speaking about the emergency department, which was something very enlightening, very comforting to know that there is that level of care from a senior medical practitioner that will put his name up—that is almost like target practice—that people would refer to. And, as he said, that since he has done that significant numbers have called. He has probably been sleepless many nights and so forth. What type of doctor would you expect to have staffed an emergency department? Because, I mean, if it is anything at all, one would have an encounter with a hospital will be on some emergency basis. Do you have an emergency specialist doctor in your casualty department? Or that is not the case?

Dr. Chatoorgoon: Yes, we do. And there was a time for many years at the San Fernando General Hospital where the emergency department was not run by a doctor who had a specialist degree in emergency medicine. But that is no longer so. We have now got four doctors functioning in a consultant capacity who have got post graduate degrees in emergency medicine.

Mr. Chairman: Would you say that is a necessity?

Dr. Chatoorgoon: That is?

Mr. Chairman: That is a necessity? It is compulsory?

Dr. Chatoorgoon: Absolutely. No doubt about that. Definitely. Emergency medicine is now a speciality in its own right, and that has made a significant difference to us in the emergency department, because we have now got doctors who are trained in emergency medicine, and that has made a significant difference.

Mr. Chairman: So, therefore, where San Fernando, where your region is concerned,

all your emergency department will be staffed with such a doctor?

Dr. Chatoorgoon: Yes, our emergency department is staffed with specialists in emergency medicine. Yes.

Mr. Chairman: Now, the other question I have is, in terms of medical malpractice, you have a register at the Ministry or at your region where persons, doctors, or medical professionals who have been sued as the case may be for medical malpractice on a register. I mean, whether or not—you know, you go to the United States, if you are looking for a doctor you can go up on a website, put in a doctor's name and you can get a history of whether this doctor is successful, he has done a hundred cases, he has been sued five times, he has been sued one time, or as the case may be. Are we moving into that or do we have it already?

Mr. Gosine: Yes, we are moving into that. But our legal department would have that data, because that is where we handle all the litigation with respect to malpractice.

Mr. Chairman: Sorry, Dr. Chatoorgoon you wanted to say something?

Dr. Chatoorgoon: No. If I understand you, you want to know whether we have got a list of the doctors against whom have been found guilty in the courts.

Mr. Chairman: I ask if you all are in the process of generating such a policy.

Dr. Chatoorgoon: No. I am not aware that we are in the process of generating such a policy, but we do keep our fingers on the pulse of cases that have gone to the lower courts. If our doctors have been found guilt or have been found negligent, yes, we do take note of that. But I will have to be honest with you, Sir, I cannot think in recent times of any of our doctors who have actually been found guilty in the lower courts.

Mr. Chairman: Trinidad have some super doctors. [*Laughter*]

Dr. Sinanan: If I can just add. So, no, there are no plans to put a public database

of—

Mr. Chairman: There are no plans for that.

Dr. Sinanan: Well, not from the RHA point of view. You see I was about to explain, the Medical Board of Trinidad and Tobago is responsible for the licensing of doctors, and for regulation of doctors, and any disciplinary issues go through the Medical Board of Trinidad and Tobago for which there is a council. So, if that sort of information were to be made available that would have to be done through the medical board and not through the regional health authorities.

Mr. Chairman: Just continuing from a continuation of that, who vets foreign doctors when they come here?

Dr. Sinanan: The Medical Board of Trinidad and Tobago.

Mr. Chairman: The medical board.

Dr. Sinanan: And, at the same time they are also responsible for local doctors as well, licensing of all doctors in determining whether they are eligible to be licensed as a specialist.

Mr. Chairman: Do the RHAs employ their own doctors directly?

Dr. Sinanan: As a part of the employment procedure you have to show your medical board registration card.

Mr. Chairman: No, no, that is not the question. I am asking, if the RHAs directly employ their medical staff, your doctors?

Dr. Sinanan: Yes.

Mr. Chairman: You all do. So do you all do a due diligence or you just rely on what comes from the medical board?

Dr. Sinanan: Well, due diligence is performed obviously.

Mr. Chairman: By you all?

Dr. Sinanan: By our human resource department, yes. And as part of the paperwork

that is provided, one of the things is full registration with the Medical Board of Trinidad and Tobago.

Mr. Chairman: Somebody wanted to ask a question. Yes, Mr. De Freitas, sorry.

Mr. De Freitas: Yes, I just wanted to ask a question specifically, are foreigners accessing the medical system here in Trinidad and Tobago? And if so, do we have any statistics or data on that? And do you believe that the access of this system by foreigners has an impact on our ability to meet demand for, let us say, drugs?

Dr. Chatoorgoon: You are asking whether foreign doctors are—

Mr. De Freitas: Foreign patients. So, for example, Caricom nationals?

Dr. Chatoorgoon: Yes. Yes, patients do try to, from time to time, access our service here. The answer to that is definitely, yes.

Mr. De Freitas: Do we have data on that? Because that would impact on demand for drugs. So, for example, that issue with the drugs for cancer patients, if, for example, we have a lot of Caricom nationals coming here for cancer treatment then does that not affect our ability to provide these drugs for locals?

Mr. Gosine: What is happening, again with the computerization that we are doing, we are picking them up, the non-nationals, they are coming in. Most of them would be using the emergency department, because we cannot turn them away from the emergency department. What SELMA is also doing, is that you need to give some sort of ID, and if you do not give that then you cannot be served. At this point in time we are now looking at that. What you find in the past is that a lot of non-nationals would give local addresses. But we are trying to clamp down when we get into things like cancer, in areas of oncology, because those drugs are very expensive.

Mrs. Baptiste-Primus: My final question, Mr. Chairman, thank you. And it emerges from what is being discussed, and I gather, because that was one of the questions that I wanted to ask. Whether or not any non-national can be refused

medical attention? Are there any of the medical institutions in this country—but I understand they can do so via the emergency department. If they do not come through the emergency department, what exists at South-West RHA? Is there a protocol?

Mr. Gosine: Not really. What is happening, and I will ask the PS to—

Mrs. Baptiste-Primus: I will qualify why I am asking that question. We all know what is happening in Venezuela. Yes? And we all know a lot of Venezuelans are flowing through Trinidad, I cannot say Tobago. We are told that 90-something per cent are returning to Venezuela, but given the subjective conditions in that country, and given the proximity to Venezuela, have you all observed that the South-West RHA, have you all observed non-nationals in that respect seeking medical attention from any of the health institutions that fall under the South-West RHA?

Mr. Gosine: No, we have not seen an increase, but I will have to look at the figures maybe down at Icacos and Cedros, and see what is happening there.

Dr. Chatoorgoon: And there is no doubt about it, they can come into our system apart from the emergency department. For example, Jenny, if you are not well and you go to a doctor in the private health centre, that doctor can give you a letter of referral to the San Fernando General Hospital. So you will now come to the San Fernando General Hospital and bypass completely the emergency department.

Mrs. Baptiste-Primus: So then the medical board has a role to play in terms of guidance to be issued to medical doctors? Or is it the Ministry of Health, Dr. Misir?

Dr. Misir: Well, I think the problem is bigger than that in that we need to have the policy document that speaks to treatment of non-nationals.

Mr. Chairman: Can you tell me, either the Ministry's level or certainly South-West Regional Health Authority, is the San Fernando General Hospital or the holistic service being offered in the South-West Regional Health Authority, is it geared

towards medical tourism, or we are not there? As we look to diversify and move away from the oil and gas ability to retract.

Dr. Misir: What I can say is that we provide—

Mr. Chairman: I am seeing we have 53 different services being offered in the region, the health authority, 53 different specialized type of medical services, and is any of it of a quality, of a standard and a level of efficiency that we can use that to attract medical tourist?

Dr. Chatoorgoon: Definitely.

Mr. Gosine: Yes, what I can say is that, yes, we can attract medical tourism, but at this point in time we are fighting to take care of our own nationals, at this point in time. But the quality is good.

Mrs. Baptiste-Primus: Charity begins at home.

Mr. Gosine: That is right.

Mr. Chairman: So, what will prevent it being short? You have a shortage of personnel? You mean everything we spoke about this morning, the challenges in terms of equipment and all of that?

Mr. Gosine: That is what we need. The quality of health care is good, but we need to increase our resources.

Ms. Ferraz: If I may, Chair, that question for me, I think there would have to be some precursors to that, quite apart from what the CEO is saying in terms of the operational aspects of it and the resources, I would think that what Dr. Misir referred to as it relates to policy for service to non-nationals, I would think that we would have to determine about the services, the basket of services that we are able to provide both to a basic basket of services, both to nationals and non-national, and what else you can put out for sale, as it were, for payment. And the RHAs, I know at one time only the Eric Williams had a system where they were accepting payment

but then a policy relative to how RHAs would be able to charge would have to be developed. So I am saying it is not impossible, and I hear the CEO's response, but I think that if you really want to be able to consider it there would be some other precursors that you would need.

Mr. Chairman: Thank you very much for that. Coming to the end, the last question we may want to ask. Dr. Misir, you want to say something?

Dr. Misir: Chair, and again I like the question. As the PS was saying, there are a number of precursors that need to be put into place before we can consider this, and as she mentioned the policy to support this. In addition to that and as was mentioned before by Mrs. Rawlins and others, the whole question about accreditation, because if we are going to undertake medical tourism, that would be the critical success factor if we can have our health facilities accredited to some international standard and, like I said, more recently we were looking at the ACI which is a Canadian thing, but for us to really undertake medical tourism we must ensure that our services are accredited, so then you can build safely and you can get payments and so on.

Mr. Chairman: Thank you for that clarification. And can I just ask, now, you have in your management structure there is a speciality called hospital management, how many hospitals, do you have any hospital management specialists attached to your management in your region or in Trinidad and Tobago? As far as you are aware.

Mr. Gosine: Yes, our managers they are qualified. Most of them would go through the University of Trinidad and Tobago, and they have a Masters, so they are qualified in hospital management.

Mr. Chairman: There is a speciality in hospital management, eh.

Mr. Gosine: Well, hospital management is a major part of that speciality.

Miss Ramdial: Just extending from the Chairman, in light of that, in terms of the vacancies existing as SWRHA, under what categories of staff do you have vacancies

existing at this point in time? And how soon before you fill these vacancies?

Mr. Gosine: We have vacancies in all areas, but the largest area would be in the area of nursing. We do have in medical officers, but that would be at the higher level of the specialist medical officers, registrars. There are enough students coming out from internship now to fill the house officer level. We have in administrative and the allied health areas like pharmacy and radiology. Those allied health services we do have some vacancies available.

Mr. Chairman: Let me invite closing—you know, I think we have reached the end of our enquiry this morning. I would like to thank you very much for your candid responses, and I would like to invite the CEO to give a closing remark and after that I will invite the PS, Ms. Ferraz to say something, and the chairman as well.

Mr. Gosine: Yes, I would like to thank all of you all today. It is nice when we can get out and speak about the health sector. While all of us in Trinidad are fortunate to get free medical healthcare, I do not think the population understands how expensive health care is, and how fortunate we are. At South-West I know we are fortunate to have good work ethics. We work hard and we love taking care of the health sector. We will always have problems because resources—in order to fulfil all the requirements you need to have financial and other resources. Hopefully, today, whatever comes out will assist us in moving forward in getting some of the resources. I thank you and I will put you over now to the Permanent Secretary.

Ms. Ferraz: Thank you very much, Chair and members, I will echo the sentiments of Mr. Gosine, to say that the cost of healthcare is very expensive. We recognize that we have varying conditions of stock, whether we look at the buildings or the equipment, we do recognize where the challenges are in terms of resources, financial as well as HR. But the Ministry will continue to work with the RHA's and all other stakeholders to strive to deliver quality healthcare services. I know that as we look

at our priority for primary health care and for non-communicable diseases, it would be remiss of me if I did not ask each and every member of our citizenry to understand that their health is their responsibility. While the Ministry and the State is able to provide whatever it can for their needs as far as health goes, it really does start with them. I would like on that note to thank you, Chair and the members of the Committee for the conversation this morning. There are things that arose that the Ministry will certainly take on board as we go forward to fulfil our mandate. Thank you very much.

Dr. Sinanan: Thank you. Can I just say that this being my first experience before a Joint Select Committee, it was a pleasant morning. You know, I thank you all—

Mr. Chairman: You thought differently. [*Laughter*]

Dr. Sinanan: You know, I think it was a fruitful discussion, for sure. I could only reiterate that public health care will unfortunately always be a drain on resources, because people do not realize that there is always room for improvement, no doubt about it. And no matter what quality of service we offer, there is always more that we can offer and, of course, the better the service we offer, the more people expect, and that is human nature. I would also like to reiterate what the Permanent Secretary said, especially with our Minister of Sport here, that if we can start just with people looking at their own healthcare, realizing that diet and exercise are important parts of people's lifestyles, essentially, because as you all will know that non-communicable diseases are a major cause of mobility in our country. We have recognized, due to our genetic or ethnic persuasions, that diabetes amongst young individuals in this country is so high. And, to be honest, even foreign countries realize that we are a wealth of—you know, basically research projects, because they can get diabetes in their 30's, and therefore they can look at the incidence of heart disease, et cetera.

And, one, we need to tackle diet and lifestyle, and if we can get sport involved, get young people into sport, get people—you know, at South-West and at all the RHAs I know we are willing to try to push this from our part. And then the other thing is, just getting people to stop smoking, that sort of thing, I think that would go a long way. Coming back to today's proceedings I hope that what we have provided for you is very useful. And thank you very much for the opportunity to give you all feedback on our operations.

Mr. Chairman: Thank you very much. On behalf of the members, on behalf of the staff and myself, we will also like to thank you all for being present this morning and for participating in, I think, in a very fruitful exercise. I am sure that the listening public are enlightened. Certainly there was some good that came out of this conversation. I am sure there is some enlightenment in terms of the expectation of patients when they attend the facilities in South-West Regional Health Authority, what to expect. And, on that basis I think it was a very rewarding exercise, and as all that was said so far, there is room for improvement. And we can only hope to be better than we were yesterday, tomorrow and today.

I would like to thank the listening public, I would like to thank the media for their presence, and all those who have helped to make this a very successful next Joint Select Committee hearing, and on such basis, please return home safely. Have a good journey, and again, thank you. I would like to adjourn this meeting this afternoon. Thank you.

12.24 p.m.: *Meeting adjourned.*

Appendix III

Services Provided at the San Fernando General Hospital

Some of the major services provided at the San Fernando General Hospital include:

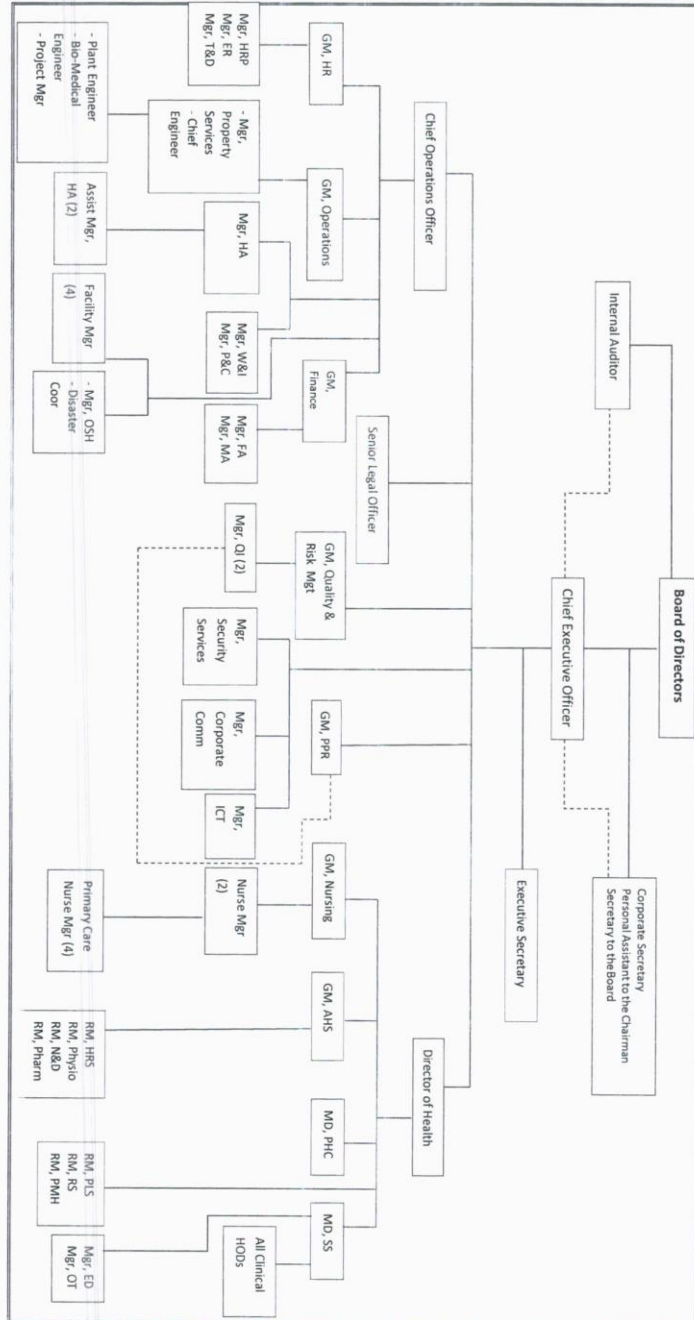
1. Emergency
2. General Medicine
3. Cardiology
4. Neurology
5. Physical Medicine & Rehabilitation
6. Rheumatology
7. Diabetes
8. Endocrinology
9. Gastroenterology
10. Endoscopy
11. Respiratory
12. Dermatology
13. Chest
14. HIV/AIDS – Testing and Consultations
15. Renal - Dialysis: Haemodialysis / Peritoneal
16. Anaesthetics
17. Theatre
18. Surgical
19. Orthopaedics
20. Neurosurgery
21. Plastics
22. Urology
23. Paediatric
24. Neonatology

25. Surgical
26. Ear Nose &Throat
27. Ophthalmology
28. Gynaecology: Cervical Screening; Pap Smear
29. Obstetrics: Lamaze; Ante-natal; Post-natal
30. Gynaecological Oncology
31. Family Planning
32. Colposcopy
33. Intensive Care
34. Psychiatry
35. Substance Abuse
36. Mental Health Counselling
37. Psychology
38. Histopathology
39. Autopsy
40. Haematology
41. Blood Bank
42. Radiology Services
43. Diagnostic Imaging (General X- Rays)
44. CT Scan
45. MRI
46. Mammography
47. Specialist Radiology Tests
48. Ultrasound
49. Pharmacy: In-patient, Out- patient
50. Dental
51. Physiotherapy
52. Nutrition
53. Social Services: Bereavement

APPENDIX

IV

Organisational Structure of the SWRHA


SWRHA Organisational Structure
Figure 1: South-West Regional Health Authority Organizational Structure
Board of Directors
Internal Auditor
Chief Executive Officer
Corporate Secretary
Personal Assistant to the Chairman
Secretary to the Board
Executive Secretary
Chief Operations Officer
Senior Legal Officer
Director of Health
GM, HR
Mgr, HRP
Mgr, ER
Mgr, T&D
GM, Operations
- Mgr, Property Services
- Chief Engineer
- Plant Engineer
- Bio-Medical Engineer
- Project Mgr
Mgr, HA
Assist Mgr, HA (2)
Facility Mgr (4)
Mgr, W&I
Mgr, P&C
- Mgr, OSH
- Disaster Coor
GM, Finance
Mgr, FA
Mgr, MA
GM, Quality & Risk Mgt
Mgr, QI (2)
Mgr, Security Services
GM, PPR
Mgr, Corporate Comm
Mgr, ICT
GM, Nursing
Nurse Mgr (2)
Primary Care Nurse Mgr (4)
GM, AHS
RM, HRS
RM, Physio
RM, N&D
RM, Pharm
MD, PHC
RM, PLS
RM, RS
RM, PMH
MD, SS
All Clinical HODs
Mgr, ED
Mgr, OT
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