Third Session of the Twelfth Republican Parliament

TENTH

REPORT FROM

THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE

EXAMINATION OF

An Examination into the Findings of the Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago

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

PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

Public Administration and Appropriations Committee

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

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

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

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

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The current staff members serving the Committee are:

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Ms. Hema Bhagaloo	Assistant Secretary
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Date Laid in HOR: **Date Laid in Senate:**

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EXECUTIVE SUMMARY

This Report of the Public Administrations and Appropriations Committee (PAAC) contains the details of the PAAC's examination into the Findings of the Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago, prepared by a Committee appointed by the Minister of Health in January 2022.

The Committee focused on a review and analysis of the report, which was laid in Parliament on February 18, 2022. Subsequently, the Committee conducted a Public Hearing with officials from the Ministry of Health on May 11, 2022. The Committee considered the issues identified and recommendations made in the Report of the appointed Committee.

The PAAC made recommendations related to the issues identified. Issues, observations and recommendations are presented in **Chapter 3.**

1. INTRODUCTION

THE COMMITTEE

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

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

Change in Membership

1. In the Twelfth Parliament, the Members of the Committee were appointed by resolutions of the House of Representatives and the Senate at sittings held on Friday November 9, 2020 and Tuesday November 17, 2020 respectively.
2. Senator Clarence Rambharat's seat in the Senate was declared vacant on May 16, 2022 as such he ceased to be a Member of the Committee.
3. Senator Yokymma Bethelmy's seat in the Senate was declared vacant on May 16, 2022 as such she ceased to be a Member of the Committee.
4. By resolution of the House of Representatives at a sitting held on June 13, 2022, Mr. Symon de Nobriga, MP was appointed a Member of the Committee in lieu of Mr. Stephen Mc Clashie, MP.
5. By resolution of the Senate at a sitting held on Tuesday June 14, 2022, Senator Laurence Hislop was appointed a Member of the Committee in lieu of Senator Yokymma Bethelmy and Senator Randall Mitchell in lieu of Senator Clarence Rambharat.

Chairman & Vice-Chairman

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

Quorum

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

2. METHODOLOGY

Determination of the Committee's Work Programme

The Committee agreed to conduct an examination into the Findings of the Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago.

The Inquiry Process

The Inquiry Process outlines steps to be taken by the Committee when conducting an inquiry into an entity or issue. The following steps outline the Inquiry Process followed by the PAAC for its examination into the Findings of the Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago.

i. Identification of entity to be examined: Ministry of Health;
ii. Preparation of an Issues Paper which identified and summarised matters of concern in the report conducted by the Government appointed Committee;
iii. Based on the issues identified, the Committee agreed to have a Public Hearing. The relevant witnesses were invited to attend and provide evidence on **May 11, 2022;**
iv. Following the Public Hearing, a request for further details was sent to the Ministry of Health on **May 17, 2022**, and the responses were received on **August 5, 2022.**
v. Report Committee's findings and recommendations to Parliament upon conclusion of the inquiry;
vi. Request for Ministerial Responses.
vii. Review responses; and
viii. Engage in follow-up.

3. ISSUES, OBSERVATIONS AND RECOMMENDATIONS

1. Staffing Challenges

The Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago[1] found that the Ministry of Health (MOH) was short staffed in key operational areas. Human resources refer to the trained and proficient individuals who constitute the workforce of an organisation. At the public hearing held on May 11, 2022, officials from the MOH specified that staff shortages were due to the increase in patient load and hospital occupancy rates. However, it must be noted that the MOH explained that it had adopted a strategic and comprehensive approach to the development of its Human Resources in order to face the challenge of staff shortages[2]. The pandemic compounded pre-existing staffing challenges[3] in the health sector and emphasised the need for additional support to the health workforce, to ensure the sector's resilience in the future.

In the Report of the Committee Appointed to investigate the factors contributing to clinical outcomes of COVID-19 Patients in Trinidad and Tobago, the following challenges were noted regarding staffing[4]:

- Staff shortages were common and seen at every level, from Executive Management, to doctors, nurses, orderlies and patient escorts;
- Job Insecurity: staff members were hired on short term contracts for example, month to month and three (3) month contracts;
- The "treatment of medical staff"; and
- There was an issue of "no dedicated consultant for the COVID-19 facility in Tobago".

[1] Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://190.213.84.147:8081/PapersLaidViewer/TempFiles/Report%20of%20the%20Committee%20Appointed%20V10_FINAL.pdf. Accessed on August 28, 2022

[2] The Ministry of Health: The Human Resource (HR) Factor: https://health.gov.tt/about-us. Accessed January 02, 2023

[3] The Report: Trinidad and Tobago 2015: https://oxfordbusinessgroup.com/overview/trinidad-and-tobagos-public-health-care-system-works-expand-services-while-coping-labour-shortages , Accessed January 2, 2023
"58 more Cubans hired by Health Ministry": *Daily Express*, April 3, 2019: https://trinidadexpress.com/news/local/more-cubans-hired-by-health-ministry/article_6689ae1c-564a-11e9-9d8e-473d08ae54d7.html. Accessed January 2, 2023

[4] Pages 82-83 and 100.

Additionally, with respect to the staffing challenges highlighted, the Report made the following recommendation to rectify the identified issue:

- "Job security – this issue be addressed by giving such staff contracts for a minimum of one year."[5]

At the time of the public hearing, officials from the MOH indicated that the following measures had been taken to resolve these challenges:

i. The South West Regional Health Authority (SWRHA) hired five hundred and forty-seven (547) additional staff in the areas of medical nursing, allied and operational staff to fill the vacancies;
ii. The SWRHA increased the lengths of the contracts to a minimum of one (1) year, with benefits which include paid/unpaid leave and ancillary gratuity;
iii. The North Central Regional Health Authority (NCRHA) hired thirteen (13) additional nurses and thirty (30) doctors on initial short term contracts which were then increased to one (1) year contracts;
iv. There was training in critical care which allowed for a wide cross-section of general staff who were able to provide other tiers of core competencies;
v. Staff was migrated from certain sections/departments to areas where urgent critical care was required; and
vi. An Intensive Care Unit (ICU) consultant relocated to Tobago to provide the requisite support.

Further, the report highlighted interviews conducted with staff at the various RHAs. The staff were asked questions relative to issues surrounding:

- admission/transfer processes;
- management of COVID-19 patients;
- care of the patient on the wards,
- meals,
- availability of drugs and services,

[5] Pg. 100 of report

- patient discharge and transfer home,
- death and communication with the family of deceased patients;
- stressors experienced at work that might have affected their output; and
- ways to improve patient care, given the country's limited resources.

In the analysis of the responses received from staff, several key issues were raised concerning the staffing challenges at the RHAs. They include:

- Mental health: The large number of patient deaths had an impact on the staff members, especially the nurses and junior doctors;
- Continuity of care: Some felt that the level of care in step down facilities might have been inadequate and resulted in poor outcomes;
- Comorbidities: In particular, obese (challenges moving the patients) and diabetic patients were difficult to manage; and
- Availability of supplies: Facilities ran out of basic supplies, especially during periods of surges in the number of patients.

Observation:

- ***Evidently, the RHAs faced staffing challenges in their response to COVID-19, and therefore it is important that the MOH work collaboratively with the RHAs to address the issues highlighted.***

Recommendations:

- ***The MOH should review trends in staff turnover, setting out an action plan addressing the shortage of personnel over the medium term into FY 2023 and submit this plan to Parliament by May 31, 2023;***
- ***The MOH should submit a status update to Parliament on the following by May 31, 2023:***
    - ***The support (technical or otherwise) provided to the RHAs for the implementation of the measures taken;***

- ***The metrics used to track the effectiveness of the measures adopted, and; and***
- ***The evaluation of performance against these metrics***

➢ ***The MOH should submit to Parliament by May 31, 2023, an update on the status of the ex-gratia payments to health sector workers in accordance with the commitment made by the Minister of Health in October 2022.***

2. <u>Data Collection and Management</u>

The MOH experienced challenges with data collection and management. It is important for data collection and management systems to be purpose driven, accurate and robust. The Appointed Committee noted in its Report, several challenges relative to the accessibility and quality of data required for the preparation of the report. The following challenges were highlighted[6]:

- There was difficulty in accessing data, for example, patient records and medical notes were incomplete or missing;
- The removal of the variables such as 'Ethnicity' and 'Obesity' from the data collection template;
- Data on comorbidities was submitted using an open text format with inconsistent spacing delimiters and spelling that could not be easily coded for analysis;
- The exclusion of key datasets such as:
  - 'outcome of the patients' (alive or dead);
  - the 'duration of stay';
  - data on patients who were still being managed at home (for both Trinidad and Tobago);
  - data on whether patients needed a higher level of care during hospitalisation;
  - data on the facility of admission, that is "data were missing or unusable for 68.7% of the patients";
  - inconsistent data entries for vaccination status.
- The data collection processes utilised by the MOH were not provided to the Appointed Committee.

[6] Pg. 22 of the Report

Officials from the MOH emphasized that a key hindrance in the provision of the data needed for a comprehensive analysis was the brief period allotted for the collation of the requisite information. Several other reasons were provided for the challenges in data collection and management. They included:

- The quality of data was not deemed satisfactory to making sensible correlations;
- Late start in collecting data; and
- The data collection forms evolved throughout the pandemic to take into consideration various data fields.

Observations:

- ***Regarding data collection and management, the PAAC notes that, in the Eleventh Parliament, the Public Accounts Committee presented its Thirty-Third (33rd) Report - Follow-up on the status of the implementation of the recommendations on Information and Communication Technology (ICT) governance and general controls as stated in the Reports of the Auditor General on the 2017, 2018 and 2019 Public Accounts[7]. The 33rd PAC Report noted, inter alia, the challenges faced by the MOH's information management system dating back to 2017 and the need to ensure ICT system integration at all RHAs. In its Ministerial Response to the 33rd PAC Report, the MOH indicated that an ICT Service Continuity Plan had yet to be developed as at the first quarter of FY 2021.***
- ***The PAAC notes that the MOH acknowledged several challenges to its data collection and verification methods and indicated its intent to digitise its data collection processes through the creation of an e-health information management system. That notwithstanding, many of the MOH's challenges highlighted in the 33rd PAC Report remained relevant at the onset of the COVID-19 pandemic.***
- ***The PAAC notes that the completion of the report by the Appointed Committee was hindered by several limitations. These limitations affected the overall quality and accuracy of the report and led to several challenges in the analysis of critical variables.***

[7] Accessible at: https://www.ttparliament.org/wp-content/uploads/2021/11/p11-s5-J-20200701-PAC-R33.pdf

Recommendations:

- ***The MOH should undertake a further assessment of the areas in which the data collected are in greatest need of improvement and indicate its further plans for the implementation of those improvements to Parliament by May 31, 2023;***
- ***The MOH should provide a roadmap for the implementation of the e-health information management system and its plan to address data and IT issues. This should include ongoing projects aimed at improving quality and data availability and the process of each project and be submitted to Parliament by May 31, 2023.***

3. Challenges identified by the Tobago House of Assembly (THA)

According to the Report, the THA identified several challenges encountered in its COVID-19 response efforts. The Report featured comments from the Secretary for the THA's Division of Health, Wellness and Social Protection, who highlighted that the Tobago health system was in a state of flux as they had what was described as a "semi" parallel health system to treat and manage COVID-19 patients. The major challenges faced in Tobago were:

- Insufficient infrastructure or capacity to house acutely ill COVID-19 patients;
- Inadequate ambulance vehicles to transport critically ill patients;
- Lack of requisite staff such as an Intensive Care Unit (ICU) Consultant, Senior Medical Officers (SMOs), Registrars, House Officers, nurses, patient escorts and orderlies;
- Incomplete ICU for the exclusive care of COVID -19 patients;
- Logistical challenges such as lack of storage space for Personal Protective Equipment (PPE);
- The shortage of sedatives for ventilated patients in the ICU's; and
- Monitoring and evaluation challenges in that staff saw data requests as a critique of their performance.

At the PAAC's public hearing, officials from the MOH highlighted the ways in which the Ministry assisted authorities in Tobago in mitigating many of the challenges faced. The MOH advised that a communication network between doctors in Trinidad and counterparts in Tobago

be established to share best practices in terms of policies, procedures, and protocols. Additionally, the following recommendations and changes were applied with respect to Tobago:

- The institutionalisation of the infection apprenticeship and control guidelines;
- Provision of additional staff;
- The development of a parallel health system report for Tobago; and
- Continued technical support and the sharing of relevant information.

Observation:

- ***The Committee notes all efforts made by the MOH to build Tobago's capacity to effectively fight against COVID-19. The enhancement of communication between medical personnel on both islands helped to ensure unity of purpose in the execution of pandemic-related health policy by promoting a shared understanding of the problems to be addressed, the overarching goals of policies to address those problems, and the means whereby the policies would be implemented on each island in its respective contexts.***

Recommendations:

- ***The MOH should report to Parliament on the measurable outcomes of pandemic-related initiatives undertaken to support Tobago, by May 31, 2023;***
- ***The MOH should consult with the THA's Division of Health, Wellness and Social Protection and submit a status update on the results of efforts to address the challenges experienced in Tobago and lessons learnt during the pandemic with Monitoring and Evaluation in Tobago by May 31, 2023.***

4. **<u>Non Communicable Disease (NCDs) Management</u>**

Trinidad and Tobago, like many countries in the world, is faced with the prevalent issue of NCDs. According to the World Health Organization (WHO), NCDs, also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental and behavioural factors[8]. High rates of NCDs were noted during the COVID-19

[8] World Health Organization: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases. Accessed January 2, 2023.

pandemic among many of the patients who were hospitalised or succumbed to the virus.[9] The Minister of Health, in his message on the National Strategic Plan for the Prevention and Control of NCDs (2017-2021)[10] noted the significant increases in the domestic occurrence of NCDs namely, heart disease, diabetes, cancer and cerebrovascular disease. The Committee notes the efforts made by the MOH in addressing the issue of NCDs through the implementation of several initiatives during the period 2017 to present. Some of these include:

- the recruitment of an NCD Coordinator position within the MOH;
- in April 2017, the prohibition of the sale or serving of sugar sweetened, non-alcoholic beverages with added sugars by manufacturers and other producers in all government and government assisted schools;
- in January 2018, the launch of an aggressive health care screening programme for cancer, diabetes and hypertension to reduce their prevalence and incidence rates;
- in July 2019, the launch of the HEARTS Programme to significantly improve cardiovascular health by providing a set of practical step-by-step modules that operationalise the chronic care module for an integrated approach to the management of NCDs;
- in October 2020, the launch of the Gestational Diabetes Screening Programme with training being completed on the use of improved quality control procedures in laboratory management and the use of an interactive online platform for medical staff within all RHAs. Also, the procurement of laboratory equipment and supplies and ICT devices has commenced; and
- in May 2022, the consultation and upscaling of the Diabetes Foot Prevention and Management of Infection Initiative

Observations:

- ***The Committee commends the MOH for the substantial efforts made in identifying and addressing the significant challenges associated with the prevalence of NCDs***

[9] Report, pg. 99.
[10] A message by the Minister of Health on the National Strategic Plan for the Prevention and Control of Non Communicable Diseases (2017-2021): https://health.gov.tt/ncd-microsite/the-ministers-message-on-ncds, Accessed January 2, 2023.

in Trinidad and Tobago and encourages the Ministry to continue with these important initiatives; and

- ***The Committee notes that the "NCD Morbidity Debt" was created as a result of the COVID-19 pandemic as highlighted in Conclusion #2 of the Appointed Committee's Report.***

Recommendation:

- ***The MOH should identify the measures undertaken, to date, to address the backlog regarding Chronic Disease Clinic appointments and the measures to deal with the "NCD Morbidity Debt" and submit to Parliament by May 31, 2023.***

5. Implementation of recommendations made by the Appointed Committee

The Government appointed Committee made several recommendations (*full list at Appendix I*) **to the MOH in an attempt to mitigate the issues highlighted in the report**. Some of the key issues made in the report by the Committee were as follows:

- Data management system, data verification;
- Non-Communicable Diseases (NCDs) Management ;
- Oxygen;
- Mental health support for staff;
- On site recreational facilities for all RHAs;
- Meals;
- Self-Assessment; and
- National Policy regarding ICU admissions for different age groups.

The MOH advised that the recommendations were duly received and that some of them had been actioned. These included:

- **Data management system, data verification**: the MOH indicated that it had completed the planning process for an e-information management system and was currently consulting with the Ministry of Digital Transformation, after which the tendering process would begin.

- **NCDs Management**: the MOH indicated that it was in the process of conducting a national step survey on NCDs to measure the status of these diseases in Trinidad and Tobago. Additionally, the MOH advised that programmes were on the way in addition to the already existing programmes and policies.
- **Oxygen:** the MOH acknowledged the importance of oxygen supply and oxygen support. Oxygen was supplied by means of masks and the use of high flow nasal cannula used as a step to prevent the need for ventilator support.
- **Meals**: Meals were centralized at some of the available kitchens throughout the RHAs, as a means of sufficiently utilizing the current resources. Additionally, the timeliness of the delivery of meals was improved, along with menus to facilitate the new tier of patients.
- **Mental health support for staff:** the NCRHA provided the following mental health support for staff:
    - Psychosocial support;
    - The intervention of psychologists; and
    - A hotline for staff to be able to engage with families etc.

  The SWRHA provided tele mental health services such as telephone consultations. Additionally, contact information for mental health personnel was made easily available to staff. Staff was also rotated on a regular basis in an attempt to ease some of the strain of treating critically ill patients.
- **Self-Assessment**: The MOH advised that it has been undergoing self-assessment on a continuous basis. The MOH intended to hire an external consultant to look at the COVID-19 response in its entirety, possibly through the intervention of the Pan American Health Organization (PAHO).

Recommendations:

- ***The MOH should submit a report to Parliament by May 31, 2023 including the following:***
    - ***The Ministry's plans to collaborate with other Ministries, Departments and Agencies to fully implement the recommendations made by the Appointed Committee;***

- ***An estimated timeline for its full implementation;***
- ***The lessons it has learnt during the pandemic to ensure the resilience of the health sector;***
- ***The mental support for measures implemented for staff in the NWRHA, ERHA and the TRHA;***
- ***The development of onsite recreational facilities for all RHAs: and***
- ***An update on the creation and implementation of a National Policy regarding ICU admissions for different age groups.***

- ***The MOH should report to Parliament by May 31, 2023 on whether any of the Appointed Committee's recommendations will not be implemented including a brief description of the reasons for which each of these recommendations will not be implemented.***

CONCLUSION

The Ministry of Health is the national authority charged with oversight of the entire health system in Trinidad and Tobago. It plays a central role in the protection of the population's health and in ensuring that all organisations and institutions that produce health goods and services conform to standards of safety.[11]

The COVID-19 pandemic has tested government's preparedness for and ability to respond. The MOH plays a crucial role in protecting the population through its support of the ongoing COVID-19 response, the provision of essential medical services and the dissemination of accurate and timely information.

During the Second Session of the Twelfth Parliament, the PAAC conducted an examination into the Findings of the Report of the Committee Appointed to Investigate the factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago. Several issues such as staffing, data collection and management, challenges identified by the THA, limitations and recommendations were identified. Additionally, the Committee highlighted a number of recommendations to rectify these issues.

The Committee is of the view that the implementation of its proposed recommendations will lead to greater adeptness in the health care system by the MOH particularly in its response to COVID-19. Moreover, the Committee intends to monitor the improvements made in the implementation of the recommendations suggested in this Report.

[11] https://health.gov.tt/about-us

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

Sgd.
Mrs. Bridgid Mary Annisette-George
Chairman

Sgd.
Dr. Lackram Bodoe
Vice-Chairman

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APPENDIX I

Recommendations made by the Appointed Committee

Recommendations made by the Appointed Committee

1. **Data management system, data verification**: The hallmark of a modern health care system is information management, which allows continuous assessment of the effectiveness of the provision of health care vis-à-vis national expenditure. We had a lot of difficulty in accessing data for example the patient records. There is an urgent need for electronic medical records. The ambulance transfer database, community care database and the hospital care databases need to be urgently linked to support cost-effective and oriented patient outcomes.
2. **NCDs management**: The high rates of NCDs among the patients who died or who were hospitalized for COVID-19 were notable. More attention needs to be paid from a young age to the prevention and management of NCDs to ensure that our citizens become and remain healthy. Preventive management needs to be aimed at children, adolescents and young adults. A national survey of NCDs is urgently required and the data used to guide the review and revision of health promotion and treatment programs.

   It is likely that citizens with NCDs would again be at increased risk for poor outcomes if and when there is another event such as the COVID-19 pandemic. The clinical staff who have been hired temporarily and whose contracts would be discontinued at the end of the pandemic should be redeployed to respond to the NCD morbidity debt that has accumulated during this pandemic.
3. **Dedication of frontline staff:** We were impressed with the application of the nurses, doctors, paramedical and support staff who managed COVID-19 patients. However, at some RHAs, some of the staff in the frontline felt abandoned by the leadership. We recommend the RHAs implement a specific feedback system to monitor the needs of the staff on the frontline.
4. **Supplies from C40**: The frontline staff need 24 hours per day x 365 days support during the pandemic. We recommend that C40 should be continuously open, seven days per week.

5. **Oxygen**: At two sites we saw large oxygen concentrators which meant that these sites had less dependence on importation of liquid oxygen from elsewhere. We recommend that the oxygen requirements of all large institutions be reviewed with consideration of purchasing oxygen concentrators.
6. **Mental health support of staff is critical:**

   a) at one site there was a staff psychology service – we thought that this was a very good practice and should be encouraged at all sites.

   b) job security – short locum and lack of job security took a mental health toll on young doctors and young nurses. We recommend that such staff should be given contracts for a minimum of one year.
7. **On site recreational facilities for all RHAs**: At one site we saw a recreational facility for staff where open air gym exercises could be done. This was also a good practice for implementation at other sites.
8. **Meals**:

   a) Of the patients who participated in the survey, 49% felt that the meals were poor or very poor. In a qualitative analysis of open ended responses, patients were very concerned about the quality and timing of meals. Staff also told us that because of low nurse to patient ratios, meals could be very late. We recommend the use of specific patient care assistants to help with feeding and distribution of meals.

   b) Staff assigned to distant facilities reported inability to procure meals when on service to the RHAs. We recommend that meals should be provided for such staff who work in isolated areas.
9. **Communications with patients**: Anecdotal reports suggested that in the past, there has been severe dislocation between families and their loved ones admitted to hospital. Of the patients who participated in the survey, 60% were satisfied with communication with their doctors but a qualitative analysis showed recurrent complaints about communication with family. When we toured sites as well as during the staff interviews, we were told that there was a policy of telephone (+/- video) communication between doctors and next of kin on a daily basis. At one site the policy seemed to be for communication three days per week. We suspect that there has been recent improvement based on prior criticisms by patients. We feel that the RHAs should aim for a target of more than 90% satisfaction in

the area of effective communication. We recommend much more emphasis on patient communication and there should be daily communication with next of kin across all RHAs.

10. **Empathy**: In the qualitative analysis of the responses of the patients who participated in the online survey, concerns about empathy were highlighted. We recognize that with the surges that occurred, the staff were under tremendous stress in providing care. However, we must recall that the health care system is devoted to exactly that – care – and we urge all health care providers to remember this in all circumstances.
11. **Accommodation:** Participants of the online survey of patients ranked accommodation highly among their concerns. The major areas of dissatisfaction were facilities under the tents and bathroom facilities (temporary accommodations). We noted the complaints of two patients whose attorney submitted the documents on their behalf (please see the appendix). On the days on which we did our tours we did not see any overcrowding and facilities seemed adequate but at that stage, the surge was decreasing. However, the temporary accommodations need to be improved to more readily respond to surges.
12. **Sites within hospital where demise occurs**. Data on hospital deaths provided to us did not allow for us to discern where death occurred in the hospital: whether in the tents (biocontainment units), A&E, wards, ICU or step-down facility. We recommend that data on site of demise should be added to the national database as this would allow for site-specific evaluation of quality of care.
13. **Tocilizumab**: Tocilizumab is given at an advanced stage of COVID-19. Most staff were very impressed by its effects and perhaps C40 needs to increase purchasing of this drug. Though it is an expensive drug there is a cost-benefit to be realized from its use. We recommend that the policy regarding Tocilizumab use be reviewed.
14. **National Policy regarding ICU admissions and care of the elderly**: It was noted that 15.2% of paediatric admissions were to ICU compared with 1.2% of persons over 80 years of age. This was remarkable given the high death rates amongst the elderly. It was also noted that there were special paediatric ICU beds whereas there were no such facility for the elderly. In addition, the demand for paediatric ICU beds was in absolute terms much smaller than that for adult ICU beds. We did not find any mention of a national policy

regarding admissions to ICU for persons of different ages, and recommend that such a policy needs to be articulated.

15. **Views of relatives of COVID-19 patients.** This is an area that needs further investigation. We could not assess their views due to the time constraints of this rapid assessment. We noted that relatives had no or limited access to patients during admission. We recommend a formal survey of the views of relatives of patients who were cared for in the parallel health care system.
16. **Self-Assessment:** Further external assessments of the health care system should be preceded by a written self-assessment. The latter is the vision, the mission, the methods by which the mission is accomplished and a review of the outcomes of these processes. This would allow for the ready availability of data and facilitate a better outcome of external assessments. For example, to evaluate the ambulance transfer system it would have been useful to see in writing what the Ministry intended and their view of whether it was implemented, including the data that would support such views. An external assessor could then review the data objectively applying the standards that the Ministry had agreed to.

APPENDIX II

The Inquiry Process

The Inquiry Process

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

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

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

11. Engage in follow-up.

APPENDIX III

Minutes of Meetings

THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE
SECOND SESSION, TWELFTH PARLIAMENT
MINUTES OF THE TENTH MEETING HELD VIRTUALLY ON
WEDNESDAY MAY 11, 2022 AT 1:31 P.M.

Present were:

Dr. Lackram Bodoe	-	Vice-Chairman
Mr. Wade Mark	-	Member
Mr. Hassel Bacchus	-	Member
Mr. Stephen Mc Clashie	-	Member
Ms. Amrita Deonarine	-	Member
Mrs. Lisa Morris-Julian	-	Member
Ms. Keiba Jacob	-	Secretary
Mrs. Hema Bhagaloo	-	Assistant Secretary
Ms. Khisha Peterkin	-	Assistant Secretary
Ms. Rachel Nunes	-	Graduate Research Assistant
Ms. Kelly Cipriani	-	Parliamentary Intern
Ms. Khadija Gonzales	-	Parliamentary Intern

Excused were:

Mrs. Bridgid Mary Annisette-George	-	Chairman
Mrs. Ayanna Webster-Roy	-	Member

COMMENCEMENT

1.1 At 1:31 p.m. the Vice-Chairman called the meeting to order and welcomed those present.

EXAMINATION OF THE MINUTES OF THE NINTH MEETING

2.1 The Committee examined the Minutes of the Ninth (9^{th}) Meeting held on May 9, 2022.

2.2 The Minutes were then confirmed by Mr. Wade Mark and seconded by Mr. Stephen Mc Clashie.

MATTERS ARISING FROM THE MINUTES OF THE NINTH MEETING

3.1 As per item 3.2, page 2: The Vice-Chairman informed Members that questions were received from Ms. Amrita Deonarine, Mrs. Ayanna Webster-Roy and Mr. Wade Mark on Friday May 11, 2022 with regard to the inquiry into island-wide power outage and blackout that occurred on February 16, 2022.

3.2 As per item 4.4, Page 2: The Vice-Chairman indicated that a list of Reports for follow-up was compiled by the Secretariat, and emailed and uploaded to Rotunda for Members' consideration and approval.

3.3 As per item 11.2, page 6: The Vice-Chairman informed Members that questions for additional information were sent to the Ministry of Public Utilities, Ministry of Works and Transport, Ministry of Planning and Development and Ministry of Rural Development and Local Government on May 24, 2022 with a deadline of April 12, 2022. Responses were received from the:

i. Ministry of Rural Development and Local Government on April 11, 2022;
ii. Ministry of Works and Transport on May 6, 2022; and
iii. Ministry of Public Utilities on April 20, 2022.

Responses were uploaded to Rotunda.

PRE-HEARING DISCUSSION: AN EXAMINATION INTO THE FINDINGS OF THE COMMITTEE APPOINTED TO INVESTIGATE THE FACTORS CONTRIBUTING TO CLINICAL OUTCOMES OF COVID-19 PATIENTS IN TRINIDAD AND TOBAGO

4.1 The Vice-Chairman reminded Members that this meeting would be an examination into the Findings of the Committee Appointed to Investigate the Factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago.

4.2 The Vice-Chairman invited Members to review the Issues Paper prepared and circulated by the Secretariat with possible questions that can be used during the public hearing.

4.3 The Vice-Chairman invited Members to raise any issues or concerns on the examination into the findings of the Committee Appointed to Investigate the Factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago. Members discussed the areas of concern and the general approach for the public hearing.

SUSPENSION

5.1 There being no further business for discussion *in camera*, the Vice-Chairman suspended the meeting at 1:59 p.m., to reconvene in public.

AN EXAMINATION INTO THE FINDINGS OF THE COMMITTEE APPOINTED TO INVESTIGATE THE FACTORS CONTRIBUTING TO CLINICAL OUTCOMES OF COVID-19 PATIENTS IN TRINIDAD AND TOBAGO

6.1 The Vice-Chairman called the public meeting to order at 2:30 p.m.

6.2 The following officials joined the meeting.

MINISTRY OF HEALTH (MOH)

Mr. Asif Ali	-	Permanent Secretary
Dr. Roshan Parasram	-	Chief Medical Officer

Dr. Maryam Abdool-Richards	-	Principal Medical Officer (Institutions)
Dr. Avery Hinds	-	Technical Director, Epidemiology
Dr. Michelle Trotman	-	Thoracic Medical Director, Caura Hospital
Dr. Brian Armour	-	Chief Executive Officer, South West Regional Health Authority
Mr. Davlin Thomas	-	Chief Executive Officer, North Central Regional Health Authority

6.3 The Vice-Chairman welcomed the officials.

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

6.5 **Key Issues Discussed**:

1. The template of the medical form given to COVID-19 patients;
2. The methods utilised to encourage unvaccinated citizens to get vaccinated;
3. The recording of six hundred and thirty-three (633) deaths classified as "Other";
4. The data collection methods utilised by all RHA's during the COVID-19 pandemic;
5. The need for an electronic data collection system for all Regional Health Authorities (RHA's);
6. The data collection limitations experienced by the RHA's as observed by the Appointed Committee ;
7. The progress of standardising the data collection process across all RHA's;
8. The need to obtain World Health Organization (WHO) approved vaccines for children between the ages five to eleven (5-11);
9. The shortage of WHO-approved drugs to treat critically ill COVID-19 patients;
10. The challenges associated with South West Regional Health Authority (SWRHA) in supplying sufficient medical notes to the Appointed Committee ;
11. The ongoing process of implementing the recommendations made by the Committee;
12. The impact of manually sharing and collecting data amongst the RHA's for the preparation of the report;
13. The accuracy of the findings provided in the report;
14. The challenges associated with the ambulance services;
15. The need for decentralizing the ambulance sanitization hub;
16. The high turnover of staff;
17. The rationale for the recruiting additional staff;

18. The need for continued internal assessment of the impact of the COVID-19 pandemic on the country;
19. The need for more cohesion and collaboration amongst the RHA's;
20. The plans in place to recruit an international consultant assess the impact of COVID-19 on T&T;
21. The impact of recruiting patient liaisons;
22. The improvements made to the tent accommodations provided by the step-down facilities;
23. The issue of staff burnout amongst healthcare workers;
24. The implementation of psychological aids for staff;
25. The additional technical support introduced into the COVID-19 management system and the timeline for implementation;
26. The challenges associated with the transferring of patients between RHA's;
27. The circumstances that lead to drug shortages and the effects on the healthcare system;
28. The procurement process for the acquisition of oral anti-drugs and Pfizer vaccines;
29. The efforts made by the MOH to assist the TRHA in achieving its own parallel healthcare system;
30. The reasons for the lack of post mortems conducted and analysed;
31. The effectiveness of the policy for the protection of staff performing post mortems;
32. The concerns expressed by WHO on the decreasing number of countries performing COVID-19 testing;
33. The implications of the transferring of the twelve (12) highly trained doctors;
34. The impact of redeployment of staff recruitment during the COVID-19 pandemic;
35. The need for a national survey to be conducted on the Non-Communicable Diseases (NCDs); and
36. The process for monitoring and evaluating the implementation of the recommendations across the RHA's.

Please see the verbatim notes for the detailed oral submission by the witnesses.

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

SUSPENSION

7.1 At 5:52 p.m., the Vice-Chairman suspended the public meeting to resume for a post-hearing discussion with Members only.

RESUMPTION

8.1 At 5:54 p.m. the Vice-Chairman resumed the meeting.

POST-HEARING DISCUSSION

9.1 The Vice-Chairman sought Members' views on the public hearing. A discussion ensued.

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

9.3 The Committee agreed that the next inquiry would be an examination into that island-wide power outage and blackout that occurred on February 16, 2022.

ADJOURNMENT

10.1 The Vice-Chairman thanked Members for their attendance and the meeting was adjourned to **Wednesday May 25, 2022 at 1:30 p.m.**

10.2 The adjournment was taken at 6:04 p.m.

We certify that these Minutes are true and correct.

VICE-CHAIRMAN

SECRETARY

May 11, 2022

Appendix IV

Additional Information Requested

Questions for Additional Information

Provide in Writing

1. How each RHA implemented the recommendations listed in the Report;
2. The details of the data requested by the Committee to complete the Report and the timeline for which each RHA accumulated data in preparation for the Report;
3. The impact of the transfer of the twelve (12) highly trained staff members on the analysis of data;
4. The number of staff members on short-term contract at the North Central Regional Authority (NCRHA) and the South West Regional Health Authority (SWRHA);
5. The number of persons expected to be given 1-3 years contracts at the NCRHA and SWRHA;

Questions for written response

Challenges in the comparisons of COVID-19 data including case fatality rates

1. Briefly explain the statement 'the usefulness of the case fatality rates in a country like Trinidad and Tobago essentially resides in tracking the national situation and can be useful if accurate data is collected and analysed in relation to facilities and a time period in which these cases and death occur. The accuracy of the data will be critical for proper analyses and comparisons.'

Questions

i. How can this situation be rectified going forward?

Questions based on the TOR#2, #6: The Public Health Context of Deaths and Other Clinical Outcomes of COVID-19 in Trinidad and Tobago (pages 41- 42)

The following were the most common suggestions given to the Committee in a survey conducted on COVID-19 patients to understand how to improve the care and treatment they received:

- Improve the quality and timing of the meals (26 respondents);
- Improve facilities for communication with relatives and communication between staff and patients (22);
- Improve the accommodation including under tents (18);
- Staff should be more empathetic (18);
- Improve bathroom facilities - cleaning, privacy, especially in the tents (13);
- Increase staff numbers (11); and

- Better monitoring of patients (7).

Questions

1. Does the MOH agree with the findings of the survey? If yes, how will it be addressed?
2. Regarding the linking of hospital performance to the case fatality rate, state the following:
    a. The ratio of staff to patient - whether there were longer patient wait times and less responsiveness to services;
    b. The accessibility of health care delivery and also the measures taken to evaluate the quality of health care;
    c. Patient satisfaction; and
    d. Training of health professionals.
3. What is the health status of the population?

Questions based on the Analyses on TORS #3, #4 to #5 (pages 51- 52 of report)

1. What is the status of the issues identified in the preliminary review of the data and the solutions offered?

Questions based on 4.3.4 Patients Online Survey (page 60 of report)

1. Were any of the suggestions to improve the care of COVID-19 patients implemented? If yes, how and in what ways?
2. If no, how would these suggestions be taken into consideration going forward?
3. What were the lessons learnt?

The following were the most common suggestions given to the Committee in a survey conducted on COVID-19 patients to understand how to improve the care and treatment they received:

- Improve the quality and timing of the meals (26 respondents);
- Improve facilities for communication with relatives and communication between staff and patients (22);
- Improve the accommodation including under tents (18);
- Staff should be more empathetic (18);
- Improve bathroom facilities - cleaning, privacy, especially in the tents (13);
- Increase staff numbers (11); and

- Better monitoring of patients (7).

Question

1. How does the MOH intend to address the suggestions made by COVID-19 patients in this survey?

Questions based on key findings (page 77 of report)

1. What were some of the challenges encountered when relatives were unable to visit their loved ones during their hospital stay?
2. Would further investigation of the views of relatives of COVID-19 patients be undertaken?

Questions based on key findings (pages 81 – 82 of report)

1. What were the major challenges with the ambulance services?
2. How were the challenges rectified?
3. What were the lessons learnt?

Major findings under TOR #4 (pages 82-85 of report)

Staffing levels in T&T's public healthcare system during the pandemic

One of the issues identified in the preliminary review of the data related to human resources was staff shortages. Under the major findings of TOR #4 (pg. 82) the Committee found that staff shortages were common. Complaints were heard at levels ranging from Executive Management to doctors and nurses to Orderlies and Patient Escorts regarding the shortage of staff. The Committee stated that while it did not measure the workload of every single doctor, it was clear that the patient load had increased as evidenced by hospital occupancy rates. Almost every single doctor met complained of overwork almost to the point of exhaustion. Some doctors also had to do non-medical jobs e.g. lift and move patients, pull up patients in bed, process nasal swabs.

Questions

1. Has consideration been given to recruiting additional staff?
2. In light of the country's transition to the "endemic", what measures would be implemented to address staff shortages at the RHA's going forward?

Nurses (pages 83-84 of report)

Nurses complained of having to work long hours in Personal Protective Equipment (PPE), often without a break to drink water or go to the washroom. They reported that they had to lift and turn patients because of a shortage of attendants/orderlies and obese patients were very difficult to move. Two very experienced, very senior nurses were consulted by the Committee and they mentioned that under normal circumstances, the nurse to patient ratio would be one nurse to two patients in ICU. The National Policy on Intensive Care Services (Section 8.27 p11 MOH 2006) recommends one nurse to one patient in ICU. These senior nurses stated that on the Ward, the ratio should be one Registered Nurse to four (4) to six (6) patients. Attendants themselves gave reports of a shortage of attendants, which fits with reports from doctors and nurses about having to lift and turn patients without the help of orderlies.

Questions

1. How were these issues addressed?
2. How will it be addressed going forward?
3. Will an assessment of the effects of the extra duties being done by both doctors and nurses be conducted by the MOH?
    a. If yes, provide a timeline for this.
4. What were the lessons learnt?

Locum contracts (page 83 of report)

The Committee noted that a lack of job security took its mental toll particularly on young doctors and young nurses. The Committee found that there were frequent complaints about the prevalence of very short locum contracts of one (1) month to three (3) months being offered. The type of contracts created great uncertainty and depressed the morale of staff who were exposing themselves to great risk.

Questions

1. The Committee recommended giving staff contracts for a minimum of one (1) year. Would the MOH be implementing this recommendation?
    a. If yes, provide a timeline for this.
2. There have been reports in the past of Nurses looking for jobs and unable to get a job. Were these nurses absorbed via Locum Contracts or otherwise?
    a. If yes, provide details on this arrangement?

3. What steps (if any) will be undertaken to provide more stable, long-term job opportunities for public healthcare staff?

Challenges identified by the Tobago House of Assembly (THA) (page 89 of report)

The Secretary for the Division of Health, Wellness and Social Protection for the Tobago House of Assembly (THA) noted that the Tobago health system was in a state of flux as they had what she described as a "semi" parallel health system to treat and manage COVID-19 patients. The Secretary stated that they were working toward a full parallel health system to deal with COVID-19 cases. However, there were several challenges faced in adequately clinically managing COVID-19 patients and that the THA was exploring the possibility of accessing external international assistance and clinical support to assist with clinical training and development of treatment protocols.

Questions

1. How will the MOH aid the TRHA in achieving a full parallel healthcare system to treat COVID-19 patients?
2. The Secretary stated that there were several challenges to adequately clinically manage COVID-19 patients and that the THA was exploring the possibility of accessing external international assistance and clinical support to assist with clinical training and development of treatment protocols. How will the MOH assist in this venture?

Questions

a. What were the challenges faced in managing COVID-19 patients?
b. What assistance was rendered to THA to aid in rectifying these challenges?

Monitoring and evaluation of the quality of healthcare services in Tobago (page 94 of report)

Monitoring and evaluation is not a strong point at the primary health care level. Within the primary care setting, persons on the ground do not understand the importance of data collection and why it must be collected systematically. The Committee was also told that work was being done to tighten up how data is collected and used, but there have been challenges with employees perceiving data requests as a criticism of their performance. As such, the Committee had to utilize the date available to them.

Questions

1. Was the issue of data collection in the TRHA experienced by the MOH?

2. If yes, what was implemented to rectify this issue?

Limitations (pg. 97 of report)

Limitations encountered by the Committee were as follows:

Timeliness in the receipt of data and reports

For example a request was made for datasets by the Committee related to COVID-19 deaths and patient management on January 19th but most arrived two weeks after the request. Some datasets arrived too late for the Committee to utilise or it was never received: data such as the patients' experience while using the ambulance transfer system, patients' notes from some RHAs were not submitted. Some critical variables could not be analysed because they were either not captured or the quality of the data entered was inconsistent e.g. ethnicity data, comorbidities for community-treated patients.

Questions

1. Outline the measures the MOH would implement to address this issue.
2. How are COVID-19 patients' data records managed?
3. What are the reasons for nurses' notes or nurses' treatment charts not being included in medical notes?

Post-mortems of COVID-19 patients in T&T

No post-mortems were performed on COVID-19 patients, therefore datasets on COVID-19 patient care was not received and conclusions could not be made with regard to deaths. This could potentially pose a challenge with the proper treatment and care of COVID-19 patients.

Questions

1. What were the reasons for post-mortems not being conducted on COVID-19 patients?
2. By not conducting any post-mortems, how does the MOH evaluate the deaths of patients in T&T?

Quality of the data in the datasets received by the RHA's

It was not clear whether there were internal processes at the RHA's and MOH to address data quality and verification for all COVID-19 data collected. A request was made for these processes by the Committee but there was no response by the time of writing the report. The Committee noted that

there were many instances of entries in the wrong columns in the Hospital Admissions and Patients Managed at Home datasets. One example discovered was the presence of dates of birth and addresses in the column for sex in the Patients Managed at Home dataset.

Question

1. What were some of challenges faced that have been associated with data management at the RHA's?
    a. How is data currently being managed?

An Electronic Data Management System can be used collaboratively amongst the RHA's for more effective data collection and management of all patients.

Questions

1. Has consideration been given for the implementation of an Electronic Management System in the health sector?
    a. How will the MOH implement such a system?
2. What is the average cost for the provision of the electronic medical records system?

Medical notes being compiled by the RHA's did not always have the nurses' treatment charts or nurses' notes attached

There was difficulty in confirming what medications were actually received by the patients and therefore a complete assessment of TOR#5 was not possible. This was due to the fact that nurses' treatment charts or nurses' notes were not always attached with medical notes. The Committee therefore relied on reports of staff and management to conduct its research and findings. This could limit the accuracy and wealth of information accessed, to fully comprehend the medical notes of COVID-19 patients in T&T.

Questions

1. Were notes and treatment chart updated prior to the COVID-19 pandemic?
2. How would the missing information affect the overall efficient care and treatment of patients presently and in the future?
3. How were these records stored after COVID-19 patient recovers and leaves the hospital?
4. Are there measures in place to better compile patient records during treatment at the public healthcare institutions?

a. If yes, state.

Recommendation 2 - Management of Non-Communicable Diseases (NCD's) (page 99 of report)

The Committee found that high rates of NCD's among patients who died or were hospitalised due to COVID-19 were notable. The Committee stated that more attention needs to be paid from a young age to the prevention and management of NCD's to ensure that T&T citizens become and remain healthy. The Committee further suggested a national survey of NCD's was urgently required and the data should be used to guide the review and revision of health promotion and treatment programs in Trinidad and Tobago. The Committee also suggested that clinical staff who have been hired temporarily and whose contracts would be discontinued at the end of the COVID-19 pandemic should be redeployed to respond to the NCD morbidity debt that has been accumulating during this pandemic.

Questions

1. What is the status of NCDs management?
2. State the lessons learnt from the NCDs management.
3. Given the high rates of NCDs in COVID-19 patients who died or who were hospitalised, what further measures would the MOH undertake to promote healthier lifestyles particularly during the COVID-19 pandemic?
4. Would the MOH consider the suggestion of the redeployment of clinical staff and if so, how would this be undertaken?
5. What communication strategies has the MOH utilised to promote healthy lifestyles and aid in the combatting of NCDs during the COVID-19 pandemic?
    a. What plans does the MOH have in place going forward?

Another challenge identified was in relation to comorbidities i.e. obese (challenges moving the patients) and diabetic patients were difficult to manage.

6. What additional resources were allocated towards helping healthcare to manage COVID-19 patients with varying degrees of comorbidities and its varying challenges?

Recommendation 3 – Dedication of frontline staff (page of report)

'Some of the staff felt forgotten by the leadership/management in the RHA's'.

Questions

1. What steps can the MOH undertake to alleviate this concern?
2. What is the status of the implementation of a 'specific feedback system'?

Recommendation 5 - Oxygen (page 100 of report)

Questions

1. What is the cost of oxygen concentrators?
2. What is the status of purchasing oxygen concentrators at all large institutions?

Recommendation 6 - Mental health support of staff is critical (page 100 of report)

The Committee in its assessment observed that at one site there was a staff psychology service. In the recommendations put forth the Committee felt this should be practiced at all RHA sites to support staff emotionally and mentally.

Questions

1. Were psychological services established throughout the RHA's to support staff during the ongoing COVID-19 pandemic?
    a. If yes, please provide a timeline for this service.
2. In the daily briefings by the MOH, health care professionals indicated that 'we are now in the phase of an "endemic"', does the MOH intend to address the Mental Health of its staff going forward?
    a. If yes, provide details.
    b. If no, why not?

One of the challenges highlighted (page 51) regarding Mental Health was the impact of the large number of patient deaths on the staff members, especially nurses and junior doctors.

2. What support measures have been implemented or plan to be implemented to support staff that were affected in this manner?

It was also reported that about one Registered Nurse was on the ward nursing twenty (20) to thirty (30) patients. This severe workload must take a toll mentally, physically and psychologically. Some nurses spoke of the psychological pressure they felt when confronted with many deaths in a day. They also spoke of the extreme mental stress they faced whenever one of their colleagues died from

COVID-19. One nurse, who is the mother of two young children, made a plea for Day Care Centres near to the hospital. She pointed out that she often finished her shift late because of the very ill patients. Having her children nearby would ease her anxiety.

Question

1. How does the MOH plan to treat with its nursing staff that were mentally affected in such ways?

Recommendation 7 - On site recreational facilities for all RHA's (page 100 of report)

At one site, the Committee observed a recreational facility for staff where open air gym exercises could be done. The Committee stated that this would be another good practice to have across all RHA sites.

Question

1. Are there plans in place to implement this initiative across all RHA sites? How would this recommendation be included going forward?

Appendix V

Verbatim Notes

VERBATIM NOTES OF THE TENTH VIRTUAL MEETING OF THE PUBLIC ADMINISTRATION AND APPROPRIATIONS COMMITTEE HELD, (IN PUBLIC), ON WEDNESDAY, MAY 11, 2022, AT 2.30 P.M.

PRESENT

Mrs. Bridgid Annisette-George	Chairman
Dr. Lackram Bodoe	Vice-Chairman
Mrs. Lisa Morris-Julian	Member
Mr. Wade Mark	Member
Ms. Amrita Deonarine	Member
Mr. Hassel Bacchus	Member
Mr. Stephen Mc Clashie	Member
Ms. Keiba Jacob-Mottley	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Ms. Hema Bhagaloo	Assistant Secretary
Ms. Rachel Nunes	Graduate Research Assistant

ABSENT

Mrs. Ayanna Webster-Roy	Member

MINISTRY OF HEALTH

Mr. Asif Ali	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Maryam Abdool-Richards	Principal Medical Officer (Institutions)
Dr. Avery Hinds	Technical Director, Epidemiology
Dr. Michelle Trotman	Thoracic Medical Director, Caura Hospital
Dr. Brian Armour	Chief Executive Officer, South West Regional Health Authority
Mr. Davlin Thomas	Chief Executive Officer, North Central Regional Health Authority

Mr. Chairman: Good afternoon to all, and I want to say a very special welcome to the officials of the Ministry of Health and the Regional Health Authorities. I am Dr. Lackram Bodoe, the Vice-Chairman of the Public Administration and Appropriations Committee.

The Committee on Public Administration and Appropriations has the mandate to consider and report to the House on:

a. The budgetary expenditure of government agencies to ensure that expenditures is embarked upon in accordance with parliamentary approval;
b. The budgetary expenditure of government agencies as it occurs and keeps Parliament informed of how the budget allocation is being implemented; and
c. The administration of government agencies to determine hindrances to their efficiency, and to make recommendations to the Government for improvement of public administration.

The purpose of this meeting is to examine the findings of the committee appointed to investigate the factors contributing to clinical outcomes of COVID-19 patients in Trinidad and Tobago.

The role of this Committee is to:

1. Assist the stakeholders in achieving the efficient delivery of services, while ensuring that expenditure is embarked upon in accordance with parliamentary approval;
2. Determine the challenges being faced and possible solutions to these challenges; and
3. Make recommendations for improvement of public administration.

This meeting is being broadcast live on the Parliament's Channel 11, on Radio 105.5 FM, and the Parliament's YouTube Channel *ParlView*. Viewers and listeners can send their comments related to today's enquiry via email at Parl101@ttparliament.org, facebook.com/ttparliament and Twitter, @ttparliament.

I just wish to advise participants that if you can keep your microphones muted until recognized by the Chair. So, I would want, first of all, to ask the members of the Committee to introduce themselves. They are members of the PAAC committee. Can I ask you to introduce yourselves?

[*Introductions made*]

Mr. Chairman: So, thank you, members. I am Dr. Lackram Bodoe, Vice-Chairman of the Committee, and will be chairing the meeting this afternoon. Again, I want to say a very special

welcome to the officials of the Ministry of Health and the officials of the Regional Health Authorities. I thank you for being here with us this afternoon. I know that since the beginning of the pandemic you have joined this particular Committee on many occasions, and I thank you again. So, I want to say a very special welcome to Permanent Secretary, Mr. Asif Ali and if I can invite you, PS, to have the other members of your team introduce themselves. PS Asif Ali.

Mr. Ali: Thank you, Chairman. So, Asif Ali, Permanent Secretary, Ministry of Health. I will let the other members of the Ministry introduce themselves first and then the RHAs. Thank you.

[*Introductions made*]

Mr. Chairman: Thank you. Thank you, PS and thank you officials and, again, welcome. If I may start, of course, it is a very important enquiry that we are doing this afternoon and a matter, of course, which is still on the minds of our citizens. So, if I can just open by inviting you, PS, may be to make a brief opening statement, if you are so inclined.

Mr. Ali: Thank you, Chairman. Good afternoon Chairman and, once again, members of the Committee, colleagues from the Ministry of Health and the RHAs and members of the viewing public. As we begin, Chairman, I just want to take this opportunity to really thank and acknowledge our health care workers, all of them, for their continued dedication and commitment, especially during this global pandemic.

The Ministry of Health and the RHAs, we welcome this opportunity to review and discuss the findings of the report conducted by the Government Appointed Committee into the factors contributing to the clinical outcomes of the COVID-19 pandemic. The Ministry recognizes the importance of these findings in addressing possible constraints and challenges in the system during the pandemic. In fact, both the Ministry and the RHAs would have already taken action with regard to some of these recommendations prior to the submission of the report, and would have considered the other recommendations for immediate action. The Ministry of Health and the RHAs continue to ensure that our public health care system remains agile and resilient as we treat and care for persons during this pandemic. I thank you, Chairman.

Mr. Chairman: Thank you. Thank you very much, PS. And PS and officials of the Ministry and the RHAs, even though this enquiry really is meant to focus on the report of the committee, I just want to open, to put us in perspective because, of course, this report is some three months old. And PS I am happy that the Ministry has taken some action, and we look forward to hearing what has been done so far. But before we go into the details of the report, may I ask you PS and,

perhaps, I could invite the CMO, because I am sure the population at large would want to know, would want to get some sort of update as to where we are. So, if I could just invite, through you PS, the CMO, Dr. Parasram, to give us a brief update as to where we are as we speak with regard to the COVID-19 situation in Trinidad and Tobago, particularly, with respect to the issue of whether we are still in pandemic stage or whether we are endemic, and other factors that the population and the Committee would want to be apprised of at this point in time.

Dr. Parasram: Okay. Thank you, Chairman. So, maybe I can begin with, as we normally do with our press conferences, the daily summary, so it would kind of start—I do not know—the ball rolling. So, if I could summarize as of yesterday, which was the 10th of May, 2022, we would have had 574 new positive cases recorded. There would have been five reported deaths at that point in time. Our total active caseload, 8,817; number of patients in hospital, 192. And, again, our vaccination status by way of total: country vaccination, 50.8 per cent, which is really 711,698 persons that have been fully vaccinated. By way of our boosted programme, we have 151,870 persons that have taken the initial Vaccination Programme, which is the primary series and, of course, opted to have a booster and have been, of course, beyond their six-month period where they could have had a booster.

By way of variants of concern, we are still within the pandemic phase. We have seen the introduction of many variants into Trinidad and Tobago over the last two and a half years. Initially, the Wuhan lineage, which is the original lineage of this particular COVID-19 virus came into Trinidad, firstly, on the 12th of May, 2020. Subsequent to that, we would have seen many stages of our pandemic, where we would have had increases and decreases in the number for cases and the number of deaths. Throughout the years, we would have seen first, the introduction of Gamma, as the first variant of concern, followed by—we would have had some introduction of Alpha, but it remained very, very low level, but our major concern really came when we had Delta into the country in late 2021. At this stage, we now have what seems to be a much more manageable variant of concern in the sense that it is less virulent, but it is highly infectious, meaning, it can spread quickly and more quickly than any other variant we have seen before. But it seems to be, on the face of it, less virulent, meaning, causing less severe disease and less death. Whether that is a combination of when it was introduced into the population, and largely into Trinidad and Tobago, given the fact that we have quite a level of immunity—whether it be from vaccination plus naturally acquired infection, of course, time will tell us as to

what will happen as we go forward.

But it seems like we are in a phase where the hospital admissions are holding in terms of the management of it. Aside, that being said, we have removed most of the public health restrictions, at this point in time, as of the 04th of April, 2022. So, it is a time that we are looking very closely at the daily data as it relates to hospitalization more so and deaths. We have a seven-day rolling average of three as it relates to deaths, and it is something that we are paying very close attention to but it is, I think, heartening, a little heartening, that after a month or so of having the full reopening of the economy, removal of restrictions aside from masking, that we are still seeing that reduction or holding in hospitalization and deaths, which is a good sign.

Of course, you have to be—COVID-19 has taught us that we are in a time of uncertainty, and we have to look out for new variants of concern coming into the country at any point in time and then through the world, and I think that is the greatest threat that we all have going forward. But if we continue in this vein, I think, we will be well on our way to go towards the endemic phase in the near future in the world and in Trinidad and Tobago.

Mr. Chairman: Sorry. Thank you, CMO. And you mentioned the full reopening of the economy and, of course, another area of concern is with the reopening of schools. I do not know if you would want to comment on what the current situation is in terms of the numbers in the schools and so on and also with regard to—well, I would let you answer that first.

Dr. Parasram: So, I mean, the Ministry of Education is the authority that deals with all matters related to schools. The Ministry, of course, stands ready to assist in any way as it relates to the COVID-19 management of cases as they may arise. The hon. Minister would have given some statistics which she had gotten from the Minister of Education directly this morning at our press conference. I do not have it with me right now, but that information was shared Minister to Minister and, as such, I was not privy to it in terms of the number cases and the like. But, certainly, we would have had full reopening of schools on this, the third term so, meaning, that all levels of school are now out. So we are looking closely at what is happening daily especially our paediatric hospitalizations on our end to ensure that we are, at least, ready in the event that there is an increase in paediatric cases and, certainly, if there is an increase in MIS-C presentations amongst that age group.

Mr. Chairman: Thank you, CMO. PS, if I can just, before we leave the issue of schools, I recognize and appreciate the fact that the Ministry of Education would be primarily responsible,

but from the point of view of the vaccines for the five- to 11-year-olds, can you provide any update at all as to where we might be with that issue?

Mr. Ali: Sure. Thank you, Chair. So, this was also discussed at the press conference this morning. We have signed off on all the necessary legal documents with the Government of Spain and Pfizer, and we are currently working on the logistics. So, we hope to have word within the next few days as to an exact date when to expect those vaccines, but it would be shortly, Chair.

Mr. Chairman: Thank you. Thank you, PS. Before I move on to the report, I just wanted, from the public's point of view, and I know that some institutions are no longer being used for COVID and so on. Some of the institutions have been decommissioned. So, PS, if I may, perhaps, through you, I know Dr. Richards has been involved in the institutions and so on. Could we, perhaps, get a lil update as to where we are currently in terms of what facilities are being used currently for COVID and what the situation is there? PS?

Mr. Ali: Sure. Dr. Richards?

Dr. Abdool-Richards: Good afternoon everyone. The current facilities that are in use for COVID-19 as of today include: the Caura Hospital; the Couva Medical and Multi-Training Facility; the Area Hospital Point Fortin; the Augustus Long Hospital; the St. Ann's Hospital, which has a separate section for COVID; the Scarborough Regional Hospital; the Scarborough General Hospital and the St. James Medical Complex. The Field Hospital at Couva is ready and available to be used, although there have no patients in that hospital since about February or so.

Today, we are at about 23 per cent of the occupancy, when we looked at our overall numbers and somewhere in the vicinity of about 33 per cent with our adjusted denominators. That is, as of today, we have removed some of the institutions that were previously being used as part of the Ministry of Health plan to consolidate centres within the parallel health care system. So, for example, in Arima, we would have reduced the footprint, meaning, the number of beds that are being used to manage COVID patients from approximately 71, we now have a reduction to about 20 beds that are being used to manage COVID-19. All of our step-down facilities are empty. The Tacarigua Racquet Centre has been returned. The other step-down facilities: UTT Debe, UWI Debe and UTT Valsayn are currently empty. Thank you.

Mr. Chairman: Thank you, Dr. Richards. And, of course, it would be remiss of me, PS, if I did not ask our friend, Dr. Hinds, just to give us a lil perspective and, perhaps, in terms of where we are where we might be heading, through you, PS.

Dr. Hinds: Thank you, Chair; thank you PS. As we have been seeing and we have been noting, what we have seen from the start of the year through to the present time was at the start of 2022, we had higher numbers coming out of the peak of Delta we would have been experiencing at the end of 2021. We then noted Delta then got superseded by the newer variant Omicron, that some of the case numbers did begin to come down. So we had a period when the numbers began to fall and that period lasted us through May into a bit of April. We got to almost a sort of rolling average, four cases for the year 2022, at least, in just around the first week of April or so. We got down to about 238 and then we saw an increase again up to the start of May, and now we are seeing fluctuations in a downward direction to whereas at the start of May our rolling average was about 530-something and now it is 486.

So we are looking at that overall trend in cases against the backdrop of the other information that the CMO and the PMOI would have given with respect to how that is impacting on the health facilities, the strain on the health system, et cetera. So, we are observing the trend at this point in time, subsequent to the changes that CMO would have mentioned with respect the opening of the majority of the economy at the start of April, removal of the remaining restrictions. We are looking to see how those changes would result in a new equilibrium with respect to the number of new positives that come to light. So that continues to be under observation. Like the CMO and the PMOI have indicated, so far the health system and the health system capacity continues to be more than adequate to deal with what is presenting itself at this point in time.

Mr. Chairman: Thank you very much, Dr. Hinds. So, if we can move in really into the purpose of the enquiry, which is really to examine the report of the committee appointed to investigate the factors contributing to clinical outcomes of COVID-19 patients in Trinidad and Tobago, and this was submitted on the 14th of February, 2022. So, as I mentioned earlier, this report is just under three months old. And just to focus on the findings of this report, but before I do that, I just want to thank the members of the committee for their very hard work. I know that there would have been some limitations in terms of time and so on, and this enquiry would have been conducted in a time which would have represented a peak or a wave. But, nevertheless, I just want to thank the members of the committee.

I am in the fortunate position actually of personally having interacted with four members of the committee. And I say this for a reason, because the quality of any report depends, in addition

to the information and the data that is gathered, also depends on the expertise of the people who are conducting the enquiry. I was fortunate to have Prof. Phyllis Pitt-Miller as my lecturer in anaesthetics, during my medical school days, many years ago. And I remember her being very meticulous. I also worked with Dr. Anton Cumberbatch when he was previous Chief Medical Officer when I was Chairman of South West. I found him to be very professional and I have also had the privilege of working with Prof. Terence Seemungal as Dean of UWI, as Chairman of South West and Dr. Vidya Dean would have been my contemporary in medical school days. I do not know Prof. Simeon, personally, but his work seems to be of good calibre. So, I just say that in terms of and to thank the members of the committee for the work in preparing a report, despite the challenges and so on that they may have encountered.

So, before I invite other members of the Committee to raise issues, I just wanted to go through a few points, PS, in the report, and it may be easier in terms of if we look at the report by way of page. I will open by looking at page 21, under the heading of "Audit of Medical Records of the COVID-19 Patients". Now, one of the things, one of the issues that came about in this report is—I do not want to say the shortage of data in terms of the difficulty of the committee accessing data. If we look at the paragraph, second to last paragraph, it says that 90 notes were requested for audit—90 medical records—but, at the end of it, only 25 were submitted.

To me, that itself is a lil bit worrisome. Again, I know there were constraints in terms of the medical records. But when I looked here, I saw that the committee accepted a convenience sample of 25 patient notes chosen by the ERHA, the NCRHA and the NWRHA. And the question that comes to my mind, PS, and, perhaps, the CEO of SWRHA might want to jump in here for a moment—I see that the SWRHA was unable to provide any sample notes at all for the committee. I do not know, perhaps, PS, if there might have been a reason for that. So, I would invite, through you PS, maybe whether the CMO Dr. Armour may have some explanation for that. It is something that stood out, stood out in my mind.

Dr. Armour: Thank you, Chairman. With your leave, PS?

Mr. Ali: Yes, please.

Dr. Armour: Okay. Thanks, Chairman. The information for the patients' medical records it was sent at the request of the Ministry. As you indicated, there were logistics issues for us in terms of two-fold: One, the size of the notes, particularly the nurse in ICU notes, as well as matters of redacting for patient confidentiality, and then the newer period based on the actual clinical nature

of the note. There are in areas of what we call hot zones. So, by the time we were able to turn around the logistics and submit it to the Ministry of Health, we were advised that it was beyond the deadline as desired by the committee. So, the committee decided that they would have deferred accepting the submission from the Ministry of Health as we in South West provided through them a little bit beyond the deadline, at that point in time.

Mr. Chairman: All right. Thank you. Thank you, CEO. That is reassuring. So we have an explanation as to why the SWRHA notes were not included in the analysis.

Dr. Parasram: Chairman, if I may add to the discussion. I remember the initial number being 90, but the actual formal request that came through Dr. Stewart Smith, which was our focal point, actually was 60 notes. So, we actually got a request for 60 notes in that format and Dr. Armour would have had a certain number of that total quantity which he just explained as well. So, it was not quite 90 on the face of it.

Mr. Chairman: Thank you. Thank you, CMO for that clarification. So, I just want to move on to the next page, page 22, under the heading "COVID-19 Deaths" and that paragraph—now, we have been speaking about the comorbidities and so on, but I see here that, and I quote from the report:

> Ethnicity and obesity were not included and the Ministry of Health informed the committee that these variables were originally included in their data collection template, but due to their inability to verify the entries they were removed.

As you would appreciate, CMO, an enquiry of this nature and an event of this nature gives us the opportunity to gather as much data as we can, not only to analyze the current situation, but in terms of moving forward. So, I do not know if, through you PS, whether an explanation can be provided as to this situation where this data was not collected with regard to ethnicity and obesity.

Mr. Ali: Sure. Thank you, Chair. CMO, you want to take that question?

Dr. Parasram: Yes. So, I would ask if it is possible between Dr. Hinds and Dr. Trotman to explain the way data, in terms of deaths, are collected, the forms and the like, so that persons understand how it is collected and maybe try to explain this statement that is in the body of the report.

Dr. Hinds: Thank you, CMO. If I could jump in at the start. With respect to just clarifying something that I do not think was may be properly represented in the summary, but was given.

It was not that the data on obesity and ethnicity was originally collected. In fact, the initial set of data did not have any of those entries on either ethnicity or obesity for the first maybe 50 per cent of the deaths that would have been collecting up to the point in time when we do the marker and submitted this data that began to be collected a little later on at the request of Dr. Trotman and the team, and even then the information was, (a) "hatchy"; and (b) sometimes not in a quantitative format for the obesity information, in particular, added to which there are known difficulties with self-reporting ethnicity in any population.

So, self-reporting being one thing, a third party assessment of ethnicity being another thing; the late start in collecting the data being a third thing. It was not considered that the quality of data available for ethnicity or obesity would have been contributory to making sensible correlations and, therefore, it was suggested that that information in its existing format not be utilized, because you can make erroneous correlations based on data that was not (a) complete; and (b) verifiable. So, I think that is a better explanation that what was summarized in the paragraph. And I would also let Dr. Trotman add to the discussion in terms of the actual mechanism for collecting or extracting that data from the files.

3.00 p.m.

Dr. Trotman: Thank you, Chair. Michelle Trotman here. Through you Chair, I echo what Dr. Hinds would have said. Data is collected regarding deaths, and always when we speak of deaths, we send our condolences to all of the families who would have experienced a death within this COVID-19 pandemic.

The actual groundwork that goes into the collection of data realizes itself in a format that is a template, and on that template would include information that is demographic in nature, inclusive of the name, the age and, as we evolved, ethnicity and also obesity or assessment of body mass index. That information is collected by the physicians who are actually taking care of the patients, and submitted via a template to myself, where it is audited for the most part to ensure that as much information as possible that could be gathered is on the form and then directed on to the Ministry of Health and on to Dr. Hinds' team.

As could be well imagined, that information is not always 100 per cent. However, whenever it was available the physicians would put that information on board, and when lacking we would go back to try to collect and fill in the gaps as much as possible. I thank you.

Dr. Parasram: So before I hand you over, just to add and to close it off a little bit, the form that

Dr. Trotman has spoken about is our data collection form that really evolved from the start of the pandemic onwards, and as you could imagine, as vaccines actually became available, vaccination status was also added to the form as we went forward. So it is a form that continuously evolved throughout the pandemic to take into consideration various data fields, and it was added to as we went along. Now in its final format, I think it is a very good tool, and really it is one of the ways the pandemic has shown us that even through the pandemic we can evolve as a system, and improve the systematic collection of data. So the pandemic, I would say, has helped us quite a lot in the health system to see how there can be continuous improvement in the management of data, and the presentation—the collection of data, so really helping our surveillance system above and beyond COVID-19.

[*Pause*]

Mrs. Morris-Julian: Chairman muted.

Mr. Chairman: I am sorry. I was saying CMO, whilst I understand that it might be difficult to collect data like BMI and so on and to define obesity, whether the data of ethnicity is that being collected now in the modified forms, in the updated forms?

Dr. Parasram: Yes, sure. So I will pass you back over to Dr. Hinds, maybe to go into detail as to what the final form looks like in terms of those fields.

Dr. Hinds: I will actually in turn defer you to Dr. Trotman who has the template for the form before her. Sorry.

Dr. Trotman: Certainly. The template for the form, as I would have begun to establish earlier, includes the patient's name; the patient's date of birth; the patient's gender; the patient's ethnicity; the patient's vaccination status; their BMI or body mass index, and if that is not available a description as to whether they are overweight, within normal weight or obese; the patient's date of admission, the patient's date of death; the patient's location of death.

The other information centres around the clinical information that has to do with the symptoms of presentation, following which the patient's physical examination, inclusive of vital signs and then assessment and treatment plans, and hospital course or home course where are applicable.

Mr. Chairman: Understood.

Dr. Trotman: The patient's—

Mr. Chairman: Sorry, I interrupted you.

Dr. Trotman: The patient's COVID status would also be indicated with the date of their COVID swab. Of course, most time in this context would have been a positive COVID swab. Thank you.

Mr. Chairman: Thank you. So just to be clear, and I want to leave this issue. Just to be clear, we are saying that at the beginning the data regarding ethnicity was not included in the form? Am I correct in assuming that?

Dr. Trotman: Yes.

Mr. Chairman: Okay, but it is now currently included? Correct?

Dr. Trotman: Yes, it is.

Mr. Chairman: So thank you. I want to hand over to my colleagues on the Committee, but I just want to raise one more issue. If we go page 25, page 26, and this is the analysis based on the terms of reference—there are five terms of reference for the Committee, and this one is to identify the profile of the patients and so on. I refer particularly to the place of death, and one statistic that strikes here is the fact that in terms of recording the place of deaths, we have 633 or 19.3 per cent of the 3,278 deaths. That is the number of deaths at that point in time when the enquiry was done. So 633 that were the subject of this report were included in the category described as "Other". You know, PS, CMO, I was a little bit flabbergasted by this data, or lack of data some might say. Is there perhaps an explanation as to how this could have come about?

Dr. Trotman: So yes, if I may. We have to be minded that the report was written, as you said, by our esteemed colleagues. So there were five persons that were authors of this particular document, at the start of it. So they have put together a document, which we received, at the Ministry of Health, trying our best to recognize them as independent. We would not have had access to the data sets, for example, even the data on the reports collected, the surveys done among staff, for the mere fact we tried to let it be independent, and the Ministry never got its hands in the report, or in the body of it, and in the nitty-gritty of the report.

Having said that, that particular area of concern was of concern to us as well, and Dr. Hinds would elaborate when I am finished. But we did write the committee, after receiving the report, I think a day or two after getting the report, trying to clarify what that categorization by the committee meant, the categorization of "other".

So Dr. Hinds, I do not know if you want to go into some more detail as to what we would have asked for, clarification and maybe what we would have provided.

Dr. Hinds: Thank you, PS, Chair. So one of the things that we noted, having not interfaced with

the committee members during their examination of whichever data sets we did provide to them, what we noted when we looked back at this particular report, was that the categorization of "other" was actually quite broad and, in fact, included San Fernando General Hospital, which accounted for 11.3 per cent of the deaths, out of that 19.3 that you see there noted.

The other parts of "other" included other institutions that would have been grouped as smaller institutions and not the big ones that you see listed here. So "other" did not mean "data not available", but it did mean that they used a catch all for anything that was not in the list that they provided in their table, and the most significant chunk of that "other" was the 11.3 out of 19.3 per cent that actually were attributable to one of the local hospitals. But as we have explained, we did not actually interact with them or look at the data and the assessment thereof prior to the release of the report. So we only noticed that this is how it is categorized subsequent to the report having gone into the public domain.

So we do not want the impression to be that there is not information on this "other". The "other" just includes a wide range of institutions, including a fairly large one, and if it were to be re-categorized using that same list, but just adding San Fernando General, then the "other" would have already dropped to 8 per cent, and that "other" would be other smaller institutions as well. So it is not really a large percentage of unknown, which is what I think "other" might be currently being interpreted as. So one of the caveats in interpreting some of what we see here.

Mr. Chairman: Thank you, Dr. Hinds. So you are saying that the category "other" we can actually account for those 633 deaths? Am I to understand that? And if that is the case, therefore, PS, if I can ask if the Committee could be provided in writing a breakdown of where those 633 deaths would have occurred. Just for completeness. I know you mentioned some of the smaller institutions, but I would want to have, and I am sure the Committee and the population would want to have that breakdown in detail. So PS, can I ask for that in writing, if those figures are not readily available?

Mr. Ali: Dr. Hinds, is that possible?

Dr. Hinds: Absolutely. We would be quite happy to provide that in writing with some additional categorization for that "other".

Mr. Chairman: At this point, I would want to open up the discussion to other members of the Committee. Member Mark, I think you wanted to come in at this point?

Mr. Mark: Yes, thank you very much, Mr. Chairman. Let me join you in welcoming the team

from the Ministry of Health as well as the various RHAs. Mr. Chairman, before I delve into some of the areas I would like some clarification on, I just wanted to ask the Permanent Secretary, based on a statement made by the CMO earlier, is there a management system in place that would allow data, once received by an external agency, given the management responsibility of the Minister of Health, for those pieces of data or information to find their way to some unit, or some institution, or some individual within the framework of the Ministry of Health?

I make reference specifically to the point that was made earlier that even though data would have been provided on a state of play as it relates to children, it was on a Minister to Minister basis and, therefore, the CMO indicated—and he can correct me if I am wrong—he was not privy and the information was not shared with him. So I just wanted to find out, is there a mechanism in place at the Ministry to permit information flow, so that the Ministry at all points of time would be on top of what is happening in our society relevant to COVID-19 matters? Through you, Mr. Chairman, I would like to ask the Permanent Secretary that question.

Mr. Ali: Thank you. Through you Chair, yes member Mark, there is a system. It is through our National Surveillance Unit. I would let the CMO maybe expand a bit more on the actual mechanics of that system, if I may.

Dr. Parasram: So the National Surveillance Unit would capture certain pieces of data that is over time related to communicable diseases, related to non-communicable diseases, and they would have, I suppose, an arrangement with entities outside of the Ministry of Health who they would have routinely collected different types of data from.

In this regard, the data collected by the School Health Unit that we spoke about, is data that really resides with the Ministry of Education, separate and apart from what is collected by the CMOHs for example. So we would have data from the CMOHs as a separate data source as to the number of community infections and the like, but to get that particular data stream, our normal mechanism is to write through our Permanent Secretary to the Permanent Secretary of the other organization requesting data sets in a particular format, which we have done through the Permanent Secretary Ministry of Health to the PS of Education asking for data to be sent to the National Surveillance Unit via the office of the Permanent Secretary.

We have not received that data in that particular format as yet, and we are hoping that in the coming days or weeks that that is provided to us, but we have given them the template in which the format will help us guide the national COVID-19 response. So the mechanism I think for

stakeholders outside of the Ministry of Health would be for a senior technical officer of the Ministry of Health to quantify and say exactly what data is required and, of course, write that other agency to attain that data and get the approval to have that data.

Mr. Mark: Mr. CMO, through the Chair, would you say that the system has turned out to be a bit too bureaucratic and, therefore, maybe you may wish to suggest ways and means that this Committee can make a recommendation to the Parliament to seek to improve the efficiency and efficacy of this whole arrangement, so that in real-time your office, and the Ministry of Health by extension, can be made privy and can have access in real-time to all these pieces of data? Would you want to share with us your position on that matter?

Dr. Parasram: Generally speaking, in terms of internal data sets, there is of course having it in an electronic format to begin with is something that everyone would like to have, right. So establishment of an electronic health record is something that the Ministry is working towards, but aside from that, we have spoken about, in the country I suppose, unique identifiers and the way that data sets can be set up so that multiple agencies can view that data, creating single electronic windows from time to time.

As it relates to infectious disease data, as you know under the Public Health Regulation, and even under the Quarantine Act, there is a duty for certain diseases, which are notifiable diseases, to be reported to the office of the CMO within a certain time frame. So one mechanism may be through legislation, where we enable the office to get data that is relevant, by updating that list of notifiable diseases as well. So the regulatory part of it, as well as strengthening the IT backbone, so that the data could come to us in a more timely manner.

Mr. Mark: Thank you very much, CMO.

Mr. Chairman, may I also ask the Permanent Secretary, as it relates to what is called an online—patients' online survey, which was conducted by this Committee and it is reflected on page 60 of this report. Several common suggestions were advanced to this Committee in this survey conducted on Coronavirus patients. For example, they provided information on how to improve care and treatment through improving the quality and timing of meals, improving facilities for communication with relatives and communication between staff and patients, improving the accommodation, including under tents, and staff being more empathetic, among other suggestions. May I ask, through the Permanent Secretary, were any of these suggestions to improve the care of COVID-19 patients implemented, and if yes, how and in what ways, and

if no, how would these suggestions be taken into consideration going forward? So this is my first line of questioning, through the Permanent Secretary, based on this patients' online survey, Mr. Chairman.

Mr. Ali: Thank you, thank you. Through you Chair, so yes those recommendations, suggestions were actioned. I would want my respective CEOs, Dr. Amour and Mr. Thomas maybe speak a bit more about what they have been doing at their respective RHAs with regard to some of those suggestions. Maybe Mr. Thomas might want to go first and then Dr. Amour.

Mr. Thomas: Thank you PS, through you Chairman. So basically we acknowledge that there were some teething problems, particularly with the timeliness of meals, for example, at the initial stages of our response to the pandemic. A lot of our meals were centralized at some of the available kitchens throughout the RHA, as a means of engaging, leveraging our current resources to be able to facilitate our response.

However, we very early were able through our PHO, and certainly the Ministry of Health, to access projections for our responses. So we would have tiered our responses into three categories, which implied when the facilities were entirely full at 100 per cent, blue if we had to make novel engagements based on the fact that there were over 100 per cent, and certainly red for if it is way beyond the inherent capacity.

So we engaged in twofold. One was a general improvement posture, so that in particular for food, for meals, et cetera, we would have improved the timeliness of our delivery of foods and certainly altered, in some ways, the menus to facilitate the new tier of patients. Just to say a bit about food. I mean, food at a hospital requires that, in particular, we do not engage in high salty foods. We do not engage in highly seasoned foods, et cetera. So we attempted to alter a lot of our menus to include more Trinidad and Tobago style menus to facilitate the general palate, because notably a lot of the COVID-19 patients some of them were mobile and so on, but, basically, that was one of the things.

The other issue with specific regard to communication, we engaged, and it was mentioned in the report, an army of psychosocial support for both our staff and for the patients. So that meant that our patients and staff—that we not only engaged the communication issue by hiring a tier of staff called "patient liaison", ensuring that we had communication between the patient and the families, if that was available, but certainly with the families and the staff of the Regional Health Authority to give a sense of what the patient status was. That happened on a daily basis and as

necessary.

But in addition to that, those patients who were able to access, and certainly you would understand the confines—the sense of confinement with patients who are quarantined—we engaged by providing access in red zone areas or quarantine zone areas, to our psychiatric team, psychologists who did not just interventions for those patients, but also for patients who were basically—but also for staff.

The other issue though is that we also started to engage in other novel ways. We had a hotline as well for both our staff, patients and for their families to be able to call in to engage simultaneously. So those were some of the interventions that we provided as improvements.

Mr. Mark: May I ask through the Chairman, if we can have in writing all those suggestions that were advanced in this report, and what specifically has been done by the various RHAs to effect and/or implement these measures.

The second area I would like to clarify through the Chair and the Permanent Secretary has to do with ambulance services. I know right now there appears to be a monopoly by a single provider in the system at this time. I wanted to ask what are or what were and what continues to be some of the challenges with the ambulance services, and how have we proceeded to rectify those said challenges?

For example, Mr. Chairman and to the Permanent Secretary, my information, and I stand corrected or to be corrected, is that the current ambulance service operated by some company called GMT, they have one major cleansing, disinfecting, cleaning, reorganizing hub, and that hub is located in Port of Spain. The question is, have we given consideration to decentralizing those cleansing or disinfecting hubs, so it can go to central and to south Trinidad, as examples?

So I would like to get some clarification from the Permanent Secretary on this burning issue of the ambulance services, and what is being done to deal with the challenges and to rectify same.

Mr. Ali: Sure, thank you. Through you Chair, so we would have also used the ambulances within the respective RHAs to provide some of those transports that member Mark was speaking to, but in terms of the actual management of the ambulance service and how it works, I maybe would want to ask Dr. Richards to maybe speak a bit more about the quality issues and what is being done in that regard.

Dr. Abdool-Richards: Thank you, PS. The Ministry of Health has a contracted service with the GMRTT service, and this ambulance service provider provides transport for patients from the

call centre or where they—from their home to a registered or to the relevant accident and emergency departments within the public sector. So, for example, a patient may make a call and they may reside in Siparia, and they would be taken to the Siparia District Health Facility.

During the COVID-19 pandemic and when we had an increased number of patients requiring transfers within the hospitals, meaning, for example, the Eric Williams Medical Sciences Complex to the Couva Medical and Multi-Training Facility, or to the Caura Hospital, the GMRTT service was also utilized for we call inter-facility transfers. That was to support and to really ensure that persons received the relevant care within time, from moving from the A&Es to the hospitals in the parallel health care system.

There have been several measures that we have put in place to ensure a high quality of service from the GMRTT. Firstly, we did look at the issue of turnaround time. That was a general complaint, about long waiting times to access the ambulance service, and we did put operational improvements in place at the accident and emergency, so when a patient arrived they could be offloaded. So we added, for example, at the Port of Spain General Hospital trolleys and stretchers, so when the ambulance came with the patient that trolley that is being used could have been cleared with the patient being transferred to the hospital trolley.

We also started to monitor the turnaround time. So we get a report from the GMRTT every four hours, that shows where every unit is with respect to each hospital, and we have a metric that we use in once it is above a certain time period, we investigate why that unit is at the hospital.

3.30 p.m.

We also look at what we call advance life support and basic life support ambulances that are out in each fleet and the number of ambulances per fleet. The Ministry of Health does inspections and spot checks to ensure that the ambulances are functioning well, so that the fleet is not compromised, for example, by defective units or so. And we also have regular meetings with the GMRTT, and we receive the analytics on a daily basis. Now, there was a discussion about, or a concern about the decontamination process. The GMRTT has provided the Ministry of Health with detailed policies and procedures with respect to the infection prevention and control practices, and also all other policies that they would use, for example, bypass policies, transfer policies and so on. So, we are not responsible for dictating or for identifying their decontamination point which was identified as Port of Spain, however, we can have that discussion with them when we have our meetings, and we can provide a recommendation

moving forward in line with their policies and guidelines. Thank you.

Mr. Mark: Yes. Mr. Chairman, I now go to a very interesting and I would say quite relevant matter, and I want to tie three issues into one, under the broad rubric of human resource management in the system. The first area I want to look at is staffing levels which were outlined on pages 82 to 85 of the report that we are addressing. Also, the situation involving nurses who complained of working long hours, pages 83 to 84. And of course the whole issue of contracts and job security among professionals, be they nurses, be they doctors.

I would like to ask the Permanent Secretary, given the complaints brought to the attention of the committee that is the investigating committee, as it relates to human resources shortages in the system manifested in staff shortages. And I do not want to repeat what you already know and what is already in that report. So the first question I want to ask directly to the Permanent Secretary: Has consideration been given, given the situation that we are addressing to hiring additional staff to address what has been described as major staff shortages during this particular period that we are in, the COVID-19 pandemic? That is the first area.

The second area I would like to have clarified deals with the nurses who complained of working very long hours, to put it mildly, and they talked about the amount of patients they had to deal with, which was contrary to what was supposed to be obtained. So I want to ask the Permanent Secretary, how have these issues been addressed? Have they been addressed? How are they going to be addressed as we go forward? Will an assessment of the effects of the extra duties being done by both doctors and nurses be conducted by the Ministry of Health, and could you offer us a time line?

Now, I will pause at this time because the other area I want to go on to is contract labour and the duration of these contracts; three months, month-to-month, six months, and this is something that is totally unacceptable according to the report I have before me. But I will pause before I go there to just get some information and clarification on staffing levels, and as it relates to the report, pages 82 to 85, and the long hours nurses complained about which is reflected on pages 83 and 84, respectively. So, through the Chairman to the Permanent Secretary.

Mr. Ali: Thank you, and through you Chair. So, there are two issues raised there. One of, was there sufficient staff during the period in question of the review, and the other one would have been the issue of the working hours for the nurses. I would let the CEOs again speak to those issues within their respective facilities. Maybe we can have Dr. Armour speak to those issues at

the south-west, if I may?

Dr. Armour: Ok, thank you, Chairman and PS. So, thanks for the question. For the South West Regional Health Authority, yes, from an HR perspective we would have recruited additional staff, primarily medical and nursing staff. The strategy involved noting it is a pandemic and the relative caseload of COVID patients, the rapidity of admissions versus discharges. So we would have hired around 547 additional members of staff between medical nursing, allied and operational staff.

Initially the staffing contract—and yes the traditional now would have been six months, but looking at the entire system there is a silver lining with the—we look at finance and human resources in terms of decent conditions of work. We would have evolved during the pandemic. We are now in a position to offer persons a minimum one-year contract with the leave and ancillary gratuity provision within the fiscal space we are asked to operate. Of course, that puts a limit as to how much staff you can hire, but that is now the HR management practice at the SWRHA. And of course we look at matters of our filling against our pre-existing vacancies, redeployment within Ministry policies and guidelines.

So, I will say between the fiscal prudence and HR management during the course of the pandemic we have been able to business process improve to reach to that point. In terms of the issue with the nurses and the relative ratios, the COVID has taught that there is a teamwork approach, there is need for task-shifting, so the traditional ratios, as far as I understand, would look at registered nurses to patient ratio. However, within the legal framework as well as with the different staff skills mixed, you have registered nurses enrolled nursing assistants, patient care assistants, and even in our context, I believe we took these from north-central, we even use emergency medical technicians, and in terms of providing that level of patient care support in a pandemic era that goes beyond the traditional regular nursing.

So when you add those categories of staff, we actually start to look at a nursing personnel to patient ratio. And as much as possible it asked us to be very lean as to ensure that who is able to put all hands on deck to do a particular task at the level that you are trained and qualified for and you would be that true frontline, and therefore we would be able to conserve energies and reserve. And I want to remind the Committee that during the pandemic we also had issues of staff themselves being stricken with COVID and having to go into quarantine, particularly during the Delta variant, so that impacted on the HR manpower.

So I would admit it, it has been challenging, regular team meetings, HR science and technologies in terms of recruitment, manpower planning, contract terms and conditions and work and so forth. But, all in all, notwithstanding the concerns in the report, the hours of work, that is at an operational level with the RHAs; typical sessions would range between eight hours to a maximum of 12 hours depending the exigencies of the service and the need for patient care. And that would have been stretched at the times of the peak, the last one being between the end of 2021. But certainly these staffing ratios and hours of work are much better now that the COVID numbers are over, declining in terms of hospitalizations. Thank you.

Mr. Mark: May I ask, through the Chair, to the CEO of south-west. Can you provide us, whether you can do it now or you would prefer to do it in writing, since this report was issued in February, can you give us an undertaking, to provide us in writing, one: How many workers, nurses, nursing personnel, medical personnel, doctors, as the case may be, how many of them were on short-term contracts; one-month, two months, three months, six months? How many have now been promoted or have been given the facility of a one-year contract as the case may be? So that, for instance, the mental and psychological agony and tone that this particular matter would have had on these people could at least be eliminated or if not significantly reduced?

So could you provide us in writing with what has happened, how many on short-term contracts, and how many have now been given one year, and then you would go to two years, and then to three years. So you could put that in writing for us, Mr. CEO of the South West Regional Health Authority. I think the Permanent Secretary would have wanted to move on to Dr. Davlin Thomas so he can give us a little perspective on this matter as well, both in terms of nursing personnel long hours as well as staff shortages, and what is called short-term contract at the North Central Regional Health Authority.

Mr. Chairman: Member Mark, if I can ask whether that information could come in writing as well, is that what you are requesting for NCRHA as well?

Mr. Mark: Yes, that can be done. We can have it in writing.

Mr. Chairman: Thank you, member.

Mr. Mark: I was just thinking, Dr. Bodoe, whether he could have given us a tight summary as to what action would have been taken to effect this since the decision of, or—[*Inaudible*]

Dr. Thomas: All right, through you Chair, as the members may recall, the NCRHA provided

the first response to the pandemic. The implications were that at the initial stage we were a bit tentative in terms of the length of the contract. So basically, the initial contractual agreements, particularly for those additional members of staff—on the first instance we would have hired at least 13 nurses and 30 doctors who were initially given about a three-month contractual arrangement. Again, the disease was new, we were unware of what the implications were in terms of the longevity of our engagement.

Subsequently, the Ministry would have engaged the IDB to provide some funds—some assurance of funding to facilitate a longer term arrangement. We did extend the arrangement directly to the doctors and nurses that we hired at that juncture. When we subsequently had discussions between Dr. Richards, the CMO, the PS and their teams, it became more clear that, one, we were heading into a place where we would be a lil more long-term. So, we engaged one-year contracts in the same way that south-west would have. But the projections implied the possibility of shortages in the future. We felt that we needed to at least prepare for some other kinds of novel arrangements. We hired ENAs; those are Enrolled Nurse Assistants; some additional nurses. We hired as well some EMTs, as CEO South-West would have indicated. Those are Emergency Medical Technicians. Those provided eyes and so on, and oxygen and so on. We hired additional patient escorts.

What also ramped up for us was the level of training which factored and made a difference. We would have trained a number of our staff in other critical care training, treatment for pulmonary disease and so. So, we had a wide cross-section of general staff who were able to provide other tiers of core competencies that are non-traditional, in preparation for the possibility of what we termed to be the red tier of engagement where all hell broke loose in terms of the numbers were significantly too high for our inherent capacity. Thankfully, we were managing within blue. We also had other tiers of response that we discussed with the Ministry in waiting, and I think in the second wave we had to initiate that tier where we would have had to engage—we would have engaged additional tiers of staff, doctors, nurses and so on, to assist in vaccinations, primary care engagements and so on.

So, we were prepared in terms of the numbers to be able to migrate staff based on when we saw what we interpreted as alignment between projections, in terms of the trajectory of the projections, and certainly the actual experience that we were having at the time. And so based on that we were able to migrate staff from areas which did not require as intense a response. So,

we had some flexibility in the system that basically was guided by projections from the public health observatory, and certainly our own discussions in terms of the inherent capacity that was available, and—

Mr. Mark: All right, Dr. Davlin, thank you very much.

Mr. Chairman: Thank you. Member Mark, member Mark, if I may—

Mr. Mark: Thank you very much.

Mr. Chairman: If I may ask you to give way at this point, I am sure I will have you back on.

Mr. Mark: Yes. Thank you very much.

Mr. Chairman: If I can ask you to give way to member Deonarine, and I also recognize member Morris-Julian after. Member Deonarine.

Ms. Deonarine: Thank you, Chair. Welcome again to the team from the Ministry of Health and all the RHAs. I have been listening to the discussion so far and it is quite informative in the context of the findings of the report. But before I delve into questions on the findings of the report, I want to dial back a little bit on the accuracy of the findings in the report and how the limitations that the committee highlighted impacted on the methodology that was used. So my first very general question, I am not too sure exactly who would be able to answer this question, is that: How comfortable is the Ministry of Health with the accuracy of the findings of this report given the limitations that were placed on the methodology that the committee had to resort to due to the different constraints, not only data limitations but also time limitations?

Mr. Ali: Thank you, Chair. CMO, you want to take that question?

Dr. Parasram: Sure. Thank you very much for the question. So, it is something—whenever you get a report you have to look at the report in its entirety. One, you look at the timing as to when the report was done, and certainly this report would have been done at a time in Trinidad and Tobago's history where the health system would have been stretched to the limit in terms of our COVID-19 cases. We would have been at our highest level of COVID-19 infection in the country. Certainly, at the highest level of hospitalization and death. And I just want to draw reference to the summary page of the report, and to quote on what the authors of the report have said. So in the first paragraph you will see in the summary of the document:

> "The Committee would like to note here, that the time was far too brief to allow a thorough assessment of COVID-19 clinical outcomes in Trinidad and Tobago and so the most that could have been done was a rapid assessment which is presented."

And I think it is important to keep at the back of our minds that to really do an assessment of this form, I think a lot more time would have been required, and certainly a more in-depth look of—to look at a health system in its entirety, especially a parallel system, would really require a lot more resources, a lot more not only physical time, maybe even additional support otherwise to the committee so that we could get an actual, better in-depth look, and it is something maybe that the Ministry through its continuous review process, Dr. Richards and Dr. Trotman since the beginning of the pandemic have been conducting monthly reviews of the system, clinical management parallel system, so that we could try to learn from the preceding waves and learn from the preceding hospital clinical cases. But certainly, it is something that we have to keep in the back of our mind when we look at the findings and we look at the limitations, but certainly there is a lot to be learnt and we actually take the report in good stead, in the way that it is meant, and we are always looking for ways to improve the health system. And having an independent review of this nature with our colleagues of—which we hold in high esteem, certainly will give us a good steppingstone to start in reviewing the COVID-19 response.

Ms. Deonarine: Thank you, Dr. Parasram. Then my next question is that, in order for us to have a more detailed assessment of the situation which is not as time constrained going forward, would such a detailed assessment have to be mandated by the Cabinet or would it be something that would be done within the Ministry of Health on an ongoing basis, taking special consideration to Recommendation No. 16 of the committee stating that self-assessment should be something that is being done within the Ministry of Health on an ongoing basis?

Dr. Parasram: Yes, I fully agree with that recommendation, and it is something that we have been doing continuously at the Ministry during the COVID-19 pandemic, and before even. But certainly tangibly, we have taken the steps already to develop a terms of reference to actually get a consultant hired, to look at the COVID-19 response in its entirety, possibly through the intervention of the Pan American Health Organization so that we can actually get someone to come in from the outside. It is difficult when you are in the middle of a pandemic for us to do a full self-assessment. But certainly we can get, with the help of a consultant, all the activities that would have occurred through the pandemic, and we need to learn from our experiences and leave some record of what we would have been doing during the pandemic so that the future—for future pandemics we can learn from the mistakes, and, of course, build from the

successes and have sort of a blueprint as to how we can manage a pandemic if one occurs in the future.

So it is something that we have started already. We have our internal documentation, quite a large amount of it already which has been gained from different heads of department as we track the pandemic throughout, so we are really trying to get an external consultant to pull it all together and have a report, similar to this one, in a little more detail so that we can actually have a look at lessons learnt and the way forward.

Ms. Deonarine: Okay. Are you at a position currently to indicate what a timeline or something that is to how soon this consultant would be on board? I know you said that terms of references have been drafted. I know it is a long process after terms of references are drafted.

Dr. Parasram: I think I have to get into the phase of the engagement process before we can give an actual timeline to see if we are able to get a consultant that is suitable, but certainly we will go full ahead with that activity from the Ministry's end.

Ms. Deonarine: Okay. Thank you. I will pause at this point, Mr. Chair, for other members.

Mr. Chairman: Sure. Thank you, member Deonarine. I invite member Morris-Julian.

Ms. Morris-Julian: Thank you, Chairman. Chairman, I noticed in the results of the online survey it was brought up that the failure, or actually the communication with relatives and communication between staff and patients—now, I had, Chairman, through you, a different experience with Arima General Hospital when my relative was ill, and they did not know my name. They just had me as Lisa Morris, not as Lisa Morris-Julian, and I was contacted every single day with an update. So, I would like to know if steps were taken to improve the communication aspect, at least from the relatives and the staff members as well as the communication between patients and staff members, if any steps were taken, and what happened in the process? Because this was done about three months ago.

Mr. Chairman: Yes, maybe you may want to delegate.

Mr. Ali: Yes, sure. Thank you, Chair. Since member Morris-Julian mentioned Arima maybe I will let Dalvin, CEO Thomas speak to the experience within the north-central.

Dr. Thomas: All right, thank you, PS. You know, as I mentioned before, we were learning on the go, eh. This was a new disease and the numbers were unprecedented in terms of the numbers of persons who required care. What was new to us was the idea of quarantine in terms of mass quarantine. So we were basically having persons secluded away from their families in large

numbers, and we had to grapple with a way of engaging that. And so at the initial stages, certainly, we did have considerable—at the learning curve was steep.

However, we quickly were able to develop systems, as Minister Morris would have mentioned, that worked. We set standards for communication not just from a clinical level, so there were two tiers of communication. One that existed on a daily basis between the clinicians and the families; the other was another tier of communication for any special needs that, for example, families had who needed to be responded to. And certainly, if there was any non-clinical issue that we felt that the families needed to—we needed to engage with the families. And we hired a tier of staff to facilitate that, called patient liaisons. So, that occurred like clock-work on a daily basis to the extent where we created something, an app called the PreView app for at-home patients who were able to access that app by downloading the application on Google Play, and basically they were able to check their status.

We had over 5,000 persons who utilized the app, and basically what they did was they put in their SpO2 readings, and certainly once we felt that—and immediately you were contacted by a physician at home. And certainly if there was need for that patient to come in, we brought them in via one of the traditional means that was set up within the COVID context, but in addition to that we created what we called the COVID-19 drive-through. That drive-through facilitated us being able to have patients drive to the emergency department, pass through an area where they would quickly receive the relevant examinations, and determine what their status was. So we learned as we go, as we got along, and basically we attempted to not just—to exceed compliance and to exceed some of the standards that we were seeing worldwide.

Mr. Ali: Chair, if I may, thank you, CEO Thomas. If I may, maybe I just want to get Dr. Armour to maybe share a bit on the south-west perspective, if that is okay.

Mr. Chairman: Sure. Dr. Armour.

Dr. Armour: Sure, through you, Chair. PS, thank you. For south-west we have had a—well, our experience at least from our data and our feedback is also that as a large outcome, once patients come into our health care services, if the patient is coherent and conversant we would liaise with them and encourage them to contact their relatives. Once they are conversant and coherent, in the case of persons that are critically ill, even for the conversant ones the value of the next of kin and identifying the next of kin, and that is the person we would then contact daily via phone.

We had two levels of communication, one was the actual process of inter-facility transfer and getting from one point to the next through contacts, that generally would involve our clinical staff or even our medical records staff, and then if there are any issues of concerns or complaints either from patients or next of kin, persons would have experienced an average about two calls. So one from the clinical staff and then almost like a "checking call" from the quality staff as well, to find out if there is any issue about the clinical care that they want to express as a concern that we could help to address. As my colleague said, that system has—pre COVID the system is always one where we contact relatives or next of kin to update on progress, and always you have had quality checking.

4.00 p.m.

You would appreciate with the number of cases, we did business process reengineer and we did feel that we have got on top of it. So, for example, from May to December 2021 we would have contacted 1,500 persons during this method. So at our treatment facilities, contact every day. What we have found is that while the communication has been reasonable and enabled to get shared decision making, there are certain nuances with COVID. One is because family is in mass quarantine, so the next of kin themselves has COVID. So therefore, the personal home dynamic of that patient in hospital also has families impacted and affected by COVID.

And then of course issues with the previous regulations with respect to when persons die, how do we treat with the remains and so forth and that is an issue that even though you talk to the patient, what has evolved now over the last six to eight months, we do WhatsApp, FaceTime, video calls, so that relatives, they are home in quarantine, at least they could get to see their relative in quarantine, speak to them, particularly in instances where if the person is still continuing to deteriorate before you put the person on a ventilator at least they could speak with their relative who is in hospital once the shared decision is made, that you know, I have to go on a ventilator or that the person is too ill to breathe on their own.

And therefore, since this report as well, within the findings we are pursuing further to procure those tablets, face tablets, we have checked and cleared it with our internal infection prevention and control, so therefore we are in a position to purchase the tablets and ensure that there is no cross-contamination with internal sanitization of the device and so forth. So even beyond the WhatsApp and so forth, we actually do have our internal devices where that could even get a greater connection between the patient, the health care providers and the families outside who

are enquiring about the status of their loved ones. So that has been our experience to date on how we have evolved based on pre-COVID strategies to mature it in our view, based on the nuances with COVID and related with communication.

Mrs. Morris-Julien: Chairman—

Mr. Chairman: Thank you, sorry.

Mrs. Morris-Julien:—I just have some more questions.

Mr. Chairman: Sure, sure, member Morris-Julien.

Mrs. Morris-Julien: Chairman, again through you directed to whomsoever the PS decides to call upon, the accommodation under the tents. I do recall again, Chairman, a relative being under the tent for a couple of days and because the relative could not use a phone or contact, the communication was not the best—this would have been at Mount Hope. But I want to know, has that been—the accommodation, has it improved? What is the scenario with the tents? Have we packed up the tents? And also just for clarification, the relative did not have COVID but he had to go through this COVID tent, I think. I think that was the process, Chairman.

Mr. Ali: Sure. Thank you, Chairman. Mr. Thomas, if you want to just speak.

Mr. Thomas: Well certainly we do, we still do have the tents although we have managed to place air conditioning and so on, into those areas. And certainly we still have finite infrastructure available. COVID still requires segregation of those patients and particularly the unknown patients and certainly—sorry, the suspected versus the known COVID-19 positive patients. So we have improved the level of stretchers, et cetera, that we utilize in those areas.

In addition to that because it is a transient area the flows within those designated areas—patient spends between within less than 24 hours is able to transition from COVID-19 zone into one of those tent areas into another hospital, one of the designated COVID-19 hospitals. But certainly we have implemented—we have added plinths**,** so it is basically—the tents are air-conditioned now. So we are paying a lot of attention to our service improvement and certainly the comfort of the patients while they are within the "tents".

Mrs. Morris-Julien: Thank you very much.

Dr. Trotman: Chair, if I may chime in here, Michelle Trotman, from a clinical point of view responding to that patient who has to be seen under the tent. That is an indeed initial screening area where based on your symptoms that you present with we may feel the need that you need to be tested for COVID to determine if you are COVID positive or COVID negative. During that

time the procedures and infection control policies are maintained so that patients who may be positive or may be negative are separated and treated in a particular manner. A lot of systems have been put in place to accelerate processing of those patients. So no lengthy time. As much as possible with the advances, as we came along with COVID, with the actually testing, in terms of the timing to receive testing, being so improved with machinery, patients are often out of that area within 24 hours, often for the longest, especially at this point and sometimes within four to six hours out of that tent area. The tent itself has been enhanced as Mr. Thomas has said by making it a lot more comfortable with air conditions and other such facilities.

Mr. Chairman: Thank you, Dr. Trotman. Member Morris-Julien, you had one more question?

Mrs. Morris-Julien: Yes. I just want to also tell Dr. Trotman and Mr. Davlin Thomas, thank you. I think in that particular time unfortunately, with my relative, it was at the height of the crisis. So testing would have taken at least a couple of days to get back the results, et cetera. But moving on, Mr. Chairman, through you, we saw an item saying that the staff should display more empathy. Now, I have some concerns about that, because very often I think people misinterpret when somebody is busy for lack of caring, especially if the person has to deal with X amount of patients at the same time, et cetera. I am concerned, Chairman, about who is caring for the caregivers? What have we put in place for the doctors, the nurses, for those persons who may also experience mental health strain because it is not easy? For those of us not in the trenches just looking on, I am sure almost everyone on this Committee would have experienced loss, lost loved ones to COVID-19 and I cannot fathom what it is like to be in the hospital system and seeing death, upset relatives daily. So I would really like to know, through you, Chairman, what is being done for our doctors and nurses and medical personnel who have gone through or are currently going through nothing less than a war? Thank you, Chairman.

Mr. Chairman: Yes. Thank you, member. PS.

Mr. Ali: Sure. Thank you, Chairman. So, Chair, I really want both CEOs to touch on what has been happening at the respective RHAs. Maybe I would ask Dr. Armour to go first and then Mr. Thomas afterwards, if that is okay with you?

Dr. Armour: Sure. Thank you, through you, Chair, thank you PS. And issues that relate to staff functioning in a pandemic and the welfare of staff and their families because we know that staff come from an environment that they are expected to professionally function. Those things have been actively looked at based on our own initiative as well as even the guidance from the Ministry

of Health. So I will summarize, for example, issues of meal provisions. Not only meals from our nutrition department but a lot of kind donors and sponsors who earlier on in several ways over the pandemic would have offered donations for wholesome meals and really show that appreciation, that have been highly regarded by the staff and we worked quite systematic to ensure that all categories of staff, not only frontline literally, every member of staff would have benefited. As it evolved we would have asked that those who want us to continue you could just put your order for your meals. That is one aspect.

The other aspect as I mentioned before for us at south west was just persons' terms and conditions of employment, and at least on our end, attempting to regularize their peace of mind on security. Mental health was a big issue for us. From day one in the early days we would do a lot of positive messaging as the pandemic wore on and the pandemic fatigue started to set in. And if you appreciate community pandemic fatigue is one thing with regulations and so forth, but health care worker pandemic fatigue is a whole different scenario. And you are putting yourself out there. Our staff went there for a whole year without vaccines, right, and they had to do PPE and so forth.

So mental health, we had tele-mental health, telephone consultations; we went to all the facilities, made ourselves available on a rota; we even went as far as putting on all duty rosters the names of mental health officers within our employ that you can reach out if you have an issue. We have an employee solutions desk that employees could also call on as well. And therefore, particularly, for those facilities and we even have things in terms of facing realities, disaster management training, mass casualty management training, how do you manage your emotions when you are seeing a lot of persons critically ill.

So all of that was done and even the initial restrictions of leave, you know, was stressful for staff and therefore as we were allowed, we quickly got to easing leave restrictions so that persons could have their work life balanced. So those are the things that we have done in south west for the COVID parallel facilities and you have to record that the regular facilities were also under some strain and particularly when we also have to have staff rotating. So, therefore we would also do a mechanism where we send staff in the "hot area", then they would come back out, work in regular areas and send a lot of staff in from regular into the hot areas. So all those strategies based on needs and views of staff given to us, as senior managers we try to work as a team. So that was the south west experience.

Mr. Thomas: Through you, Chair—

Mr. Ali: Davlin.

Mr. Thomas: Through you, Chair, the NCRHA in particular was particularly concerned about—from a structural space on the resilience of our staff, how do we engage that need to sustain and maintain mental resilience. So we actually hired psychologists and psychiatrists, as well as social workers to become a part of a team to engage those needs. So we basically would have had detox sessions on a cycle with our staff, webinars directly with the team of experts, group workshops consistently. We also engaged a staff psychological hotline, we had staff relief centres as interventions for those persons who needed to speak to a psychiatrist or psychologist offline and many did. So the numbers are documented.

But in addition to that those individuals' psychosocial interventions were facilitated immediately once that was required. So in terms of— [*Technical difficulties*] —our structured response we would have, as I said, engaged the need to have to hire that tier or category of response. But in addition to that to create, to generate an infrastructure in which or a safety net and scaffolding that facilitated our staff if they fell or in addition to build that resilience for the onslaught of the disease that was approaching and impacted us.

Mr. Chairman: Thank you, thank you, CEO. If I can just, through you PS, ask CEO Thomas to indicate when were these mental health staff engaged? Can you indicate at what point in the pandemic this category of staff, which is commendable of course, when they were engaged?

Mr. Thomas: Well in tiers, eh. Our initial response would have required us to engage a lot of psychiatrists who were on board at the NCRHA initially. At the early stages, prior to the first peak of the disease, subsequently we would have, based on our discussions with Prof. Hutchinson, who is our in-house head of department, we found it necessary to hire psychologists particularly because we wanted to engage that resilience, preventative side of our response we subsequently hired up to, possibly if I recall, up to eight psychologists because we were in charge of a number of facilities. So basically we hired psychologists and then we found it simultaneously necessary to have another tier of what we called social workers to provide interventions. So we hired even more social workers who were and are still working with the staff.

What became more and more important was the communication between that team and certainly the executive to identify recurring issues that needed some kind of attention from certainly the CEO's office or any office that is delegated to intervene to provide an immediate

response and intervention. And so some of those needling issues that may have affected the psychosocial health of our staff were reported via those tiers of staff. And what they did for us was they facilitated immediate improvements. But to answer directly, different tiers, our first tier very early would have been psychiatrists. Subsequent to that we would have engaged a number of additional psychologists, and again this is in the first wave of the disease and by the time Delta had hit we found it necessary to engage even more.

Mrs. Morris-Julien: Chairman—

Mr. Thomas: We are not hearing, Chair.

Mr. Chairman: Sorry. Thank you, Mr. Thomas. Before I invite member Bacchus to the discussion, I just wanted to go back to the issue of communication and with regard to the initiatives at the south west, Dr. Armour. And I think what we saw in this pandemic, so it is both a comment and a suggestion, is that we saw the best and worst with regard to communication. Now although we seemed to have had a very good process in theory, on many occasions I think we have to accept it did work. As a Member of Parliament on many occasions I would have been asked by constituents to try and get information. And of course I could not because of the patient confidentiality issue and so on.

So I want to commend, I think that the WhatsApp, video calling and relatives being able to speak to patients was excellent, it was a great initiative and this is something that we should consider going forward. Not always, not even in a pandemic certainly but certainly in all situations where patients might be at risk of being seriously ill and so on. So that was commendable. But I also found that in many instances bona fide relatives could not get information, especially in terms of where their relatives were located and I think that would have been the experience of many. But I just make that in passing, it is an area that we certainly need to improve upon. The complaints were really that many, I mean even though the outcome would have been bad in the end, the fact that many were not able to speak or to have view of their relatives in the pandemic would have been of concern. So I will just move on and I want to invite member Bacchus to raise some issues. Member Bacchus.

Mr. Bacchus: Thank you, Chair, and good day to all members of the medical team and I want to express my thanks for all that you and all of your charges do for the people of Trinidad and Tobago, my thanks. I also want to congratulate PS Ali, much overdue and further congratulations. As far as I—you know, I tend to lean on the technical side and in going through

the report one of the things that jumped out at me was the fact that the Committee had asked for processes relative to the collection of data. And I know data has been a topic that we have talked about a bit, addressed the quality of data and the verification of data collected, all the COVID-19 data that was collected. And the Committee had asked, I guess various RHAs and maybe to the Ministry as well, for the processes that would have been used in either the collection or the validation and verification of the information. And at the time of the report as what is written here is that they were not forthcoming at that time. And the Committee also noted that there were some issues of discrepancies and from what they could see obviously they can tell if this information was wrong, it was just in the wrong place as an example of that.

So with that being so I want to ask what were the challenges that the RHAs and so on, would have encountered in what they were doing? And it was not lost on me some of the innovative things that Chairman Davlin and his team would have been doing in a number of ways specifically with data and so on, would those things have been shared with the other RHAs and would they have been able to participate and benefit from that? And more so is there really coordination in terms of across the RHAs and with the Ministry of Health in terms of data collection, data validation and verification and or having common systems that would work across all the RHAs and the Ministry?

Mr. Ali: Thank you member. Through you, Chair, so I will let CMO jump in here. I am not sure he want to answer or he would want Dr. Hinds to speak to member Bacchus's last question, the very last question with regard to what exist at the Ministry in terms of that oversight and guidance for the rest of the sector across the RHAs. CMO.

Dr. Parasram: So I do want to say that the data stream that was actually put in place to get the data to the various offices from the RHA was as such that we had a focal point at the Ministry of Health. Dr. Smith, who is the senior health systems advisor, would have been our focal point and he is mentioned in the report as such, so that all data from the Ministry, be it RHA or Ministry, would have flowed through Dr. Smith and go to the committee. And we would have gotten timelines from the committee as to how soon they would have wanted the data and what type of data.

Because of the type of epidemiological data that was required we even set up a number of meetings between Prof. Simeon who is the lead in that regard and Dr. Hinds and his team so that we could clarify the types of data, make sure it was validated properly and then move forward.

So we worked very assiduously at the Ministry and the RHA to provide all the data that was required and I think that we did so in a very timely manner meeting most of the deadlines. There were some validation issues as it relates to the epidemiological data, specifically, and that is why I intervened and got Dr. Hinds to actually sit with Prof. Simeon and go through the data streams to iron out that bit of it.

But I think in going forward before Dr. Hinds comments that if the Ministry can be given a chance to respond in writing to the Committee to let you know what sort of data was actually asked of us, the timelines and how we responded. Because in my view at least what I had sight of we responded in a very timely manner from all divisions, including the RHAs, and if we could put that in writing to the Committee we will be grateful to be given that opportunity. But I would ask Dr. Hinds to go specifically into the details.

Mr. Chairman: Yeah, certainly CMO, that would be something that would be appreciated, that written submission.

Dr. Parasram: Yeah, thank you. Dr. Hinds, if you want to just speak particularly to member Bacchus' queries.

Dr. Hinds: Okay, thank you, through the Chair, for the opportunity to address some of the statements made. And just to follow on with what the CMO would have said, the conversions specifically regarding the data collection mechanisms, the processes, the way data flowed, we had detailed conversations with the data managing member of that committee being Prof. Simeon. And we explained in detail how that information flowed. Now it does give me the opportunity to point out that there is no sort of uniformed and cross-cutting platform on which held information, data is currently shared from one institution to the next or from the institutions to the higher levels. So there is a lot of manual data collection, a lot of, basically, purpose built data basis that were created for capturing specific sets of data at the time when the data analysis was recognized as being necessary for a particular set of things. And a lot of that was done on a separate basis, county by country, institution by institution.

And as I believe Mr. Bacchus would be aware, many of the institutions, the counties, the various players on the field would capture the data even if they were given the template, then they make their own modifications to the templates as they are provided. So that if we attempted to put all of them together there would be a need to go back to and verify that we have not changed things. So we in our initial, in our routine data analyses would have analyzed those sets

of data separately and then combine the analysis.

For the convenience of the Committee, the Committee member asked that all the data sets from the various institutions and counties be compiled into one table and at some point in that combination there was an initial issue with alignment of variables that have been switched around that was identified, was rectified, and I am not particularly certain why that comment found its way into the final report, but as I said, we had no sight of the final report. That was an issue that was identified, flagged, rectified and are usable and corrected, and validated data set was provided for the final analysis that took place.

But the recommendation that the Committee would have put forward to have better access to electronic records that can be shared across institutions are from one level to the next. That recommendation is a welcome one because it would then facilitate better, more standardized data collection and collation and analysis at the national level when that becomes necessary. I believe that may fall particularly into your shop, Mr. Bacchus. I would sort of request that be given some attention because it is useful, it would be useful to have that sort of support so that data analysis is not as manual, as tedious as it currently is with all these different non-overlapping systems. So I do not know if that answers the questions that you may have with regard to those technical comments that were made, but I do also want to throw my support behind the CMO for being allowed to respond in writing to the commentary so that we can clarify anything else that remains in play at this time.

Mr. Chairman: Thank you, thank you, Dr. Hinds. Would that satisfy your request, member Bacchus?

Mr. Bacchus: Yes, it does for the last part as I know I had asked for the last part to be dealt with first. And I do accept and Dr. Hinds your request for speedy electronic implementation. I am sure PS Ali would be music to his ears. Permanent Secretary did you want to answer the other part that I have dealt with, because what I got in terms of the process and the thing was very comprehensive. The other piece was really about the RHAs and their issues in collection and/or of course their ability to even within themselves exchange things that worked during that time. I do not know if you want to take that as well.

Mr. Ali: Sure, sure. So I could let the respective CEOs maybe speak to their experience in their respective RHAs. If we can start with north central first and then south west.

Mr. Thomas: Well, I just wanted to put on the table, through you, Chair, that we do have an

avenue, we meet basically with, all CEOs meet with the PSs and so on, on a Tuesday morning, promptly. And in a very relaxed setting where we share ideas and communicate our concerns and receive responses for engagement. That persisted throughout the pandemic. What happened though is that the NCRHA in particular as you know would have engaged the flagship facility initially, that is the Couva Hospital, and subsequently had to do renovation works and so on, to like Caura Hospital to enable access for COVID-19 patients and simultaneously to engage the Arima General Hospital.

So a lot of what we would have, a lot of our learning, because we had consistent hurdles within the organization itself that extended upward to the board even to where the board would have engaged directly with the CEO and the executive on our plans for the pandemic and certainly we use the Tuesday meetings to share some of things that we were seeing in terms of our own projections to match with what the CMO and certainly the Minister had been, the way they saw it from a very informal space. That facilitated other kinds of exchanges particularly with some of the innovations. But what we appreciated even when that was happening was that each RHA was having a different kind of experience based on their own tier of responses to the pandemic or their allotted responsibilities at different times during the pandemic. Our concerns, for example, for the preview app as an example came from our understanding that there were a number of persons who remained at home and approach the facilities late. And so we had to find ways at the early stages and that meant that we would have possible congestion in the tents, possible congestion in our emergency departments.

4.30 p.m.

To alleviate that kind of congestion at the earlier upstream, we really basically once patients left the emergency department, we armed them with SpO2 monitors that were supplied by the Ministry after discussion with the Ministry of Health. They gave us the SpO2 monitors, we gave those patients those, we contacted them at home and basically what they were able to do was use the app to input those sent—the app basically would have highlighted for us if we needed to intervene beyond just the telemedicine aspect of it.

But particularly at different stages, we would have had to have very novel approaches but what we were clear on was that certainly we initially buffered the first engagement and so that we had considerable discussion at the Tuesday meetings particularly initially with South West and North West and the Ministry on what our experiences were and certainly Dr. Richards and

the CMO in particular to really share those experiences. So that occurred. So it then became a question of what was applicable to a specific kind of situation or experience that was occurring. So there was a cross fertilization of ideas amongst the RHAs at those sessions in particular.

Dr. Armour: Mr. Chairman.

Mr. Chairman: Thank you, Mr. Thomas. Did somebody else want to come in? Dr. Armour.

Dr. Armour: Yes, sure. At the South West RHA, overall, we have very robust data management systems in my respectful view and not only because of COVID, we have an armament of policies and protocols. We are actually in the midst of COVID still keeping sight of our SWRHA strategic plan that has a quarterly report with both qualitative data and—sorry, quantitative and qualitative data. And in the context of COVID, we had several layers of data. So I think our data management is strong.

We had at the operational level basically census bed bureau data three times a day at the height of it. Now that the COVID is eased up, it is once per day. We have bed bureau data, admission discharge, transfer data. We also paid a lot of attention to oxygen security data so we would know several times a day how much oxygen is in each facility and that was operational-level type data. We would have had epidemiologic type data that has evolved.

So right now, we crystalize it in a three-page report every week so on that one report, we would know the sociodemographic breakdown of all the cases in South West by age, by gender, you know, positivity rates of the COVID samples, how many are positive. We know about seven-day rolling average in South West context on our time—[*Inaudible*]—graphs similar to what was done at the national level that Dr. Hinds presents so we replicate it at the South West. We have hospitalization data, we have vaccination data and we also look at the weekly— [*Inaudible*] —trend averages. We even monitor operational process data as well: how many meals are being delivered, how many persons are in quarantine as well, what are our regular services maintaining, are we doing our surgeries, our EDs are looking like. So we even have our lab throughput management data as well.

So at least where from I speak, I like data so I ask for it all and I look at it all, even though I have my executives who would take the different arms of it and action their executive decisions, but I asked to be administratively copied in all, and then of course, you have the larger organizational data based on looking at the operational data and the epidemiologic data and even some of the qualitative data—well quantitative/qualitative through quality in terms of staff and

customer needs and satisfaction surveys and so forth. That allows our board of directors to get line of sight, so they would ask through the office of the CEO to account on any risk, any enterprise risk that they see or that they are aware that we actually have to report: are we proactively planning to keep ahead with respect to those things?

So our data system was robust. I like what the CMO has said because we have supplied at the request of the Committee to the Ministry of Health, we gave them the full armament of policies and protocols and processes that we do. We gave a sample of this report that I referred to as far as I recall and even that could be provided upon request and we would have provided all the data that was asked, whether it be facility level, operational and so forth. So data is what it is but I do believe South West has been able to process that data into information and into evidence-based management at all levels: individual, clinical, institutional, organizational. So that is how South West manages their data.

Mr. Chairman: Thank you, Dr. Armour. Member Bacchus, did you have another question?

Mr. Bacchus: No, Chair, you can go ahead. Thank you very much and thank you for the comprehensive details of the answers.

Mr. Chairman: Yeah. Thank you. I know other Members waiting to come back in but I believe member Deonarine wanted to jump in on this particular issue. Member Deonarine.

Ms. Deonarine: Yes I did, Chair. Thank you so much and thanks to the other members for allowing me to intervene at this point. I just had a quick follow-up question to member Bacchus' question. Now I understand the robustness of the data management that is being taken place at the South West Regional Health Authority but based on the recommendation number one of data management system and data verification that is outlined in the recommendations of the report, I think what the Committee is alluding to is really that coherent integration of information across the board, across all RHAs and in that context—I will be relying on some institutional memory here. I know all the way back in 2014, the Ministry of Health would have signed on with the IDB on a loan which had a specific component which dealt with an e-health information management system. So with that context, I am wondering how much of that loan is going to be assisting with rectifying or addressing the recommendation number one in the committee's report because I believe a lot of work has already gone into trying to get pilot sites for an e-health information management system across all RHAs. Is that not so?

Mr. Ali: Thank you. Chair, if I may, through you, so with regard to the loan that member

Deonarine spoke about, that IDB loan was re-scoped and HIS, our health information system was not part of the loan anymore, so that would be funded by the Government. All right, so it was not part of the revised and re-scoped loan. Having said that, we are pretty far advanced with that particular project, we actually have the technical requirements already completed having been through a process of consultation with the RHAs and the Ministry then. That is actually being reviewed right now by the Ministry of Digital Transformation. We hope to have that ready to go out to tender very shortly and it will be done on a pilot base and we would start but that speaks to the IT part of it. But I would want maybe Dr. Hinds to speak a bit about the business process side of it because we do not need to wait on the IT to really starting seeking data management and data collection. So that IT system is coming, as I said, we are pretty far advanced, we are almost ready to go out to tender but in terms of the business side of it, the business processes, maybe I can let Dr. Hinds speak a bit about that if I may.

Mr. Chairman: PS, before you invite Dr. Hinds, can you give the Committee any indication at all as to the timeline for this IT system?

Mr. Ali: Chair, we are just waiting on some feedback from the Ministry of Digital Transformation and iGov. Once we get that, we are ready to go out for tender. We have been working with them and that is pretty shortly, I do not expect that to be much longer again.

Mr. Chairman: Couple of months, maybe this year?

Mr. Ali: Less than a couple of months, this year definitely but it would not be a couple of months. Definitely not that long.

Mr. Chairman: Sure and I think you wanted Dr. Hinds to jump in.

Mr. Ali: Yeah, thank you.

Dr. Hinds: Yeah, thank you, PS. Through you, Chair, there is not a lot of detail that we can add at this point with respect to the business processes but we can outline that what we have in place is background work to standardize the kinds of variables that we expect we would collect data on across the board and once that is standardized and we have a platform whichever one is finally provided once it goes out to tender that can collect that data and we have standardized the sort of analyses that we want to do, the indicators we would want to report on, et cetera, it becomes a fairly easy process to actually generate the kinds of information that we are looking for.

So the standardization process is actually something that is currently being worked on in various domains. It is being worked on in a modular sort of fashion where a standardization

looking at the visits that occur for what we call NCDs, non-communicable diseases, for specific communicable diseases and we are also looking at aligning what we can produce with the international best practice indicators that we used to judge the performance of our systems. So all that work is going on in the background as we speak. We engage both the international and regional public health agencies for some of the technical support in ensuring that we are aligned with international best practice as we go about trying to shore up the data collection standardization, making sure we have what we need to have so that when we get whichever platform is provided, we can put it in and generate some automated analyses. So that is something that has been going for some time even in the background while the IT bits are being worked on and that work goes on at least.

Mr. Chairman: Thank you, Dr. Hinds. Before I invite member Mark to come back, PS, through you and well perhaps, I can address this to the CMO and I am just looking back at Table 1 which is on page 28 of the report and we are looking at data and maybe I am just trying to see whether I can translate this into information. So I am looking at page 28, that table which speaks to the place of death and we already had an explanation for the 633 in terms of "Other" but I am just looking here at the Chaguanas Health Facility and the St James Medical Complex and again, this is just for information purposes. And I am looking, for example, at the Chaguanas Health Facility, the numbers there would be 188 compared to the Couva Medical and Multi-training Facility of 476 and Eric Williams of 157.

And the question that comes to my mind is in my recollection and again I would stand corrected here. Would the Chaguanas Health Facility—would that have been a facility, CMO, for holding of patients prior to transfer to another facility? So that would be the first question and the second would actually relate to the St James Medical Complex, again, as to whether that would have been a full service facility so to speak for the management of COVID-19 patients or whether those facilities would have been holding facilities prior to transfer either to Couva or to Mount Hope or Port of Spain in the case of St James.

So I do not know whether the Committee can have some clarification on that because it would appear and again this is raw data, it would appear that those numbers are a little bit high for those facilities. I do not know if there is some explanation for that, CMO. I do not know if we are on the same page, page 28, that Table 1.

Dr. Parasram: Yeah, we are. So basically, those facilities would function in their normal capacity

as an Accident and Emergency Department. So as you know, people with viral illnesses would seek health care at any of our facilities, so people will come to our facilities as an entry into the system through any of the A&Es. So all the emergency departments were equipped by way of having a parallel track for viral illnesses and that is what Mr. Thomas would have spoken about, having a tent that is separate and apart while people are waiting for diagnoses for example, and then from there, they would be transferred to one of the parallel systems or if you are not COVID, of course, transferred to another major facility for treatment. So generally speaking, those deaths would have probably occurred in the emergency department.

And throughout the pandemic, we have brought something to the public's attention which I think these figures sort of highlight a little bit in the sense that what we saw at the height of the pandemic was that we had a lot of late presentation of persons presenting to our A&E departments very late in the progress of the disease, very much into the cytokine storm phase so they would have gone pass the first five or six days. A lot of cases presented having had home care by a private physician at that point in time as well. So the late presentations, late to the point of very close to their demise would have contributed to some of it.

And bearing in mind, the demography of the cases and for the Caroni case for example, throughout the pandemic, we would have noted the majority of cases in counties Caroni and Victoria. There would have been a preponderance of cases beyond other counties through the pandemic aside from St. George East and possibly St. Patrick at one point. So it is a number of factors that would have contributed. I would really like if you allow us the time for Dr. Trotman to really speak to the types of patients that were presenting and to build on what we were seeing at the height of the time the report was generated which was November, December into January. So that it will give some reflection of what we are seeing in the data.

Mr. Chairman: Sure. Certainly, CMO.

Dr. Trotman: Thank you, CMO. Through you, Chair, Michelle Trotman. To add to what the CMO was saying, the interpretation of the data has to look at many variables, particularly at the time when this report was generated. We saw clinically a patient who generally when they presented to the accident and emergency room for attention for their viral illness, that was, a) a patient who was quite ill. So that patient would have been along or advanced in their medical condition; a patient who often had comorbidities; a patient who often unfortunately would have been unvaccinated. So these patients would present and would immediately need a type of support

to actually keep them from falling off of a cliff and during that process, the engagement of the health care worker would be to stabilize that patient and ultimately to transfer as soon as it would be safe for that patient to do so. And unfortunately, in some instances, that opportunity may not have presented itself before their demise. So patients were not held there per se, while there, they were treated and when presented there, they were ultimately quite ill, particularly in this last surge. So that would account for some of the numbers of unfortunately deaths in those areas.

Mr. Chairman: Understood, Dr. Trotman. Thank you. I just want to clarify further and I understand the dilemmas that the health care staff would have faced at the height of the pandemic, especially in that wave in January. But would any effort have been made for example to have ventilators provided at these facilities as an interim measure—I am just curious about that—in terms of providing additional support? I guess Dr. Trotman, you would want to answer that.

Dr. Trotman: Certainly. Even before we get to the ventilator stage, we would have learned from the management of these patients that often when they present, they needed oxygen supply and oxygen support so they would be needing oxygen and oxygen could be provided by way of masks and also by way of a type of machinery by the name of a high flow nasal cannula that would often be a step to be used to prevent that patient to move on to ventilatory support. Because unfortunately patients with ventilatory support often sometimes do not do as well as a patient who would not have gone onto the ventilator. So at the emergency room facilities, we would have put in place support inclusive of not only ventilators if applicable but also high flow nasal cannulas with the hope that we could stay off patients from going onto the ventilator.

Mr. Chairman: Thank you, Dr. Trotman. That point is taken.

Dr. Parasram: Chairman, if I may? Just one last bit about—I think it is relevant to the country seeing that we are still in a pandemic and the hallmark of COVID and when we spoke about Delta, we were in the midst of Delta surge at the time. One of the hallmarks of COVID-19 which we saw as different from any other virus is silent hypoxia. So you will find that persons were very well at home and they felt well. They were able to converse, a lot of them were able to be on their phones, they are on their mobile phone doing maybe different sorts of social media and stuff and then an hour later, they would decompensate extremely rapidly and succumb.

So it is a hallmark of COVID-19 that was noted very early, later on in 2020 in the pandemic and it is something that the population needs to be reminded of and certainly the benefit of having home pulse oximetry needs to be underscored because although you might be feeling well, the

silent hypoxia, a component of it, misleads the individual to feel that you are well and then your oxygen saturation is very low. So it is something to be aware of as a patient and to continue to have vigilance on the health sector side so you have the late presentation occurring for that reason as well.

Mr. Chairman: Thank you, CEO. I think that is a very important message for the population but before I leave the issue for acute care and Dr. Trotman, I take your point and to some extent, it is reassuring in terms of the expectation for these high numbers at the Chaguanas Health Facility and the St. James Medical Complex.

But if I can take you to page 86 and just look at the major findings with regard to the "Term of Reference" number 5 which really was to review the standards of care of COVID-19 patients based on the acuity, for uniformity and consistency within and across hospitals in the RHAs and one of the first questions that crosses my mind and would have crossed my mind during this pandemic is, you know, whether the standards of care, whether there was a common protocol that would have been used and available at all of the tertiary facilities that would have treated—well the breakdown here is into mild, moderate and severe. And of course, we see the outcome for mild was pretty good and for moderate was not bad but the severe category, as you would have expect, the outcome may not have always been good. But the question really is whether we would have done everything possible and that would be the question in the minds of relatives and the population as to whether everything possible would have been done to save such patients.

And I ask that in the context of, for example, the report notes that there were shortages of drugs, well at that point, in terms of the biologic Tocilizumab and there was a drug called Methylprednisolone which I know was in demand and there was an apparent shortage. So if you can address that. So I will ask you to address that first in terms of whether that shortage would have affected the outcome in critically ill-patients and then there is another point I want to raise which I will come back to. So through you, PS, maybe I can invite either CMO or Dr. Trotman to address that issue.

Dr. Parasram: Okay, Chairman. So I will start and then Dr. Trotman can take over in terms of the clinical management, but generally speaking related to the query about policies and guidelines, throughout the pandemic, we relied very heavily on the WHO document which is a living guideline for COVID-19 which was updated very frequently. It is a clinical guideline which was shared from the outset to all the RHAs. Dr. Trotman being the clinical coordinator for the

national response would have had communication with my office very frequently and we would have updated it as we went along based on what we were seeing on the ground.

In terms of the national drug supply, the principal pharmacist who is the lead and I must commend her for yeoman service during the pandemic would have kept a very close eye on all things related to COVID: PPE, medication and supplies. Bearing in mind that of course as WHO began to approve various types of medication, the world would have pulled on the supplies, so the supply was not only required in Trinidad, it was required in other parts of the world very quickly as WHO gave the green light for it.

So although we had put plans in place prior to the WHO approval and bearing in mind our policy is and continues to be only to use WHO approved therapeutics and vaccines, the supply management became extremely critical. I would say that in terms of the IL-6, we would have always had a supply of either the subcutaneous or the IV form in our system at all points, even at the peak, albeit not at the levels that any one system would have liked, meaning having IL-6 or even a similar biologic available at any point in time. But Dr. Trotman can speak directly to the clinical outcome bit of it.

Mr. Chairman: Thank you, CMO. Before you go on to Dr. Trotman, you mentioned the supplies and so on, you know, one of the recommendations on page 99 of the report, Recommendation 4 and again I would want clarification. This recommendation speaks about supplies from C40 and it says:

> "The frontline staff need 24 hours per day time x 365 days support during the pandemic. We recommend that C40 should be continuously open, seven days per week."

So I am gathering from this that C40 may not have been available to supplies and so on.

Dr. Parasram: So, generally speaking, C40 is a central warehouse for the system. Right. Each individual RHA and even sometimes facilities have stores of medications and supplies as well so it is a matter of planning. So we need to be able to have medications and supplies available at the point of delivery of care across the board, 24/7 and having C40 opened 24/7 is not a necessity if the planning system is in place to have that buffer stock at the level of care which is something that we attempt to do.

However, having said that, although it may not be staffed in the way that it is staffed during the normal working week, Monday to Friday, eight to four, C40 is available for emergency medication to leave C40 at any point in time, 24 hours a day, seven days a week and that is

through the office of the principal pharmacist liaising directly with NIPDEC who manages the C40 stores.

Mr. Chairman: So just to be clear, CMO, you are saying that that facility is available to—

Dr. Parasram: We can get medication in and out of the facility at any point in the day or not if need be and have done so at many times in the past.

Mr. Chairman: Sure. Thank you. So, Dr. Trotman, before you answer, I will just include two other issues which you may want to address and one speaks to the issue of difficulties in terms of—and so I quote from the report:

"There were reports of difficulties in getting tracheostomies done."

So I would want clarification on that, whether it was a technical issue or whether there was a staffing issue and also if you can address the issue of the availability of renal dialysis for patients who required it. And I say that because for example, when the new Point Fortin facility was being utilized, I know that those patients had to be transferred and would have had to wait their turn at the Augustus Long Hospital for renal dialysis. So that is just one example so I do not know if you can include in your answer to the previous questions address those two issues.

Dr. Trotman: Certainly, Chair. Regarding the availability of medications, particularly Methylprednisolone and Tocilizumab, there is certainly benefit of those medications to outcome of patients. There were extensive protocols that were shared particularly for the use of Tocilizumab. There were also estimates that predicted the numbers of medications that would be necessary that would have been procured for the use of these patients and certainly there are advantages to the use of the medications, hence their approval by WHO and use in our clinical setting. As a matter of fact, most patients would have experienced having receipt of these drugs and particularly in the case of Methylprednisolone, there are alternatives, if not available, for this medication, it is a type of steroid, so there are other steroids that are available. So at no time particularly speaking for the NCRHA and overall, there were medications, particularly Methylprednisolone, that were not available. Similarly for Tocilizumab, I must impress upon the appreciation we have for the CEO and the board at the NCRHA in providing a continuous supply of Tocilizumab for the use of our patients here. That being said, medications are important but medications alone do not predict the outcome of patients and we have to keep that in mind.

Regarding the availability of renal dialysis, there is a coordinated system across all of the RHAs for access to renal dialysis as was the trend even from the beginning of the pandemic. The

NCRHA was the central point for patients who required in-house and in-patient dialysis and that has now been extended to those patients who are still COVID positive and require outpatient dialysis. Patients do not wait in turn but they are seen in view of their severity and the need and all are treated in that respect in terms of priority. So patients across the RHA do have access even if one particular facility is filled at that particular time to access across RHAs where renal dialysis is concerned.

The need for tracheostomies for patients who are COVID positive depends, of course, on the patient and the availability of all that is need to ensure that a tracheostomy is performed in the safest manner for that patient. So I am not aware in specifics as it relates to that report of a patient who needed a tracheostomy. Often, tracheostomies are elective and can sometimes be deferred because they are associated with a particular amount of risk for that particular patient. If a tracheostomy is deemed to be immediately needed, then that patient is offered a tracheostomy and it is performed. Thank you.

5.00 p.m.

Mr. Chairman: Thank you, Dr. Trotman. I was going to close on this point, CMO, and I quote from page 88 of the report. The end of that discussion and Terms of Reference 5. It says:

> "Taken together, these comments speak to very serious decrease in the acuity of treatment in Intensive Care for COVID-19. The data sent to us did not allow calculation of an ICU mortality rate."

I do not know, CMO, if you may just want to make a comment on that statement.

Dr. Parasram: Yes. Just allow me a second to read it again.

Mr. Chairman: It is on page 88. It is actually the last paragraph on page 88.

Dr. Parasram: Given the comments that I have made before regarding the brevity of the time to look at the data, and even by the statement's admission:

> "The data sent to us did not allow calculation of an ICU mortality."

—recognizing that persons who go into ICU generally have an extremely high mortality rate comparatively. Because of the nature of the individual, I think personally that it is a statement that, maybe use the word "unfair' or 'unfounded". But I would not ascribe that without having more data to make that statement.

Mr. Chairman: Thank you, CMO. Might I invite member Mark at this point to join the conversation again?

Mr. Mark: Yes, thank you, Mr. Chairman. Thank you very much. As we are on this subject of pharmaceutical products for COVID-19 patients, may I enquire through the Permanent Secretary as to where are we in accessing these oral antiviral drugs that can help save the lives of patients? And I am referring to some—it is a drug that is produced by Pfizer in America. And there is another one produced by some company called Merck. I understand in India there is a generic version of it. And from my research, it tells me that you can get about 50 capsules for US $50. I just wanted to find out where are we? Are we seeking to access these drugs? Have these drugs been approval by the WHO? And if so, what are we doing once they have been approved, to access those drugs for patients or persons who are suffering from COVID-19. I would like to get some clarification.

Mr. Ali: Sure. Thank you, Chair. If I may ask the CMO to speak to the issue of the WHO approval, please.

Dr. Parasram: Sure, PS. So, one of drugs Paxlovid, which we spoke about, is a brand that is manufactured by Pfizer and we have been in the process. We have been in talks with them for quite a few months now, I think late 2021, if I am not mistaken. Looking at the acquisition of Paxlovid through two streams, there is a joint Caricom initiative that we are working together with other Member States to get those medications, as well as there have been initiatives geared directly towards bilateral talks with Pfizer.

Regarding the drugs produced by Merck, Sharp & Dohme, we are also in talks with that particular company to see how soon we can acquire. They are aware of the number of capsules we require. They need to give us feedback as to how soon they can deliver those medications for us and a final cost, and then we can go forward with those negotiations. So, we are well on the way in terms of talks, but we are awaiting feedback from the respective suppliers as to if and when they can deliver, and then, of course, the cost and then we go further.

Mr. Mark: Through you to the CMO. CMO, you have any idea, given the time frame and given the fact that these things may now be available in India in a big way, and I do not know if they export it right now to many other countries, can you tell us any time frame you anticipate for the arrival of such antiviral drugs into our country? Do you see that being possible at the end of this year?

Dr. Parasram: Well, we hope that, in terms of the general scheme of things, I do not want to put a time frame for it. COVID-19 as we have all described in the world, is in a different space than

it would have been, let us say even three months ago, when we would have had Delta upon us. We are seeing a new pathogen which is a variant of concern that is much milder, in terms of the way it is behaving and interacting with the population at large. You are seeing much less hospitalization. You are seeing much less mortality. These drugs, which are antivirals oral medication are meant to actually decrease the mortality and the morbidity from a given virus.

So, the utility of it, and it must be borne in mind in terms of cost/benefit analysis, as the number of cases decline and the severity of the illness declines, is it something that we need to pursue? Given that vaccines, one, are available to us and continue to be so for the majority of the adult population and even to the 12 to 18s as well, and those vaccines also do the same thing. They prevent severe illness and death. So it is a matter of bearing, looking at the cost and determining. So a decision has to be taken as to if we need to pursue it, as the disease progresses. One, from a clinical perspective what is the risk? What is the benefit versus the cost of an acquisition? And, of course, we are still pursuing with the companies actively, so that they can give us a timeline as to how soon they can deliver. But again, as this pandemic becomes endemic eventually, we have to determine the utility of it from a clinical perspective and whether the cost will be something that we are willing to spend the taxpayers' dollars to redound to some clinical effect. So I think that decision will have to be made.

So, once we get that timeline then we take it step by step. We look at the epidemic and the way it progresses and we make that decision then.

Mr. Mark: All right, thank you, CMO. Mr. Chairman, on Tobago, on page 89 of this report we have challenges identified by the THA. We are advised in this report that the THA described their health system as a "'semi' parallel" health care system aimed at treating and managing COVID-19 patients. However, they would like to work towards a "full parallel" health system to deal with those cases. But they are faced with several challenges to adequately, clinically manage COVID-19 patients. And, therefore, the THA is exploring the possibility of accessing external international assistance and clinical support to assist with training and development of what they call treatment protocols.

I would like to ask the Permanent Secretary: How will the Ministry of Health aid the Tobago Regional Health Authority in achieving its full parallel health care system to treat COVID-19 patients conscious of what the CMO has just said about this evolving COVID-19 pandemic that may, obviously, end up being an endemic and, therefore, we have to look at the cost and benefit

analysis? So I would like the Permanent Secretary to address that, question number one.

Question number two, I would like you to address is: Based on the several challenges outlined by the THA, whether for instance, the Ministry of Health is prepared to provide any assistance to the THA, through the TRHA in accessing external international assistance and clinical support to address what they have described? Clinical training and development of treatment protocol.

So can you advise us, Permanent Secretary? How are we going to address these challenges that the THA would have outlined in that report and the support that the Tobago Regional Health Authority would require? Permanent Secretary.

Mr. Ali: Thank you. Through you, Chair, so with regard to the first question of the international support, the Ministry of Health, we would be liaising directly with our Pan American Health Organization (PAHO) and also CARPHA to determine exactly what sort of support the TRHA requires and through the Ministry of Health and CARPHA and PAHO, we will see to get that support for them through that avenue. And that is an active discussion that is taking place right now.

With regard to your second question of: How has the Ministry of Health provided support and assistance to the TRHA? I will let Dr. Parasram and maybe Dr. Richards speak about what we have been doing in the past to provide that sort of support to the TRHA.

Dr. Parasram: Thank you, member, for the question. It must be said that we are one country. The Chief Medical Officer is for Trinidad and Tobago. So we have been liaising with the THA, the TRHA through the CMOH as well, throughout the pandemic. Our policies and procedures for Trinidad are for Trinidad and Tobago. Dr. Trotman would have been the focal point as well for the clinical care and we have always liaised with the Chief of Staff in Tobago and the CMOH to ensure that policies and procedures that apply here apply there as well. To that end, Dr. Richards would have gone on two visits, if I remember right, with clinical teams, aside from our normal interactions that we would have had, and actually did two summary presentations to the executive of the ministry and the THA, related to the assistance that would have been asked of us at that point in time. So, Dr. Richards, I do not know if you want to go into some detail as to what you would have been trying to do when you physically went to Tobago on those visits and in way of summary, some of the findings the you found and how you were able to assist Tobago at that point in time.

Dr. Abdool-Richards: Thank you very much, CMO and PS. So the Ministry of Health and the office of the PMOI, under the instruction of the CMO, would have carried out two site visits, one in July of 2021, and the second follow-up visit in September of2021. The first visit in July was triggered by some concerns around the spacing, the way in which the TRHA and THA reps reached out requesting support, in terms of advice and guidance in setting up and in expanding their system for managing COVID-19.

Now, Tobago has a different context with respect to the way in which their health care system was set up. And, of course, there are challenges with transferring critically ill COVID-19 patients between Trinidad and Tobago, as we learnt in the first month of the pandemic. So there was a need for Tobago to rapidly upscale their health system and to come up with what they would have referred to as a hybrid parallel health care system.

So at the first visit I was accompanied by Dr. Anthony Parkinson who is a specialist in ICU medicine, Dr. Rajeev Nagassar who is a medical microbiologist and national lead for Infection Prevention and Control, and nurse Keisha Prevatt-Gomez. She is the head of Infection Prevention and Control and also would have provided advice and support from her NCRHA experience. And nationally she would have supported even the other teams with respect to nursing management and quality.

So at that first visit, we did a site visit and we did a meeting. It was a one-day visit, and we worked with the THA/TRHA to identify the gaps. One of the gaps that they had was with respect to how they stored their personal protective equipment, the layout of the ICU, the flow of patients in the ICU. And then the plans now to expand the ICU. We shared with them policies, procedures, and protocols that we would have been developing in Trinidad and Tobago and we created a communication and a network between our Trinidad and Tobago clinical doctors and theirs.

Now, I must note that we are involved, the Ministry of Health, in the M and M or the mortality and morbidity meetings that are held by the TRHA every month. The next meeting is scheduled for May 25th. So my office is part of that, and the information goes to the CMO.

The second visit was really a follow-up on the first visit. At the second visit we found, this was September, so this was basically two months later, that the infection apprenticeship and control recommendations were instituted, plans were afoot to start the additional ICU, a separate ICU at the TREC, which is at the Scarborough Regional Hospital. There was continued sharing

of information. We also visited a proposed step down site, because they needed a dedicated step down facility.

All in all, by December, the following recommendations and changes were applied with respect to Tobago. There were requests for additional staffing and we were able to locate an ICU consultant in Trinidad who relocated to Tobago; so they received the additional staff.

Secondly, we also noted that the seven-bed ICU that was being planned was actually executed and was in the process of being developed. The Lowlands step down facility, which provided about 25 additional beds was ready and operationalized by the third week in December. The infection prevention control guidelines recommendations and the technical support were also instituted.

And also for Tobago, the Ministry of Health also developed, in a similar way that we have a parallel health care system report which I would share on the media briefings, for Tobago a specific report is also generated on a daily basis.

So there is daily communication between the clinical team in Trinidad and Tobago regarding any challenges, regarding updates, and also we did provide support in terms of expanding their parallel health care facility and improving their practices and guidelines. Thank you.

Mr. Mark: May I ask, through the Chair, to Dr. Richards, the issue of monitoring and evaluation of the quality of health care services in Tobago seems to be a challenge; meaning that data collection that would be essential and critical in informing and monitoring and evaluating, the quality of health care services seems to be somewhat difficult to come by. And the committee, this same committee whose report we are examining, had some challenges because employees, according to the report, perceive data requests as a criticism of their performance. And in that regard, they were hesitant in providing same. So I wanted to ask you Dr. Richards, whether this issue of data collection and this TRHA, was a similar experience we had at the Ministry of Health, and if in the affirmative, what was implemented to rectify this issue?

Dr. Abdool-Richards: Okay. Thank you very much. Well, at the Ministry of Health, I can state that when we were, the information that was requested by the committee from our offices was shared immediately. And out of the office of the PMOI, all information that was requested was collated and distributed within the relevant time frame.

I cannot speak as to the request for Tobago because I was not involved in that request. I was not asked to facilitate those requests. But the findings that would have been noted, there is an

urgent need now to address the issue of, I should say, somewhat data hesitancy or the hesitancy to provide this data. Because it may imply that there is not a clear understanding of why the data is required.

However, that sort of intervention would need to be managed through the offices of the Minister of Health and the Administrator in Tobago, which is above our office, my office, in terms of rectifying. But thank you for pointing that out.

Mr. Mark: May I also ask through you, I will ask the Chairman and he can identify who you would want to recommend, through the Permanent Secretary to answer this one. Now, my information is that no postmortems were performed on COVID-19 patients. And, therefore, data sets on COVID-19 patients were not received and therefore conclusions could not have been made with regard to deaths.

Now, of course, this could potentially pose a challenge with the proper treatment and care of COVID-19 patients. So I would like to ask, to the Permanent Secretary through the Chairman, what were the reasons for post mortems not being conducted and secondly, by not conducting any postmortems, how does the Ministry of Health adequately evaluate the deaths of COVID-19 patients in the Republic of Trinidad and Tobago?

These are some issues I would like clarified, through the Chairman and via the Chairman, the Permanent Secretaries.

Mr. Chairman: Yes.

Mr. Ali: Sure. Thank you, Chairman. Maybe I can ask the CMO to respond to those two questions, please Chairman, if I may.

Dr. Parasram: Yes. So generally speaking, when we set about learning of COVID in early 2020, and the disease was declared a dangerous infectious disease by the President at the time, to form part of the Public Health Regulations, the world knew very little about what COVID-19 was, in terms of we knew it was a respiratory disease, there was a cluster in Wuhan China which was spreading very quickly, overwhelming their health care system. It is certainly a dangerous infectious disease.

Out of an abundance of caution, the Pathology Society would have written to the Ministry of Health indicating that from a very early stage, that autopsies should not be performed on COVID-19 positive bodies in order to afford the protection to the attendants as well as the pathologists. And that has held since.

So, taking that into consideration and forming the guidelines for handling of COVID-19 remains, human remains, and bodies, that has been a policy of the country since the onset and it has been a policy of other countries around the world, even the WHO in the early stages making provision to have bodies disposed of in the shortest possible period of time, post-death; making sure that they were in closed caskets, they were in closed body bags right after death, and that incineration occurred or burial, very, very soon thereafter. So it was out of caution, being a dangerous infectious disease. And the policy still stays because we have variants of concern occurring every single day. So we are wary of that and we want to protect our professionals in the field as best as we can.

By way of confirmation we do COVID-19 testing on all deceased, whether it was done pre or post mortem to confirm their status whether they are COVID-19 positive or not. And that is how we count our deaths, as it relates to COVID-19. And you would have heard us saying in the press conferences that we count COVID positives as having died of sequelae known sequelae for being in a hospital. For example, dying in an ICU of a respiratory disease that is well defined by the clinicians there, or you pick up a COVID-19 positive in a body that comes into the morgue. So there are two scenarios and that is how we categorize our deaths and we calculate our case fatality rates based on that. And I think it is a high degree of certainty that those who would have died with a COVID positive swab either just before or at the time of death would be counted as a COVID-19 positive death.

Mr. Mark: Thank you.

Mr. Chairman: Thank you, CMO. Member Mark, if I could just make one comment before you continue.

Mr. Mark: Yes, please.

Mr. Chairman: As we are on this topic, CMO, the WHO recently started to speak about excess deaths due to COVID-19, meaning not necessarily patients who have died from COVID-19 but the additional deaths that would have occurred because of the transfer and the alternative use of resources, and so on. Are we in a position at this point in time in Trinidad and Tobago to look at those figures, after two years in the pandemic?

Dr. Parasram: What I would have noted on the WHO's site is that WHO has now said that albeit that the actual numbers of confirmed cases or cases that are defined by countries to be in the region of just over five million deaths, they are now classifying and looking back at the data

from a WHO perspective and the excess mortality death would have occurred during the pandemic, to think that it is more along the lines of 15million, as opposed to five million. So it is a re-categorization from the WHO standpoint. And I think Trinidad and Tobago counting so widely from the start, making sure that we do have a check of anyone that would have died of COVID and with COVID, our figures would be very much, very close to what it actually should be in terms of our COVID-19 deaths. And we do have a system in Trinidad, as you know, that we allow for post mortems in non-COVID-19 and we are able to ascertain, through the DMO system, as well as through the hospital system, the cause of death as with the majority of the cases of persons that are in the country. And I think with that system in place, we are probably very close to our actual number of COVID deaths.

Mr. Chairman: Yes. Thank you. Member Mark, sorry I interrupted you.

Mr. Mark: Yes. No problem. Through you, Mr. Chairman, to the CMO. CMO, I fully agree that we have to protect our pathologists and all of those who are associated with them against possible infection and death. So I am with you on that. Can you advise this Committee whether the WHO have categorical guidelines that we can adopt as policy, prohibiting countries that are members of the WHO from conducting post mortems on COVID-19 patients? Do we have any positive guidelines from the WHO advising us? I just wanted to get some clarification.

Dr. Parasram: Yes. The WHO guideline speaks to limited handling of the bodies. It speaks to not recommending embalming, for example. WHO is not somebody that will—we are all Member States of WHO. The guidelines of WHO are not legally binding. So we are allowed to have sight of our local conditions and make our guidelines to suit and make our laws to suit.

So although WHO puts out a guideline, for example, not to embalm, some countries have gone ahead and said look, we have the PPE, we have the necessary infrastructure in our mortuaries to do so, and they have done that. In Trinidad and Tobago, the pathology association has written to us and said given the existing infrastructure and the lack of—the way it is constructed, they cannot guarantee that we will have protection from our staff and they took the precautionary principle and approach, they want to protect their staff as a guiding principle and we at the Ministry of Health heard their cries and our guidelines speak to not allowing for autopsy in that regard.

Mr. Chairman: Thank you, CMO. Member Mark.

Mr. Mark: May I also ask, through the CMO, I do not know and you can guide me on this one,

CMO. Somewhere I read where the WHO expressed alarm over the lack or the paucity of data submission by Member States of the WHO, as it relates to real-time data submission. And I think it drew examples, particularly as it relates to testing of persons with COVID or potential COVID. I cannot remember the exact language that was used, but they were very concerned and they were saying that in the future, because of the fact that COVID is still with us, there can be dire consequences for the global community, given the slacking that is taking place by member countries. I do not know if I got it right, or if you can guide me on the WHO concern.

Dr. Parasram: So I think generally speaking, the WHO was concerned that certain Member States had relaxed their testing criteria. Trinidad and Tobago, I can assure the country that Trinidad and Tobago's testing criteria has remained in place throughout the pandemic, and we have not relaxed our testing criteria. But certain countries have decided, for example, not to test anymore. Of course, I do not want to name any names of countries, but they have decided not to test and I think WHO is making a call that the pandemic is still among us and without testing, we do not know what is circulating in our countries and in our regions. And in that regard there is a concern.

If we cannot measure it and we cannot test it then we do not know what is happening around us. So, WHO is concerned that certain countries are changing their testing strategy a little bit too early on in the pandemic.

5.30 p.m.

Mr. Mark: Okay, and Mr. Chairman, may I ask the Permanent Secretary this question. On the human resource and staffing side again, I would like to ask or seek clarification from the Permanent Secretary on the transfer of some 12 highly trained doctors from the Couva facility at the height of the COVID-19 pandemic. Can the Permanent Secretary indicate to this Committee how did this transference of these highly trained medical doctors take place and how has this development impacted upon the COVID-19 mortality rate in Trinidad and Tobago? I want to ask for clarification through the Permanent Secretary via the Chairman on this very important matter that the public is extremely concerned about.

Mr. Chairman: Yes, in relation to the human staffing aspect, if we can get an answer.

Mr. Ali: Sure, thank you Chair. I would let CEO Thomas speak to the issue of the transfer, and then maybe CMO can speak to whether there was any implication with regard to the mortality issue.

Mr. Thomas: Through you, PS, I think that was widely aired within the public domain regarding the—our position at that junction, there were submissions by the Medical Chief of Staff at the time indicating the imminent—the fatigue that had existed within that category of staff at that facility. Certainly, we had already had available to us to alleviate some of that fatigue, equally trained and equally highly trained personnel who had been operating out of Arima as well, which would have not—which certainly got involved within the engagement with the pandemic, a few months subsequent so basically, it was just a matter of that for the main part.

Mr. Mark: But were these people ever retransferred Mr. Davlin Thomas, or were they permanently exiled, these 12 highly trained personnel in the medical field—were they permanently transferred out, or were they ever brought back in to the facility where they were transferred out? I just wanted to get some clarification from your good self.

Mr. Thomas: Through you Chair, they still—those are medical personnel still provide the NCRHA and certainly the people of the Republic of Trinidad and Tobago with services consistent with their competence and skills. So basically, they still operated within the NCRHA at various levels. In addition, we—there were other categories of staff that had been recycled through the NCRHA. But I mean, they are still working within the NCRHA and providing high quality—good quality services.

Mr. Mark: Yeah, but could you clarify here for me—

Mr. Chairman: Thank you, Mr. Thomas.

Mr. Mark:—yeah, no, just a final—

Mr. Chairman: Sorry, member Mark, yeah.

Mr. Mark:—just a final clarification. I would like to ask the CEO, whether what he has said earlier about fatigue, tiredness, would you not agree with me that that period of tiredness, during that build up, would have passed and therefore, it is high time that these 12 highly trained doctors, rather than offering their services elsewhere be placed where their services ought to be located to save lives? Could I ask the CEO to clarify whether this burn out and fatigue, is it permanent or is it temporary or is it everlasting? Could I get some clarification?

Mr. Chairman: Member, sorry. PS, I will leave that answer up to your discretion PS whether you would want to.

Mr. Ali: So I think the issue of rotation and transfer of staff is something that is standard across the RHAs and different facilities, Chairman. This is something that is part and parcel of what the RHAs do in terms of movement of staff where they are needed and utilized.

Mr. Chairman: Thank you, PS. Member Mark, if I can just indulge, member Morris-Julian has a question, would you allow?

Mr. Mark: No, no, no, no before you indulge my friend, can I ask the CMO through you Mr. Chairman, whether these transfers had any impact at all from his analysis of the data on the mortality rate in this country?

Mr. Chairman: Sure, PS.

Mr. Ali: Sure, I know CMO was having a little difficulty here, Chairman, so let me just see if I could get them back online please.

Mr. Chairman: All right so—

[*Technical difficulties*]

Mr. Ali: Can we get back to that question if you do not mind, Chairman, because I need to get the CMO back in.

Mr. Chairman: Sure, member Mark, can we—

Mr. Mark: Sure, sure, sure.

Mr. Chairman: So we would allow member Morris-Julian—

Mr. Mark: Yes.

Mr. Chairman:—to join the conversation in the interim. Member Morris-Julian.

Mrs. Morris-Julian: Thank you, Chairman. Chairman, the question that I have is a question from the public and they requested and I quote:

> We have seen during the pandemic different levels of organization and planning across the different RHAs to various degrees of success. Is the current RHA system still viable, especially in a pandemic or should there be a return to universal system?

I would assume the question would be directed to the PS or the CMO, Chairman?

Mr. Chairman: PS, would you be in a position to answer? PS, did you hear me?

Mr. Ali: Oh, yes sorry, could you just repeat please? Sorry, I do apologize.

Mr. Chairman: Member Morris-Julian, you want to repeat your question?

Mrs. Morris-Julian: Yes, Chairman, I am just looking for it again. Through you, Chairman, to the PS—I have a question from the public.

We have seen during the pandemic different levels of organization and planning across the different RHAs to varying degrees of success. Is the current RHA system still viable, especially in a pandemic, or should there be a return to a universal system?

This is a question from the public, Chairman.

Mr. Chairman: PS, I do not know if you want to venture an answer—I know it is a policy question.

Mr. Ali: Chair, that is a policy question that goes beyond COVID in terms of the health sector and the success of the RHA system. That is above my pay grade in terms of as a policy decision.

Mr. Chairman: Thank you, PS, I believe that—

Mrs. Morris-Julian: Thank you very much, Chairman.

Mr. Chairman: Thank you, member Morris-Julian. I believe that CMO is back with us, PS?

Mr. Ali: Yes he is.

Mr. Chairman: Regarding the answers to member Mark's last question.

Mr. Ali: Yeah. If you can just indulge member Mark to maybe just ask CMO because I do not think he heard the question. I do apologize member Mark.

Mr. Parasram: Sorry about that, I just had some technical difficulties.

Mr. Mark: Yeah, no problem, yeah, through the Chairman, CMO—I just wanted to ask whether the data revealed any upward tick or shift in the mortality rate, when the 12 highly trained doctors were rotated as the PS said, consistent with established practices within the medical field and maybe other institutions. I was just seeking to get some clarification from the data, whether there was any uptick, whether there was any impact on the mortality rate when these 12 highly trained, doctors were moved out of the system and redeployed to other areas of the health care system. I am just seeking clarification.

Mr. Parasram: I mean, there is nothing in the data that suggests an uptick in mortality aside from—an uptick in mortality is related to an increase in the number of cases, an increase in the—in that particular time of the pandemic, when we had Delta, you saw an increase in the mortality, which went along with the actual pathogen. We have people moving across the region, we have at one point in time we actually had about 100 plus persons on quarantine—meaning skilled healthcare workers in quarantine in our system, especially even during the Delta surge we had an excess number of personnel. I do not think having 10 people move from one place to the next will impact nationally on the statistics that we saw. And we certainly did not see it from a national

perspective that there was any change in mortality or case fatality rate nationally related to any movement of people.

Mr. Chairman: Thank you, thank you CMO. Member Mark.

Mr. Mark: Thank you.

Mr. Chairman: Thank you. So I just—PS, I am coming to the end of the report and I am looking at the recommendation section—I believe that there are 16 recommendations, and you did indicate in your opening submission that the Ministry has taken note, and is already in the process of implementing some of those recommendations. So I will not belabour the Committee with all of these recommendations but I want to look at recommendation number 14, which speaks to the national policy regarding ICU admissions, and care of the elderly. And I just want to quote directly from the report noting that:

> "15.2% of paediatric admissions were to ICU compared with 1.2% of persons over 80 years of age."

And the comment was that:

> "This was remarkable given the high death rates amongst the elderly."

So but—and then—it is—the conclusion is that:

> "We did not find any mention of a national policy regarding admissions to ICU for persons of different ages, and recommend that such a policy needs to be articulated."

So I ask whether consideration is been given to such a policy. I also understand that in the height of the pandemic, there would have been concerns as to the availability of ICU beds and so on and whether there was any policy at that point in time, PS, maybe CMO may want to answer this and whether consideration is being given to the implementation of that particular recommendation, PS.

Mr. Ali: Sure, CMO.

Mr. Parasram: Yes, so generally speaking in terms of our national ICU structure, there are three levels of ICU structure that we recognize. So there is the neonatal ICU, the NICU, there is the paediatric ICU, and as there is the adult ICU, so those are the three levels of ICU that we have in our system—throughout our system. Recognizing that there are criteria for admission to an ICU, which has been long standing, even long before COVID, as to who should be admitted—which type of patient should be admitted to an ICU bed, right. So, there will be varying criteria based on the possible outcome as it relates to that particular individual.

So, those are the three categories that we recommend—there is no dedicated ICU facility for the elderly in Trinidad at this point in time. In our planning going forward, we will have to look at—we have already certainly started to look at the geriatric population as being a very vulnerable group, even with COVID-19 and before and certainly some policies will have to be adopted as it relates to the care of the elderly, geriatric care and palliative care as we go forward. But there is no ICU specific to that category in Trinidad and Tobago at this point in time.

Mr. Chairman: Thank you, CMO. And I just wanted to look at one last recommendation and that is recommendation number two, which is on page 99, with regard to the NCDs management, and of course, what this pandemic has taught us is that we perhaps have, you know, an unhealthy population, many, many unhealthy citizens with regard to the comorbidities and so on. And the report is stating that:

"Preventive management needs to be aimed at children, adolescents and young adults."

And they recommended that:

> A national survey of NCDs is urgently required and the data used to guide the review and revision of health promotion and treatment programs."

So my question in this regard is whether such a national survey of NCDs is in progress or has been planned, PS?

Mr. Ali: Sure.

Mr. Parasram: PS, if I may, the steps survey which is a PAHO tool that was utilized before in about 2012 it was conducted so, we had one national step survey that was conducted, we in the process of actually conducting another step survey, which will give us a more recent look at what our NCD status is like. But generally there have been studies in and about Trinidad and Tobago in between, from persons in academia and other parts of society doing studies, and a desktop review has shown that upwards of 60 per cent of the deaths are attributable to NCDs.

So it is a serious problem in our country and it is one that the Ministry and the hon. Minister has put at the fore to actually prioritize over the next year or two, to put NCD at the fore and primary care at the fore recognizing that primary care—only through primary care can we get the gains that we need to get in the society getting a healthier population, decreasing NCDs and of course decreasing the need for secondary and tertiary care, which is the ultimate goal. So, programmes are well on the way and again to the IADB loan that was spoken about earlier, there is an IADB loan in place to deal with NCDs and programmes and policies are in place as well.

Mr. Chairman: Thank you, CMO. In that same recommendation, the second paragraph, the Committee recognized the possibility that citizens—the fact, in fact, that citizens with NCDs would again be at increased risk for poor outcomes, if and when there is another event such as the COVID-19 pandemic—and they go on to say that:

> "The clinical staff who have been hired temporarily and whose contracts would be discontinued at the end of the pandemic should be redeployed to respond to the"—they call it—"the NCD morbidity debt that has accumulated during this pandemic."

So that is their recommendation and my question to you, PS, is whether consideration is being given to the redeployment of the staff—the medical and nursing staff that would have been hired temporarily during the pandemic—is this going to happen in terms of this recommendation?

Mr. Ali: Sure, thank you, Chair. So, with regard to the continued engagement of medical staff, the RHAs would look at their vacancies, the needs and the budget allowing and staff would be retained once those—looking at those three factors. Having said that, in terms of NCDs and CMO spoke to it, we are also looking at other mechanisms to really treat with the issue of NCDs. It does not only have to be with the traditional method of the secondary care, we looking at primary care, we looking at partnerships with the private sector. So we are really looking at how we address NCDs at a holistic manner, all right. Thank you.

Mr. Chairman: Thank you, PS. So at this point, I would just open the floor once more, if there is any other burning question from members of the Committee, if not, at this point, I would want to close and just in closing, PS, I just want to again, refer back to one of the terms of references of this Public Administration and Appropriations Committee. And that is the one of the terms of references too is to look at the administration of government agencies, to determine hindrances to their efficiency, and to make recommendations to the Government for improvement of public administration. So with that in mind, PS, I would want to invite you, but to make any suggestions that you may have, based on this report that, you know, as a committee we can take back to the Parliament, you know, going forward, before I invite you to make that submission, I also want to take the opportunity to congratulate you on your appointment. You have been in the Ministry for such a long time I have known you for so long—you function there as the Permanent Secretary. And I also want in your closing comments to say I look forward to the final report that you alluded to, I am hoping that at the end of this pandemic whenever it ends that we will have some sort of report and some sort of definitive data going forward. As we know, inevitably,

we are preparing for another pandemic, whenever that may come. So PS, I invite you to bring any closing remarks.

Mr. Ali: Sure, thank you very much, Chair. Let me just say thank you very much to your good self and to the members of the Committee. I think it was a very useful discussion and conversation. I am glad we were able to clarify certain issues for the Committee's benefit and also the public. We will commit to providing the information in writing that was requested. And on that note, I think I would want to maybe include on behalf of the Ministry Chair, any suggestions for the Committee in that submission in writing, in terms of how you all can assist us, in fulfilling our mandate. So I would prefer to send those in writing, when we make our submission.

Mr. Chairman: Sure.

Mr. Ali: Thank you very much again.

Mr. Chairman: That will be very much appreciated. I also want to take the opportunity to invite the CMO, I know this is perhaps a breach of protocol PS, but in the circumstances that we currently are in we still in a pandemic as CMO stated whether CMO may want to have any closing remarks and perhaps advice for the population.

Mr. Parasram: I think I just want to join with PS to really say that I think the Public Accounts was very useful to us. It is always good to look at a system, especially when I suppose the pandemic has allowed us a little time to breathe as health care workers. Although, as member Julian would have pointed out, we have been through a war and all 17,000 health care workers would have felt it. And we are still, for want of a better word, still in a state of post traumatic stress disorder in general, all of us. So we are trying to get our feet back on the way to the new normal. Looking at other parts of the sector that would have slipped away a little bit like NCDs and the like, really reprioritizing but still knowing that we are in the midst of a pandemic and we have to be cautious. There is always a concern that a new variant would come as it did in November of 2021, which is, you know, something that the world is always looking out for, but we hope that we have seen the worst of it and we will be on the way to endemicity in the near future.

Mr. Chairman: Thank you, thank you, CMO. I would like to take this opportunity on behalf of myself and the other members of the Committee to again thank all the frontline health care workers, the doctors, the nurses, the administrative staff, of course management, you know, everybody. Everybody counts in this and we saw instances of where if an orderly or an attendant

is not present, the whole chain can fall down. And of course we are very grateful to those who have served during this prolonged period. And especially to our hard working nurses, tomorrow is recognized as International Day of Nurses, May 12th, so I just want to take this opportunity as well to wish our nurses all the best and to commend their efforts going forward.

It would be remiss of me as well, if I did not again express condolences to the relatives of those who have lost their lives to this pandemic, as you mentioned, CMO, it is still an ongoing event and therefore, we still need to be cautious.

As I close, I would want to thank all the members who have taken the time, PS, to attend this meeting and to give us your contributions and your very valuable input. Of course, Dr. Parasram, CMO; Dr. Abdool-Richards; Dr. Avery Hinds; Dr. Michelle Trotman and the CEOs, Dr. Brian Armour and Mr. Davlin Thomas. So we really appreciate you making the effort and the time, in all it is still very difficult circumstances for all of us in the health sector. So I thank you for being here and at this point, I would want to say that this meeting is now suspended. Thank you very much, have a safe afternoon all.

5.53 p.m.: *Meeting adjourned.*