REGIONAL MUNICIPALITY OF WATERLOO
COMMUNITY SERVICES COMMITTEE
AGENDA

Tuesday, September 25, 2012
Closed Session 8:30 a.m.
Open Session 9:00 a.m.
Regional Council Chamber
150 Frederick Street, Kitchener

1. MOTION TO GO INTO CLOSED SESSION

THAT a closed meeting of the Community Services, Administration and Finance and Planning and Works Committees be held on Tuesday, September 25, 2012 at 8:30 a.m. in the Waterloo County Room, in accordance with Section 239 of the Municipal Act, 2001, for the purposes of considering the following subject matters:

   a) litigation or potential litigation and receiving of legal advice and opinion that is subject to solicitor-client privilege related to a legal proceeding
   b) litigation or potential litigation and receiving of legal advice and opinion that is subject to solicitor-client privilege related to a contract
   c) litigation or potential litigation and receiving of legal advice and opinion that is subject to solicitor-client privilege related to a contract

2. MOTION TO RECONVENE INTO OPEN SESSION

3. DECLARATIONS OF PECUNIARY INTEREST UNDER THE MUNICIPAL CONFLICT OF INTEREST ACT

4. DELEGATIONS

5. REPORTS – Social Services

   a) SS-12-038, Provincial Transitional Funding for Children’s Services 1
   b) SS-12-043, Children’s Services, Early Learning and Child Care Service Plan 2012-2015 (Staff Presentation) 4
   c) SS-12-044, Community Homelessness Prevention Initiative (CHPI) 8

   REPORTS – Public Health

   d) PH-12-038, Breastfeeding Support Update – 2012 16
   e) PH-12-037, EMS Rural Response Time Update 22
   f) PH-12-039, EMS Response Time Performance Plan 25
6. INFORMATION/CORRESPONDENCE
   a) Memo: Fear of Crime & Victimization - RAP Sheet (Sheet distributed separately)

7. OTHER BUSINESS
   a) Council Enquiries and Requests for Information Tracking List

8. NEXT MEETING – October 16, 2012

9. ADJOURN
TO: Chair Sean Strickland and Members of the Community Services Committee  
DATE: September 25, 2012  
FILE CODE: S04-20  
SUBJECT: PROVINCIAL TRANSITIONAL FUNDING FOR CHILDREN’S SERVICES

RECOMMENDATION:

THAT the Regional Municipality of Waterloo increase the 2012 Children’s Services operating budget by $623,966 gross and $0 net Regional Levy for Transitional Operating and Capacity Funding as outlined in report SS-12-038, dated September 25, 2012.

SUMMARY:

NIL

REPORT:

In August 2012 Committee received a report that outlined new Provincial funding allocations. The funding is provided to the Region as the Consolidated Municipal Service Manager (CMSM) on a one time basis for the 2012 calendar year. The purpose of the one time allocation is to allow the Province sufficient time to develop a new funding formula for child care for more equitable distribution of funding for future years. In total Children’s Services received $834,277 in 100% Provincial funding. On August 14, 2012 Committee approved the use of $210,311 for Transition Minor Capital, Health & Safety Minor Capital and Small Water Works.

The remaining portion of $623,966 includes $532,207 in Transition Operating and $91,759 in Capacity Funding to Support Transformation. This report outlines a plan for use of the remaining portion following consultation with community operators.

Transitional Operating Funding

Transitional Operating Funding can be used to support the licensed Early Learning and Child Care sector during this period of transition and change as full day kindergarten and extended day is phased in. The funds can be used for fee subsidy, wage subsidy, to help keep parent fees in line or special needs resourcing and administration costs. In addition funds can also be redirected for use as one time health and safety funds and minor capital.

The Children’s Services Early Learning and Child Care Service Plan identified three areas of significant pressure for the licensed ELCC sector; market rates for subsidy eligible children, availability of wage subsidies and long term financial viability. Following consultation with the Early Learning and Child Care Advisory Committee, the following strategy for use of the funds is being recommended for Committees’ consideration.
Allocate the full amount of $532,207 to fee subsidy to be used as follows:

- Payment of full market per diem rates for purchase of service for rates related to infants, toddlers and preschoolers (0-4 yrs), effective July 1, 2012 at a cost of up to $210,000. Market rates relate to the operators demonstrated cost to operate a space at a licensed child care program. The current average market per diem rate for a full time preschool space is $41.13 and the current average per diem rate that the Region of Waterloo pays is $36.59. This difference results in a potential loss of revenue per space for an operator of $1,089 per year/child. This difference places increased financial pressures on licensed child care operators who are committed to enrolling subsidy eligible children. This Provincial funding is provided on a one time basis for 2012 and is anticipated to continue for 2013. The funding will be provided to operators on a one time basis for 2012 and will not be continued without Provincial funding for 2013. The total estimated cost on an annual basis is $420,000.
- Assign the maximum allowable to one time health and safety funding totalling $122,000.
- Assign the remaining portion ($200,207) to one time minor capital funding requests from licensed early learning and child care operators.

Capacity Funding to Support Transformation

This new one time funding allocation is provided to CMSM’s to “support and facilitate child care transformation within their communities.” The funding can be used to help non profit child care programs with costs related to legal fees, advice, mergers and consolidations, relocation costs to schools and costs for information technology related to business purposes.

The following plan for use of the 2012 funding was reviewed and endorsed by the Early Learning and Child Care Advisory Committee on August 14, 2012. The total funding allocation of $91,759 will be split between the following purposes:

- Up to $31,759 used to support the implementation of a centralized information, registration and wait list management software that will improve access for parents/guardians looking for regulated early learning and care in Waterloo Region.
- Up to $40,000 used to support costs related to a merger of three non profit child care centres into one organization called Bright Starts and consolidation of the Child Care Special Needs Resourcing Partnership from seven to three agencies.
- Up to $20,000 to offset staff costs and consulting fees to engage licensed early learning and child care operators in the development of common financial tools and related training supports to improve efficiencies and effectiveness.

CORPORATE STRATEGIC PLAN:

This initiative aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Objective 4.5: To work collaboratively with the community to support the development of services for children.

FINANCIAL IMPLICATIONS:

The current 2012 calendar year allocation from the Province of Ontario totals $28,986,583 including the $623,996. The new funding is 100% Provincial dollars and does not require a Regional funding contribution. The increased funding allocation is for the fiscal year, 2012 and there is no commitment to provide funding in future years. The total annual cost of paying
market rates in 2013 totals $420,000. Should no new Provincial funding be provided in 2013 the rate supplement would be discontinued for 2013.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance was consulted in the preparation of this report.

ATTACHMENTS

NIL

PREPARED BY: Nancy Dickieson, Director, Children’s Services

APPROVED BY: Michael Schuster, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 25, 2012

FILE CODE: S04-20

SUBJECT: CHILDREN’S SERVICES, EARLY LEARNING AND CHILD CARE SERVICE PLAN 2012-2015

RECOMMENDATION:

THAT the Regional Municipality of Waterloo endorse the Children’s Services, Early Learning and Child Care Service Plan 2012-2015 and that copies be forwarded to the Province, Early Learning and Care Division, Ministry of Education as outlined in report SS-12-043, dated September 25, 2012.

SUMMARY:

NIL

REPORT:

As the Consolidated Municipal Service Manager (CMSM) Children’s Services is required to develop annual service plans for the licensed Early Learning and Child Care sector. Early Learning and Child Care has been experiencing a period of rapid change since 2009 when full day kindergarten and extended day was announced for the Province of Ontario. The focus of service planning since that time has been on sustaining and transforming the current system. To ensure community input during this period of change an Early Learning and Child Care Community Advisory Committee (ELCC Committee) was formed. The ELCC Committee has been a valuable source of information, guidance and advice for staff. In addition to the ELCC Committee surveys and focus groups have been offered to gather further insight into community needs.

The Service Plan presented for Committee’s review has a different format from previous years and has been developed to encompass a multi-year approach. There are four main components of the Service Plan; The Current ELCC System, The Bigger Picture, Gaps and Issues, Priority Directions.

The purpose of the Service Plan is to provide a valuable source of information for community operators that can be used for planning. The approach of implementing a multiyear plan helps all operators understand the key directions that will be worked and allows for the appropriate amount of time to fully implement some strategies. The three key priority directions are:

- To develop a vibrant, high quality, inclusive service system of licensed early learning and care that promotes optimal developmental health for children.
- To develop a system wide approach to early learning and care that is high quality, equitable and inclusive of all children and is delivered in partnership with other service providers.
- To promote integrated planning and service delivery to improve access for families and developmental outcomes for children across Waterloo Region.

Each of the three key priority directions has a series of activities identified. These activities have been prioritized and given timelines for completion over the next three years.
CORPORATE STRATEGIC PLAN:

This initiative aligns with the Region’s Corporate Strategic Focus Area 4: Healthy and Inclusive Communities; Corporate Strategic Objective 4.5: To work collaboratively with the community to support the development of services for children.

FINANCIAL IMPLICATIONS:

All directions identified in the Service Plan will be accommodated within the Children’s Services budget and help to identify priorities should further Provincial funding be available in the future.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

A- 2012-2015 Service Plan, Executive Summary

PREPARED BY: Nancy Dickieson, Director, Children’s Services

APPROVED BY: Michael Schuster, Commissioner, Social Services
Region of Waterloo Children’s Services
Early Learning and Child Care Service Plan (2012–2015)

Executive Summary

The licensed Early Learning and Child Care (ELCC) sector is in a period of significant change with the onset of full day kindergarten in 2010. The Children’s Services Early Learning and Child Care Service Plan (2012 – 2015) focuses on supporting the transition for our licensed ELCC sector as it begins to reposition as a vital partner in a continuum of high quality early learning and care services for children from birth to age 12 years.

The Service Plan has been developed in consultation with the community and reflects the ongoing commitment to the development and delivery of a high quality, inclusive system of early learning and care for children and their families in the Waterloo Region. The Eight Elements of a High Quality ELCC system (see diagram below) guides the work outlined in the Service Plan.

Eight Elements of Quality

Service Plan Sections

Section A: The Current ELCC System – local demographics and current ELCC system information (e.g., licensed spaces, funding).

Section B: The Bigger Picture – a look at child and system health in relation to other communities in Ontario.

Section C: Gaps and Issues – emerging and ongoing challenges for the ELCC system.

Section D: Priority Directions – key strategies to support the ELCC system from 2012 – 2015.
Gaps, Issues and Comments

Gaps
- Only 17% of children under the age of six with parents in the labour force have access to a licensed ELCC space.
- More supports and services for children with special needs are needed to attend our licensed ELCC programs.

Issues
- Progress on the Eight Elements of Quality has been limited in the areas of Financing, Human Resources and Physical Environments.
- The top viability challenges for licensed ELCC operators are:
  - Lack of wage subsidy funding.
  - High cost of infant/toddler care.
  - Per diem rates not at 100% of market value.
  - Day Nurseries Act (DNA) ratios/limitations.
- To retain staff and maintain quality of licensed ELCC, the community needs to work towards salary equity and standards for Registered Early Childhood Educators in all places of employment.

Comments
- During this time of transformational change in licensed ELCC it will be important to find new ways to work together to support viability.
- If there is limited funding, the first priority should be for programs that serve children under the age of 3.8 years in our community.
- A 2-3 year plan for licensed ELCC in the Region would be helpful so we have a better sense of where we are going and who is doing what.
- Ongoing staff development and training are important to maintain and enhance the quality of our programs.
- Location of ELCC programs is a top priority for parents when choosing care – preferred locations are those close to where they live or close to an elementary school.
- It is time to increase requirements for the Raising the Bar Quality Initiative.
- The Child Care Special Needs Resourcing Partnership (CCSNRP) sees a need to restructure.

Priority Directions (2012 – 2015)

1. To develop a vibrant, high quality, inclusive service system of licensed early learning and care that promotes optimal developmental health for children.

2. To develop a system wide approach to early learning and care that is high quality, equitable and inclusive of all children and is delivered in partnership with other service providers.

3. To promote integrated planning and service delivery to improve access for families and developmental outcomes for children across Waterloo Region.

For more information please contact:
- Alison Pearson, Social Planning Associate
  PH: 519-883-2375, APearson@regionofwaterloo.ca
- Nancy Dickieson, Director, Children’s Services
  PH: 519-883-2177, NDickieson@regionofwaterloo.ca

To access the full 2012-2015 Service Plan visit: www.tinyurl.com/c439y3p

Document available in alternative formats as requested.
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 25, 2012

FILE CODE: S13-30

SUBJECT: COMMUNITY HOMELESSNESS PREVENTION INITIATIVE (CHPI)

RECOMMENDATION:

For Information

SUMMARY:

The Province has confirmed (see letter as Attachment A), that effective January 1, 2013, the following five homelessness prevention programs, administered by the Regional Municipality of Waterloo (the Region) Social Services, will be consolidated:

- Consolidated Homelessness Prevention Program;
- Provincial Rent Bank;
- Emergency Energy Fund;
- Emergency Hostel Services; and
- Domiciliary Hostel Program.

The new program entitled, the “Community Homelessness Prevention Initiative” (CHPI) will be funded through the Ministry of Municipal Affairs and Housing (MMAH). Beginning January 1, 2013, MMAH will flow the CHPI as a single funding envelope to the Region, who continue to serve as the Consolidated Municipal Homelessness Service Manager (CMSM) for Homelessness. The Region’s allocation for the CHPI is expected to be finalized by the end of September 2012. The Region will have flexibility to determine how best to utilize this funding to deliver and administer homelessness to housing stability services at the local level.

Social Planning, Policy and Program Administration (SPPPA) has initiated a three phase process towards implementing the consolidation locally. Further information will be brought forward in the fall for Council approval.

REPORT:

1.0 Background
As part of the work and commitment through the Provincial-Municipal Fiscal and Service Delivery Review (2008), the Province, through it’s Long Term Affordable Housing Strategy (2010) indicated its intention to consolidate the over 20 existing housing and homelessness programs in order to allow municipalities to use funding in a more flexible manner, reflective of local needs. The first phase of consolidation was identified to include the following five homelessness prevention programs, effective January 1, 2013:

- Consolidated Homelessness Prevention Program (100% MCSS)
September 25, 2012

- Provincial Rent Bank Program (100% MMAH)
- Emergency Energy Fund (100% MCSS)
- Emergency Hostel Services (81.2/18.8 cost-shared MCSS)
- Domiciliary Hostel Program (80/20 cost-shared MCSS)

These five programs are funded primarily through the Ministry of Community and Social Services (MCSS) on either a 100% or cost-shared basis. Locally, these five programs account for approximately $6.5M (provincial and regional share), in the local homelessness to housing stability system. SPPPA currently administers this funding for 31 community programs through 20 different organizations/operators that serve approximately 2,000 people annually.

Region staff has been aware of the Province’s intention to consolidate these five homelessness programs since the summer of 2011 following release of the Housing Services Act, 2011. At that time, SPPPA staff began sitting on the Province’s Phase 1 Homelessness Consolidation External Partner Working Group through the Association of Municipalities of Ontario (AMO), providing advice to MMAH and MCSS. Information regarding the planned Phase 1 Homelessness Consolidation was brought forward by Social Services to Regional Council through the 2012 budget process.

In spring 2012, as part of the 2012/2013 Provincial budget, it was announced that the Community Start-Up and Maintenance Benefit (CSUMB) would be removed as a mandatory benefit under OW and ODSP effective January 1, 2013. It was identified that 50 percent of this funding would be redistributed to Services Managers, based on a needs formula, as part of the CHPI allocation (SS-12-019).

2.0 New CHPI

The Province has now officially announced the new consolidated program entitled the “Community Homelessness Prevention Initiative” (CHPI) (see letter as Attachment A). Responsibility for CHPI now falls under MMAH with funding for existing programs being transferred from MCSS effective January 1, 2013.

The Region’s allocation under CHPI is expected to be finalized at the end of September 2012. As outlined in the letter from MMAH, the allocation will include a combination of base funding (current funding for the five consolidated programs) and needs-based funding (funding from the CSUMB reinvestment and scheduled upload for OW financial assistance for both Emergency Hostel Services and CSUMB according to share of Deep Core Housing Need). As identified, funding through CHPI can be used in any of the following four service categories:

1. Emergency Shelter Solutions;
2. Housing and Related Supports;
3. Services and Supports; and

Further program detail is not yet available. Over the past summer and this fall, MMAH will consult with municipal representatives through a Technical Advisory Group, on which Region SPPPA staff is participating, on the following elements of the consolidated program:

- Performance indicators and metrics
- Guidelines for the newly consolidated program; and,
- Investment Plan/Service Contract templates.

Further information regarding the CHPI from MMAH is anticipated in October and November 2012. However, key changes as part of the CHPI to note at this point include:

- Emergency Hostel Services will no longer be an uncapped program (where Province puts in its share of the per diem according to Region’s contribution) and is removed from Ontario Works legislation and eligibility requirements.
• The formula used by the Province to identify the Region’s allocation for Emergency Hostel Services (average of actual expenditures over 2009, 2010, 2011) will identify an amount lower than anticipated expenditures for 2012 given higher program demands over the past year.
• The allocation is provided as one funding envelope with flexibility to meet local needs without being tied to existing funding methodologies and program criteria (e.g., per diem funding or program requirements outlined for the Domiciliary Hostel Program and Rent Bank).
• CHPI is 100% funded by the Province and will be moving from a calendar to a fiscal funding cycle (April - March).

3.0 Local Planning for Consolidation and Next Steps
In order to prepare for the changes anticipated as part of the consolidation, Regional Council approved $70,000 through the 2012 budget. Local planning and implementation has been conceptualized to include three phases:

<table>
<thead>
<tr>
<th>Phases</th>
<th>Activities</th>
<th>Timeframe</th>
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| 1. Pre-planning and preparing for immediate requirements | • Gathering data  
• Identifying an interim approach for 2013  
• Creating a “Plan to Plan” for 2013 | 2012        |
| 2. Planning                   | • Stakeholder consultation  
• Creating an “Implementation Plan” | 2013        |
| 3. Beginning Implementation   | • Begin to make changes as identified in the Implementation Plan | 2014 and beyond |

The following principles were identified to inform this planning approach:
• Meet funding and program requirements of CHPI as set by the Province
• Involve all stakeholders who will/may be affected by any changes
• Communicate effectively with all stakeholders who will/may be affected by any changes
• Minimize system destabilization as much as possible
• Set realistic timeframes
• Identify clear roles and direction
• Explore a wide range of options
• Utilize promising practices and identified community needs to inform any changes

As part of the pre-planning phase in 2012, background information is being gathered regarding current programs, funding options, and key stakeholders. Impacts regarding elimination of CSUMB, changes to OW discretionary benefits and CHPI are undergoing community consultation and are being planned for in an integrated manner. In addition, SPPPA continues to work closely with Housing as plans are being developed.

As further information is received from the Province regarding CHPI, SPPPA staff will bring reports to Council and communicate with funded programs and other community stakeholders. Reports planned for Council at this point include:
• November – CHPI finalized allocation, CHPI Guidelines, seeking approval to enter into an Agreement with MMAH
• December – Pre-planning (2012) progress report and seeking approval on local plans for 2013 including approach, rates, program allocations, and the “Plan to Plan”. In keeping with the principles to minimize system destabilization and to allow realistic timeframes for planning, input and communication, the general plan is to provide the same programs, level of funding, and funding administration approach as exists in 2012.
• Early 2013 – Seeking approval for the 2013/14 Investment Plan for MMAH.
Any changes for 2014 and beyond will be considered through the processes identified in the “Plan to Plan” for 2013. At the end of the 2013 planning process, it is anticipated that an implementation plan for moving forward for 2014 and beyond will be brought forward to Council for approval in fall 2013.

CORPORATE STRATEGIC PLAN:

Participating in CHPI is aligned with the Region’s Corporate Strategic Plan (2011-2014), Focus Area 4: Healthy and Inclusive Communities: to “reduce inequities and enhance community health, safety, inclusion and quality of life”; and specifically, Strategic Objective 4.5 to “Work collaboratively to increase the supply and range of affordable housing and reduce homelessness”.

FINANCIAL IMPLICATIONS:

CHPI funding will be 100% provincial. Although a planning allocation of $7,702,788 is identified in the letter (Attachment A), the Province has sent further correspondence indicating that the finalized allocation will be made available at the end of September 2012. The Region is not required to cost-share in the new CHPI; however, current investments for cost-shared programs will be required to continue existing community programs. Based on the planning allocation provided by the Province, the Region’s 2012 budget includes $1,455,000 as its required contribution for these programs. In addition, should a different allocation be provided by the Province this estimate will be revised.

Funding to support the 2013 planning process for CHPI will be considered as part of the 2013 budget process.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance and Planning, Housing and Community Services have reviewed this report.

ATTACHMENTS

Attachment A: Letter from Ministry of Municipal Affairs and Housing

PREPARED BY: Marie Morrison, Manager, Social Planning Lynn Randall, Director, Social Planning, Policy and Program Administration

APPROVED BY: Michael Schuster, Commissioner, Social Services
ATTACHMENT A
LETTER FROM MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING

July 24, 2012

Mike Murray
Chief Administrative Officer
Regional Municipality of Waterloo

Dear Mr. Murray:

I am writing to inform you about the introduction of the Community Homelessness Prevention Initiative (CHPI) and to provide details about the first year’s funding allocation for the Regional Municipality of Waterloo under this program.

A commitment to housing and homelessness program consolidation was one of the outcomes from the Provincial-Municipal Fiscal and Service Delivery Review. Consolidating housing and homelessness-related programs is a key part of Ontario’s Long-Term Affordable Housing Strategy (LTASHS) to transform the housing system and put people first. Under LTASHS, the Province committed to consolidate the following housing and homelessness related programs:

- Consolidated Homelessness Prevention Program;
- Emergency Energy Fund;
- Emergency Hostel Services;
- Domiciliary Hostel Program; and,
- Provincial Rent Bank.

Beginning January 1, 2013, the Ministry of Municipal Affairs and Housing will assume financial and administrative responsibility of the new consolidated program. The Province has been working closely over the past year with a group of Service Manager representatives, selected by the Association of Municipalities of Ontario (AMO) and the City of Toronto, on the development of the new program. The input from this group has been invaluable to shaping the CHPI.
The vision for the new program is a better coordinated and integrated service delivery system that is people-centered, outcome-focused and reflects a Housing First approach to prevent, reduce and address homelessness. Over time, this approach will shift the focus of services from reactive responses to homelessness to more proactive and permanent solutions focused on the following two key outcomes:

1. People experiencing homelessness obtain and retain housing; and
2. People at risk of homelessness remain housed.

Under the CHPI, Service Managers will have increased flexibility to use the consolidated funding in any of the following service categories:

1. Emergency Shelter Solutions (e.g. emergency shelter and/or safe bed);
2. Housing and Related Supports (e.g. permanent housing, rental allowance);
3. Services and Supports (e.g. street and housing outreach, food banks, housing search); and,
4. Homelessness Prevention (e.g. rent support/eviction prevention).

All programs and services that are eligible under the current homelessness-related programs will continue to be eligible under the new program. Furthermore, many additional programming options will now be possible as a result of enhanced program flexibility.

The new approach to provincial homelessness program funding will combine funding from the five existing homelessness-related programs listed above into a single funding envelope. Service Managers will have greater flexibility to use this funding to address local homelessness-related priorities and to better meet the needs of individuals and families who are homeless or at risk of becoming homeless.

The Community Homelessness Prevention Initiative is a 100% provincially funded investment that amounts to approximately $246 million for 2013-14. This includes the current level of funding associated with the five existing programs and the scheduled upload of the Emergency Hostel Services portion of Ontario Works – consistent with our commitment under the Provincial-Municipal Fiscal and Service Delivery Review. This amount also includes 50 per cent of provincial expenditures from the former Community Start-Up and Maintenance Benefit (CSUMB) and the scheduled upload related to CSUMB.

The Ministry will consult with Service Manager representatives through a Technical Advisory Group, composed of Service Manager Representatives selected by AMO and the City of Toronto, for input on the following elements of the consolidated program:

- Performance indicators and metrics;
- Guidelines for the newly consolidated program; and,
- Investment Plan/Service Contract templates.

Further details on the program design, guidelines and reporting requirements will be provided to each Service Manager upon completion of the work of the Technical Advisory Group – scheduled for early Fall 2012.
Details of the First Year’s Funding Allocations

Funding will be issued in quarterly instalments. The first instalment will be issued in January 2013. For planning purposes, the allocation for the Regional Municipality of Waterloo in January 2013 will be $1,828,303, and for April 2013 to March 2014 will be $7,702,788. We will provide you with the final figures for these allocations by September 10, 2012.

The allocation for each Service Manager is based on a combination of current funding and needs-based funding as follows:

1. **Base Funding:** This part of the envelope consists of current funding for the five programs being consolidated. Allocations are based on a combination of:
   - What each Service Manager currently receives under four of the programs (Consolidated Homelessness Prevention Program, Emergency Energy Fund, Domiciliary Hostel Program, Provincial Rent Bank); and,
   - Each Service Manager’s most recent three-year average of expenditures for Emergency Hostel Services (to account for changes in demand for these services over time).

2. **Needs-Based Funding:** This part of the envelope consists of the reinvestment from the CSUMB program (removed from social assistance and reallocated to the consolidated program) and the scheduled upload of Ontario Works financial assistance for both Emergency Hostel Services and CSUMB.
   - Funding is allocated according to each Service Manager’s share of households in Deep Core Housing Need (a Statistics Canada measure that identifies households who spend over 50 per cent of their gross income on housing and, or, also have issues related to suitability and adequacy).

The new CHPI represents a significant change for both Service Managers and the Province and is an important step toward transforming Ontario’s housing and homeless system. We also recognize that the current five programs may be delivered within different departments across Service Managers. We appreciate your assistance in ensuring this information is shared as most appropriate.

We are committed to working with Consolidated Municipal Service Managers and District Social Services Administration Boards in the development of a more people-centered housing and homelessness system and will work with staff of the Regional Municipality of Waterloo to facilitate an effective transition to the new program while maintaining stability for clients. In the coming days, you will receive an invitation to a webcast presentation that will provide more detail on the program design and allocation model of the CHPI. We ask that you share this invitation with the appropriate staff members in your organization and, if applicable, inform us of any particular staff member that can act as a main contact for the new program.
We look forward to hearing from you if you have any questions. Please contact Tony Brutto, Team Lead by telephone at 519-673-4032, or by e-mail at tony.brutto@ontario.ca for more information.

Sincerely,

(original signed by)
Janet Hope
Assistant Deputy Minister
Housing Division
Ministry of Municipal Affairs and Housing

cc. Deborah Schlichter, Director, Housing
dschlichter@regionofwaterloo.ca

Lynn Randall, Director, Social Planning/Policy/Program Admin
lrandall@regionofwaterloo.ca
TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: September 25, 2012
FILE CODE: P29-20
SUBJECT: BREASTFEEDING SUPPORT UPDATE - 2012

RECOMMENDATION:
For information

SUMMARY:
September 30 to October 6, 2012 marks World Breastfeeding Week in Canada. Breastfeeding is the normal and natural method of feeding infants as it provides optimal nutrition, immunological and emotional benefits for the growth and development of infants.\(^1\) In Canada, exclusive breastfeeding is recommended for the first six months of life for healthy term infants, and continued breastfeeding along with appropriate complementary foods up to two years.\(^2\) The Ontario Public Health Standards requires that public health units promote and support breastfeeding thereby increasing the rates of initiation, exclusivity and duration of breastfeeding. As well, between the Ministry of Health and Long Term Care and Ontario Public Health Units, the accountability agreement sets out requirements for the board of health to achieve Baby Friendly Community Health Service (BFI) designation. This report highlights public health activities that support breastfeeding in Waterloo Region and the steps that are being taken towards attaining BFI accreditation.

REPORT:
A woman’s decision to breastfeed is usually made in the prenatal period. The proportion of women aged 15 to 49 years in Waterloo Region who initiated breastfeeding was 89.2 % in 2005 and 96.3 % in 2009-2010.\(^3\)\(^,\)\(^4\) In order to increase the rates of initiation, breastfeeding is promoted through a number of activities which include:
- Adolescent Prenatal Classes
- Canadian Prenatal Nutrition Program
- Prebirth Clinics delivered at Grand River Hospital and Cambridge Memorial Hospital

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1 Health Canada, 2004; American Academy of Pediatrics (AAP), 2005; College of Family Physicians of Canada (CFPC) 2004; Canadian Pediatric Society (CPS), 2005
4 Although these proportions suggest an increase over time, there was actually no statistically significant difference between the two proportions.
• “Me? Breastfeed?” prenatal breastfeeding classes offered through a collaborative effort with the Kitchener Downtown Community Health Centre and delivered by Breastfeeding Buddies (breastfeeding peers)
• Disseminating information to mothers and families through the ROWPH website and the New Parent Resource Guide
• Use of media to promote events and respond to issues related to breastfeeding

The percentage of women who exclusively breastfed their infants for at least 6 months was 19.5% in 2005 and 26.7% in 2009-2010.³⁴ ROWPH provides the following support for breastfeeding women:
• One to one support from public health nurses in the Healthy Babies Healthy Children program through the Healthy Children Information Line.
• One to one support from public health nurses
• One to one support provided by Breastfeeding Buddies and through a service agreement with Kitchener Downtown Community Health Centre. There are currently 100 Breastfeeding Buddies in Waterloo Region. Breastfeeding buddies are women who have breastfed their infants, and who are trained to educate and support other breastfeeding mothers in Waterloo Region.
• Information provided to mothers through the ROWPH website and the New Parent Resource Guide
• Organizing a MainPro-CME workshop for physicians. The keynote theme for the October 2012 conference is maternal-child bonding with a focus on breastfeeding.
• Project Health’s “Creating a Mother-Friendly Workplace Strategy” supports workplaces in establishing a supportive environment that addresses the needs of lactating mothers in the workplace

In addition to health promotion, the Ontario Public Health Standards state that boards of health shall also conduct assessment and surveillance and policy development activities to increase breastfeeding rates. The initiatives that ROWPH delivers include:
• Bringing key stakeholders together through the Waterloo Region Breastfeeding Alliance (formerly Waterloo Region Community Baby Friendly Initiative Advisory Group) whose goal is to protect, promote, and support breastfeeding in Waterloo Region. Recent work of the Alliance includes:
  o working closely with the City of Kitchener to assist in the development of a policy welcoming breastfeeding families at all City of Kitchener facilities.
  o Developing a website that will be hosted by ROWPH website which appeals to local businesses to abide by the International Code of Marketing Breastmilk Substitutes
  o Hosting the annual Quintessence Challenge which is the lead-in to World Breastfeeding Week. This fun event is a challenge for which geographic area has the most breastfeeding babies, as a percentage of the birthrate, “latched on” at 11am local time. This year’s Quintessence Challenge will take place on September 29, 2012.
• Assessing readiness for (BFI) accreditation: Work in this area includes:
  o A gaps analysis and a workplan based on the Breastfeeding Committee for Canada Integrated Ten Steps and WHO Code Practice Outcome Indicators for Hospitals and Community Health Services.
Staff have begun work on creating a departmental policy on breastfeeding, reviewing all resources to ensure compliance with the International Code of Marketing Breastmilk Substitutes, and educating all ROWPH staff on BFI.

- The ROWPH Infant Feeding Study (IFS) is examining the infant feeding practices at various times in a child’s development from birth to 18 months. The study began in September, 2011 and will end in April, 2013. The IFS is also a requirement for BFI designation.

- ROWPH staff continue to participate on provincial committees and initiatives that will influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address breastfeeding.

CORPORATE STRATEGIC PLAN:

Support for breastfeeding contributes to the Region’s strategic focus area #4: Healthy and Inclusive Communities to foster healthy, safe, inclusive and caring communities.

FINANCIAL IMPLICATIONS:

These programs are carried out within existing budget allocations.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

NIL

PREPARED BY: Mary Denomme, R.N., Public Health Nurse

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
REGION OF WATERLOO
PUBLIC HEALTH
Emergency Medical Services

TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 25, 2012 FILE CODE: P05-80

SUBJECT: EMS RURAL RESPONSE TIME UPDATE

RECOMMENDATION:

For information

SUMMARY:

Rural EMS call volume growth has stressed the current rural deployment plan and resulted in increasing emergency response times. The recent addition of an overnight ambulance has temporarily reversed the response time increases. Three additional coverage options are presented that would further reduce emergency response times in the townships.

REPORT:

Following the May 8, 2012 presentation to Community Services Committee regarding 2011 EMS System Performance (PH-12-017), Staff was requested to provide a specific update on current EMS response times in the four townships, and to make suggestions for improvements where needed.

Rural EMS coverage presently includes ambulances at the two rural stations located in Baden and St. Jacobs, supplemented by two single-paramedic Rural Emergency Response Units (RERUs), staffed sequentially between 0600-midnight daily (double coverage between 1200-1800 hours). When ambulances are available to staff these two stations, the Rural Emergency Response Units (RERUs) are posted in Wellesley (Cross Hill) and North Dumfries (Hwy 401/Cedar Creek) townships for additional geographic distribution.

As ambulances are required to attend calls in either their rural or urban response areas, the Rural Emergency Response Units (RERUs) move to occupy the Baden and/or St. Jacobs stations as needed. The Rural Emergency Response Units (RERUs) provide full Advanced Care Paramedic capabilities, enabling both a timely response and advanced patient care while awaiting a more distant ambulance. The time to prepare a critical patient for transfer is normally equal or longer than the travel time of the responding ambulance so no significant delay in transport time has been seen. The key benefit to utilizing Rural Emergency Response Units (RERUs) is the ability to maintain them within the townships as they have no transport capability and therefore cannot be used to offset ambulance coverage lost to hospital offload delays.

2011 saw a 19.8% increase in rural call volumes, climbing from 3,849 in 2010 to 4,613, accompanied by a 44 second increase in the 90th percentile emergency response time (17 minutes 55 seconds to 18 minutes 39 seconds). The added call volume has stressed the existing rural deployment plan, especially during the overnight hours when there are no Rural Emergency Response Units (RERUs) staffed and the ambulance complement Region-wide is significantly reduced.
Staff has reviewed the current response time performance through August 31, 2012, as well as the early impacts of an additional overnight ambulance added July 1, 2012. While first quarter 2012 results showed rural response times continuing to climb, the recent service enhancement has had the expected positive response, reversing this trend. Since July 1, 2012, the rural response time across all four municipalities is 17 minutes 40 seconds, a 5.3% reduction over 2011 results. For comparison, the Region wide 90th percentile response time is in excess of 12 minutes.

**Combined Township 90th Percentile and Average Response Times by Year**

<table>
<thead>
<tr>
<th></th>
<th>90th %</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>17:55</td>
<td>11:14</td>
</tr>
<tr>
<td>2011</td>
<td>18:39</td>
<td>11:41</td>
</tr>
<tr>
<td>2012</td>
<td>18:11</td>
<td>11:22</td>
</tr>
<tr>
<td>YTD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By municipality, 2012 YTD 90th percentile emergency response times now range from 16 minutes 13 seconds to 20 minutes 25 seconds, as compared to 2011 values from 16 minutes 43 seconds to 21 minutes 34 seconds.

As shown in the graph above, rural response times climb as call volumes increase but fall again as resources are added. A more comprehensive description is provided in Appendix A to this report. It shows that between 2009-2012 YTD, township response times have changed from an increase of 4.3% or 1 minute 10 seconds (Woolwich) to a 9.5% reduction or 1 minute (Wellesley). Over the same time period, rural response times (across all four townships combined) have climbed .4% (4 seconds) in comparison to urban response times (all three cities combined) where response times have climbed 2.6% (17 seconds).

As noted earlier, one Rural Emergency Response Unit (RERU) operates between 0600-1200 hours, two are in place from 1200-1800, and a single Rural Emergency Response Unit (RERU) on-duty from 1800-2400. No Rural Emergency Response Unit (RERU) operates between midnight and 0600. Rural response times show the expected pattern with the lowest values between 1200-1800 (15 minutes 59 seconds) when 2 Rural Emergency Response Units (RERUs) are in place, response
times in the 17:30-17:45 minute range when one Rural Emergency Response Unit (RERU) is operational, and a peak of just over 21 minutes overnight when no Rural Emergency Response Unit (RERU) is operating.

### Combined Township 90th Percentile Emergency Response Time by Hour of Day

<table>
<thead>
<tr>
<th>Hour of Day</th>
<th>0000-0600</th>
<th>0600-1200</th>
<th>1200-1800</th>
<th>1800-2400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of RERUs staffed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>From July 1, 2012</td>
<td>21:01</td>
<td>17:38</td>
<td>15:59</td>
<td>17:44</td>
</tr>
</tbody>
</table>

Committee members had asked for options on reducing rural response times from their current levels. Given the lower relative call volumes over such a large geographic area, additional ambulances are not yet the most practical option. A number of options and estimated costs are presented:

1) An additional Rural Emergency Response unit (RERU) staffed between 2300-0700 would provide overnight coverage and be expected to reduce the overall rural response time into the 17 minute range... $194,000 per year in 2013 dollars.

2) Upstaffing to ensure two Rural Emergency Response Units (RERUs) staffed around the clock would be expected to reduce the overall rural response time into the 15 minute 30 second range... $601,000 per year in 2013 dollars plus an initial capital outlay for an additional vehicle and equipment of $120,000.

3) Ensuring a dedicated Rural Emergency Response Unit (RERU) for each of the 4 townships around the clock would be expected to reduce response times towards the urban value of approximately 11 minutes...$1,800,000 per year in 2013 dollars plus an initial capital outlay of $360,000.

The additional costs would be eligible for 50/50 cost-sharing if approved by the Province.

**CORPORATE STRATEGIC PLAN:**

This report supports Strategic Objective 4.3: Enhance local health service delivery by optimizing Emergency Medical Services (EMS) delivery and collaborating with health care partners to support system change.

**FINANCIAL IMPLICATIONS:**

Operating expenditures are eligible for cost sharing with the Province of Ontario based on a 50/50 formula. Generally, provincial funding is approved a year after the resources are added by a municipality. Capital expenditures are not eligible for cost sharing, but the costs related to the amortization of capital costs are cost shared over the useful life of the asset.

**OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:**

Finance staff assisted in the preparation of this report by generating costing estimates.
ATTACHMENTS:

Appendix A – 2009-2012 Rural Emergency Response Times and Rate of Change
Appendix B- Historical Timeline- Response Time Target consideration

PREPARED BY:  John Prno, Chief, Emergency Medical Services

APPROVED BY:  Dr. Liana Nolan, Commissioner and Medical Officer of Health
APPENDIX A
2009-2012 Rural Emergency Response Times and Rate of Change

# 90th Percentile Emergency Response Times by Rural Municipality

![Graph showing 90th percentile emergency response times by rural municipality.]

<table>
<thead>
<tr>
<th>Municipality</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Dumfries</td>
<td>18:08</td>
<td>17:56</td>
<td>18:23</td>
<td>17:17</td>
</tr>
<tr>
<td>Wilmot</td>
<td>18:36</td>
<td>18:28</td>
<td>19:30</td>
<td>19:08</td>
</tr>
<tr>
<td>Woolwich</td>
<td>15:33</td>
<td>15:57</td>
<td>16:43</td>
<td>16:13</td>
</tr>
<tr>
<td>All Rural Combined</td>
<td>18:07</td>
<td>17:55</td>
<td>18:39</td>
<td>18:11</td>
</tr>
<tr>
<td>All Urban Combined</td>
<td>10:51</td>
<td>11:01</td>
<td>11:16</td>
<td>11:08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Percentage Change in Response Time 2009-2012 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Dumfries</td>
<td>(4.7%)</td>
</tr>
<tr>
<td>Wellesley</td>
<td>(9.5%)</td>
</tr>
<tr>
<td>Wilmot</td>
<td>2.9%</td>
</tr>
<tr>
<td>Woolwich</td>
<td>4.3%</td>
</tr>
<tr>
<td>All Rural Combined</td>
<td>.4%</td>
</tr>
<tr>
<td>All Urban Combined</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
APPENDIX B

Historical Timeline - Response Time Target consideration

March 2000

- The Region was planning for the transition of EMS to become a directly delivered service by Region of Waterloo
- The provincially legislated standard for a minimum response time target was based on the historical 1996 response times (10 minutes 30 seconds, 90% of the time)
- EMS was not meeting this target prior to the time of transition

October 2000

- Regional Council considered two options for setting its own response time target
  - 9 minute Region-wide response time target OR
  - 9 minute urban/12 minute rural response time targets
- 9 minutes was cited as an industry standard
- A Systems Design Working Group selected the 9 minute urban/12 minute rural response as the preferred option
- Regional Council directed staff to prepare a budget scenario based on a single Region-wide response time target of 9 minutes, 90% of the time
- Decision of a single Region-wide response time target of 9 minutes, 90% of the time confirmed via the budget process, when the operating budget for EMS was determined

December 2000

- Region of Waterloo assumes operational responsibility for EMS

2001-2012

- Annual Response Times (based on 90th percentile) have fluctuated, decreasing when resources have been added and increasing with increases in call volume as the Region has grown and aged
- The Region has not achieved the provincially legislated target of 10 minutes 30 seconds based on Region-wide response times since assuming responsibility for EMS

2008

- Ministry of Health and Long Term Care determines EMS response time targets will be set by each municipality
- Initially expected to take place in 2010, but delayed by revised regulation to October 1, 2102

September 2012

- Region of Waterloo considers options for a municipally-determined interim Response Time Performance Plan in accordance with the regulations
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: September 25, 2012

FILE CODE: P05-80

SUBJECT: EMS RESPONSE TIME PERFORMANCE PLAN

RECOMMENDATION:

THAT the Regional Municipality of Waterloo adopt interim EMS response time targets for the 2013 calendar year in accordance with the Ambulance Act, O. Reg. 267/08, amending O. Reg 257/00, under Part VIII, Response Time Performance Plans, Sections 22-24 (attached as Appendix A);

AND THAT Response Time Target Option “C” shown in Appendix B to Report No. PH-12-039 be approved;

AND THAT a Working Group be established to include staff and Councillors to review the Response Time Target plan, deal with any outstanding issues and report back to Council with any recommended revisions in 2013;

AND THAT area municipalities and the Waterloo Regional Police Services Board be requested to formally share response time information with EMS for any cardiac arrest their Police or Fire staff attend, where a defibrillator is available for use;

AND FURTHER THAT since Region of Waterloo EMS does not have universal access to the response time information from other agencies and parties, the Regional Chair on behalf of Council, be directed to write to the Minister of Health and Long Term Care, requesting that Regulation 257/00 under the Ambulance Act be amended to require all agencies and parties using defibrillators to report response time information to the relevant Upper Tier Municipality in order that a complete report of annual defibrillator activity in the municipality can be compiled, per report PH-12-039, dated September 25, 2012.

SUMMARY:

Producing a Response Time Performance Plan (RTPP) is a complex exercise. Work to date has involved a partnership with the University of Waterloo for data modelling, and has also relied on data and guidance from the Ministry of Health and Long Term Care. The required inputs and modelling have taken longer than expected. The data analysis is complex and the options are potentially numerous. Other municipalities have also struggled with developing the targets, so there has not been an opportunity to learn from others who might have made earlier decisions than the Region of Waterloo. These factors have all contributed to the short timelines that Regional Council has for approving this first interim Performance Plan.

This Response Time Performance Plan must be approved and sent to the Ministry of Health and Long Term Care no later than October 1. However, this is only the first Response Time plan, and may be reconsidered, revised and updated by Council at any time. Staff are proposing that this be considered as an initial interim plan only. Councillors may wish more time to deliberate over the various options. There are also some questions for further consideration; for example whether or not
to have different response times for urban and rural settings. These questions can still be deliberated over the course of the next year, or under any time line that Council wishes to choose. Staff are recommending that a Working Group involving Councillors be struck to review the plan, deliberate the options and then report back to Council in 2013 with recommendations for a more carefully considered Response Time Performance Plan going forward.

The response time target option recommended (Option “C”) is a stretch target when compared with 2011 statistics, but it is a realistic target based on an assessment of existing and recently added resources and improvements. Plans are in place to work towards meeting this recommended option. The Region of Waterloo must report annually on its response time results.

There are penalties under the Ambulance Act for failure to produce a Response Time Performance Plan or to report on annual results, but no penalty for failure to meet a performance target. These are operational response time targets and not operational standards with respect to response times.

REPORT:

As first identified for Community Services Committee by way of memorandum dated September 9, 2008, and again in the EMS Master Plan Update (PH-11-013) dated March 11, 2011, the Ministry of Health and Long Term Care has changed their practice of using a single emergency response time standard based on the 1996 response time performance of individual ambulances services.

Definitions:

CTAS: a triage code assigned by the paramedic after assessment of the patient, with CTAS 1 being the most seriously ill and CTAS 5 being the least seriously ill. CTAS codes are also used by hospital emergency departments to evaluate patients (See Appendix C for more details)

Code 4: a priority code assigned by Dispatch before EMS receives the call, with Code 4 being the most urgent (lights and siren) and Code 1 being the least urgent

Response time: the time from when the EMS crew is notified of the call to arrival at the patient’s location

90th Percentile: 90 percent of the time the response time is that time or faster

Initially expected to take effect October 1, 2010, and then revised by Regulation 368/10 to October 1, 2012, the new legislation requires municipalities to establish their own performance expectations for Sudden Cardiac Arrest, CTAS 1, 2, 3, 4 and 5 patients, and to send their Response Time Performance Plans to the Ministry no later than October 1st of each year. By March 31st of each year, the municipality will report to the Ministry the actual times achieved in the previous year, for publication on the Ministry’s website.

There are limitations established to some of the standard elements of the Plan, i.e., Municipalities have to determine how often a defibrillator will reach a cardiac arrest patient in under 6 minutes, followed by an ambulance in under 8 minutes. For other CTAS levels, the municipality can set both a time standard and percentage compliance target. Part of the complexity in the decision is that both the response time and the percentage targets can be varied for CTAS levels 2 to 5, making an apples to apples comparison across different proposals conceptually very difficult. Targets can also be Region-wide, or divided into separate urban and rural targets. The Ministry of Health and Long Term Care has recently confirmed that it is permissible to propose different urban and rural response time targets, so a detailed analysis of this option has not been undertaken to date.
For the first time, the municipality will be allowed to count the arrival time of any defibrillator utilized to assist a victim of sudden cardiac arrest. Unfortunately, legislation does not exist to require agencies who use defibrillators outside of hospital, to report their response times. EMS presently does not have universal access to response time information from the other emergency services (Police and Fire), nor is there consistent access to response time information from Public and Private Automated External Defibrillator (AED) users. Accessing this information is an ongoing process, currently limited to those Fire Departments participating in the ROC (Resuscitation Outcomes Consortium) study, but is expected to improve through the EMS Technology Interoperability Framework (EMS-TIF) project. As such, this year’s Response Time Performance Plan is based on EMS performance only, although plans are in motion to develop a registry of public and privately owned AEDs, as a first step to collecting response time information from these defibrillators.

The legislation allows municipalities to update their performance targets where necessary to address local requirements as long as the Ministry is notified. There are penalties under the Ambulance Act for failure to produce a Response Time Performance Plan or to report on annual results, but no penalty for failure to meet a performance target. These are operational response time targets and not operational standards with respect to response times.

**EMS Master Plan**

On December 7, 2007, Regional Council endorsed various actions with regards to the EMS Master Plan recommendations contained within Report PH-07-061. Among them were three response time recommendations:

1. Adopt 6 minutes, 90% of the time, as the Region’s community target time for arrival of a defibrillator at the scene of a cardiac arrest call;
2. Adopt 10 minutes 30 seconds, 90% of the time, as the Region’s EMS response time target for Code 4 emergency calls (from time crew notified until arrival at scene);
3. Adopt in principle, the recommended twenty-five year optimized staffing requirements necessary to maintain the 10 minute 30 second response time target, subject to a regular and ongoing review of needs and the annual budget process.

Regional Council has made regular resource investments since then, although call volume growth and significant hospital offload delays have limited movement towards the target response time. The current 90th percentile is still in excess of 12 minutes Region-wide.

**External Response Time Modelling**

To ensure appropriate, yet achievable new targets are established, the Department of Management Sciences at the University of Waterloo was engaged to quantify response times possible given existing call volumes and acuities, station locations and vehicle resources. This modelling in addition to actual historic performance data provides the basis for the recommended response time targets.

The modelling utilized actual 2011 EMS call locations and time of day, then calculated likelihood of reaching those locations given the additional EMS stations and station location changes 2012 to date. For the highest priority (CTAS 1) calls, availability of a Fire response 95% of the time was incorporated. As Ministry of Health data does not reveal where ambulances were located when dispatched from a mobile location, the University of Waterloo model assumed response always took place from a station. As such, it is expected to underestimate response compliance somewhat.
Coverage scenarios were calculated for three periods of the day: Quiet (overnight), Busy (daytime) Moderately Busy (shoulder periods), and for High acuity (CTAS 1), Moderate acuity (CTAS 2), and Lower Aculities (CTAS 3, 4 and 5) calls.

As shown below, the model suggests that a combined EMS and Fire response should reach cardiac arrest and other CTAS 1 patients (Both a Fire-based defibrillator in under 6 minutes and an EMS vehicle arriving in under 8 minutes) between 67-76% of the time, depending on the time of day. For CTAS 2 patients, an ambulance should arrive in less than 10 minutes 30 seconds (current standard) between 84-89% of the time, while for CTAS 3-5 patients, an ambulance should arrive in less than 10 minutes 30 seconds between 86-91% of the time.

### 2011 Call Compliance Modeling Based on 2012 Resourcing

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Quiet</th>
<th>Mod-Busy</th>
<th>Busy</th>
<th>Scenario:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>0.8529643</td>
<td>0.847537</td>
<td>0.902237</td>
<td></td>
</tr>
<tr>
<td>H (CTAS 1)</td>
<td>0.6698921</td>
<td>0.670234</td>
<td>0.763609</td>
<td>H covered in 6, 8 mins</td>
</tr>
<tr>
<td>M (CTAS 2)</td>
<td>0.838869</td>
<td>0.834537</td>
<td>0.893087</td>
<td>M in 10:30 mins</td>
</tr>
<tr>
<td>L (CTAS 3, 4, 5)</td>
<td>0.8603149</td>
<td>0.854514</td>
<td>0.907471</td>
<td>L in 10:30 mins</td>
</tr>
</tbody>
</table>

### 2011 Actual Performance

During 2011, EMS alone (No Fire data available), were able to reach sudden cardiac arrest patients in less than 6 minutes 41.2% of the time, and to reach all CTAS 1 patients in under 8 minutes 66.6% of the time. The 66.6% correlates extremely well with 67-76% modeled value presented above. With Fire Tiered Response utilized for cardiac arrests in all Regional municipalities, the modeled range is likely accurate for the 6 minute target.

The following chart shows 2011 response time compliance based on the existing 10 minute 30 second emergency response time target, and on the patient’s CTAS level upon EMS arrival. The actual 90th percentile response time for each CTAS level is also shown in the chart.

### 2011 Compliance to 10 minute 30 second Response Time Target

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>2011 Number of Calls</th>
<th>2011 Compliance to 10 minutes 30 seconds</th>
<th>Actual 90th Percentile Minutes:Seconds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTAS 1</td>
<td>323</td>
<td>86.38%</td>
<td>11:36</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>4,142</td>
<td>80.23%</td>
<td>12:51</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>12,536</td>
<td>74.49%</td>
<td>14:12</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>6,063</td>
<td>70.46%</td>
<td>15:02</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>892</td>
<td>68.16%</td>
<td>15:43</td>
</tr>
</tbody>
</table>

### Performance Target Options

Given the complexity of the required Performance Plan design and the limited time to explore the other options fully prior to October 1, Staff are recommending a single Region-wide performance target rather than separate urban and rural targets. Four options are presented in Appendix B for Council deliberation. Three options are based on current performance (using either 2011 data or
modelled performance using assumptions about existing 2012 resources), and are deemed achievable given existing resources and planned system improvements (as per the EMS Master Plan).

All four options show the same improvements to current performance for Sudden Cardiac Arrest and CTAS 1 patients. There is no discretion as to the choice of response time target for Sudden Cardiac Arrest and CTAS 1. Region of Waterloo only has discretion over the percentile target. The four proposals suggest a percentile target that is achievable based on a combination of existing 2011 data and the modelling of current 2012 resources. Future improvements to the Sudden Cardiac Arrest target will be driven by collection of other agency data.

Option “A” maintains the current Code 4 response time standard of 10 minutes 30 seconds for emergency calls (CTAS 2), but reduces the compliance target from 90% to 80% to reflect documented 2011 performance and resources. Non-emergency CTAS 3, 4 and 5 calls have lengthened response times with 90%+ compliance targets in line with currently achieved performance (as documented in 2011 data) and to allow flexibility to delay lower priority calls and maintain emergency coverage. This becomes a factor when EMS is in “Code Yellow” due to hospital offload delay, as Dispatch will delay dispatching an ambulance to a Code 3 call for a short period in case a higher priority Code 4 call comes in the immediate future. As Option “A” is based on documented 2011 performance levels, there is no stretch built into this target.

Option “B” utilizes the current performance level documented in 2011 at the 90th percentile, and sets that as the 2013 target. Similar to Option “A”, Option “B” is based on current performance (as documented in 2011 data) so again has no inherent stretch built into the target.

A challenge with both Option A and B with respect to varying response times and percentiles between CTAS 2 to 5 is that the CTAS code is only assigned after the patient has been reached, so it does not lend itself to operational intervention across CTAS levels by EMS or Dispatch if modifications in response are required to meet targets. At the time of dispatch, EMS is only aware if the call is priority Code 4 or 3.

Option “C” is the preferred option. It maintains the current Code 4 response time standard of 10 minutes 30 seconds for CTAS 2, 3, 4 and 5 calls, at a common compliance target of 80% for all four CTAS levels. From an operational point of view this option acknowledges that EMS has no active ability to modify response times across CTAS levels 2 to 5. Although Option C is a stretch target based not on actual 2011 data but on the modelling of current resources in 2012, it is achievable given the recent 2012 resource enhancement and soon to be implemented traffic signal pre-emption system. By proposing a model in which the response time and the percentile targets are consistent across CTAS levels 2 to 5, it will also be easier to make an apples to apples comparison over time. Option “C” does not preclude Dispatch from exercising discretion in a “Code Yellow” situation due to hospital offload delay, and to delay dispatching an ambulance to Code 3 calls while waiting for a short period in case a higher priority Code 4 call comes in the immediate future.

The first three options presented provide similar performance levels, and all are acceptable to Staff from an implementation and monitoring point of view. Option “C” is likely the easiest for others to understand, incorporating the fewest variables and maintaining the familiar and reasonable 10 minute 30 second target, while reducing the percentile from the familiar 90% to 80% of the time for all patients.

Option “D” presents the status quo response time target of 10 minutes 30 seconds with a percentile target of 90% for CTAS 2 to 5. If this option were chosen it would have to be acknowledged up front that this target is not achievable based on current resources. The purpose for making such a choice
would be to meet the October 1 deadline to submit a plan and to indicate that Regional Council needs more time to have a debate before choosing a plan that is different from the current one for CTAS 2 to 5. The only caution would be to clearly communicate that this option has been accepted on an interim basis with the full knowledge that the targets proposed cannot be met at this time.

With any option, a Working Group of staff and Council could be struck to assess the appropriate response time and percentile targets, and to report back to Council in 2013 with recommendations. Council is free to submit a revised Response Time Target Plan to the Ministry at any time. Council would notify the Ministry of Health and Long Term Care at its convenience when it had a new plan with new targets that it felt were appropriate. There are no legal penalties in taking this approach.

CORPORATE STRATEGIC PLAN:

This report supports Strategic Objective 5.3: Ensure Regional programs and services are efficient and effective and demonstrate accountability to the public.

FINANCIAL IMPLICATIONS:

The first three options presented can be achieved within existing resources and planned system enhancements as set out in the EMS Master Plan. The fourth option cannot be achieved with existing resources, assumes the targets will not be met and further deliberation at a later date will occur in order to set appropriate targets.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance, Risk Management and Legal Services were consulted in the development of this report.

ATTACHMENTS:

Appendix A – Ontario Regulation 267/08
Appendix B – Response Time Target Options
Appendix C – Canadian Triage Acuity Scale (CTAS) Guidelines

PREPARED BY:  John Prno, Chief, Emergency Medical Services

APPROVED BY:  Dr. Liana Nolan, Commissioner and Medical Officer of Health
APPENDIX A

ONTARIO REGULATION 267/08

made under the

AMBULANCE ACT

Made: May 27, 2008
Approved: July 23, 2008
Filed: July 30, 2008
Published on e-Laws: July 31, 2008
Printed in The Ontario Gazette: August 16, 2008

Amending O. Reg. 257/00
(General)

Note: Ontario Regulation 257/00 has previously been amended. Those amendments are listed in the Table of Current Consolidated Regulations – Legislative History Overview which can be found at www.e-Laws.gov.on.ca.

1. (1) Ontario Regulation 257/00 is amended by adding the following heading immediately before section 22:

PART VIII
RESPONSE TIME PERFORMANCE PLANS

(2) Section 22 of the Regulation is revoked and the following substituted:

22. In this Part,
“notice” means notice given to a land ambulance crew by a land ambulance communication service of a request;
“request” means a request made to a land ambulance communication service for ambulance services that are determined to be emergency services by the communication service at the time of the request.

23. (1) In this section,
“response time” means the time measured from the time a notice is received to the earlier of the following:
1. The arrival on-scene of a person equipped to provide any type of defibrillation to sudden cardiac arrest patients.
2. The arrival on-scene of the ambulance crew.

(2) No later than October 1 in each year after 2009, every upper-tier municipality and every delivery agent responsible under the Act for ensuring the proper provision of land ambulance services shall establish, for land ambulance service operators selected by the upper-tier municipality or delivery agent in accordance with the Act, a performance plan for the next calendar year respecting response times.

(3) An upper-tier municipality or delivery agent to which subsection (2) applies shall ensure that the plan established under that subsection sets response time targets for responses to notices respecting patients categorized as Canadian Triage Acuity Scale (“CTAS”) 1, 2, 3, 4 and 5, and that such targets are set for each land ambulance service operator selected by the upper-tier municipality or delivery agent in accordance with the Act.

(4) An upper-tier municipality or delivery agent to which subsection (2) applies shall ensure that throughout the year the plan established under that subsection is continuously maintained, enforced and evaluated and, where necessary, updated, whether in whole or in part.

(5) An upper-tier municipality or delivery agent to which subsection (2) applies shall provide the Director with a copy of the plan established under that subsection no later than October 31 in each year, and a copy of any plan updated, whether in whole or in part, under subsection (4) no later than one month after the plan has been updated.

(6) An upper-tier municipality or delivery agent to which subsection (2) applies shall report to the Director, as required from time to time by the Director and on forms or in a manner provided or determined by the Director, on any matter relating to,
(a) the nature and scope of the plan established under that subsection or updated under subsection (4), and
(b) the establishment, maintenance, enforcement, evaluation and updating of the plan.

(7) Without limiting the generality of subsection (6), no later than March 31 in each year after 2011, an upper-tier municipality or delivery agent to which subsection (2) applies shall report to the Director on the following matters for the preceding calendar year:
1. The percentage of times that a person equipped to provide any type of defibrillation has arrived on-scene to provide defibrillation to sudden cardiac arrest patients within six minutes of the time notice is received.

2. The percentage of times that an ambulance crew has arrived on-scene to provide ambulance services to sudden cardiac arrest patients or other patients categorized as CTAS 1 within eight minutes of the time notice is received respecting such services.

3. The percentage of times that an ambulance crew has arrived on-scene to provide ambulance services to patients categorized as CTAS 2, 3, 4 and 5 within the response time targets set by the upper-tier municipality or delivery agent under its plan established under subsection (2).

(8) Without limiting the generality of subsection (6), an upper-tier municipality or delivery agent to which subsection (2) applies shall report to the Director on the performance of each land ambulance service operator selected by the upper-tier municipality or delivery agent in accordance with the Act in respect of the targets set for that operator under subsection (3).

24. (1) In this section, “response time” means the time measured from the time a request is received to the time a notice is given respecting that request.

(2) No later than October 1 in each year after 2009, every land ambulance communication service shall establish a response time performance plan for the next calendar year that sets out the percentage of times that the communication service will give notice within two minutes of the time a request is received respecting sudden cardiac arrest patients or other patients categorized as CTAS 1.

(3) A land ambulance communication service to which subsection (2) applies shall ensure that throughout the year the plan established under that subsection is continuously maintained, enforced and evaluated and, where necessary, updated, whether in whole or in part.

(4) A land ambulance communication service to which subsection (2) applies shall provide the Director with a copy of the plan established under that subsection no later than October 31 in each year, and a copy of any plan updated, whether in whole or in part, under subsection (3) no later than one month after the plan has been updated.

(5) A land ambulance communication service to which subsection (2) applies shall report to the Director, as required from time to time by the Director and on forms or in a manner provided or determined by the Director, on any matter relating to,

(a) the nature and scope of every plan established under that subsection or updated under subsection (3); and
(b) the establishment, maintenance, enforcement, evaluation and updating of the plan.

(6) Without limiting the generality of subsection (5), no later than March 31 in each year after 2011, a land ambulance communication service to which subsection (2) applies shall report to the Director the percentage of times in the preceding calendar year that the communication service gave notice within two minutes of the time a request was received respecting sudden cardiac arrest patients or other patients categorized as CTAS 1.

2. This Regulation comes into force on the day it is filed.

Made by:

GEORGE SMITHERMAN
Minister of Health and Long-Term Care
APPENDIX B

Response Time Target Option

OPTION “A”
Varying Response Times and Compliance Targets
(based on actual 2011 performance achieved for CTAS 2-5)

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>Response Time Target (From EMS Notified to Arrival at Scene)</th>
<th>Recommended 2013 Region of Waterloo Target</th>
<th>2011 Number Of Calls</th>
<th>2011 Compliance (to Target Time shown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Cardiac Arrest</td>
<td>Defibrillator Response in 6 minutes or less (Set by MOHLTC)</td>
<td>50% or better (EMS only)</td>
<td>323</td>
<td>41.2%</td>
</tr>
<tr>
<td>CTAS 1</td>
<td>EMS Response in 8 minutes or less (Set by MOHLTC)</td>
<td>70% or better</td>
<td>323</td>
<td>66.6%</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>EMS Response in 10 minutes 30 seconds or less</td>
<td>80% or better</td>
<td>4,142</td>
<td>80.2%</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>EMS Response in 15 minutes or less</td>
<td>90% or better</td>
<td>12,536</td>
<td>91.8%</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>EMS Response in 20 minutes or less</td>
<td>95% or better</td>
<td>9,063</td>
<td>97.1%</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>EMS Response in 25 minutes or less</td>
<td>95% or better</td>
<td>892</td>
<td>98.9%</td>
</tr>
</tbody>
</table>
**OPTION “B”**
Excluding CTAS 1 and 2 - Maintain 2011 Response Times at the 90th Percentile
(based on actual 2011 performance achieved for CTAS 2-5)

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>Response Time Target (From EMS Notified to Arrival at Scene)</th>
<th>Recommended 2013 Region of Waterloo Target</th>
<th>2011 Number Of Calls</th>
<th>2011 Compliance (to Target Time shown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Cardiac Arrest</td>
<td>Defibrillator Response in 6 minutes or less (Set by MOHLTC)</td>
<td>50% or better (EMS only)</td>
<td>323</td>
<td>41.2%</td>
</tr>
<tr>
<td>CTAS 1</td>
<td>EMS Response in 8 minutes or less (Set by MOHLTC)</td>
<td>70% or better</td>
<td>323</td>
<td>66.6%</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>EMS Response in 12 minutes 51 seconds or less</td>
<td>90% or better</td>
<td>4,142</td>
<td>90%</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>EMS Response in 14 minutes 12 seconds or less</td>
<td>90% or better</td>
<td>12,536</td>
<td>90%</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>EMS Response in 15 minutes 2 seconds or less</td>
<td>90% or better</td>
<td>9,063</td>
<td>90%</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>EMS Response in 15 minutes 43 seconds or less</td>
<td>90% or better</td>
<td>892</td>
<td>90%</td>
</tr>
</tbody>
</table>
**OPTION “C” Preferred**
Excluding CTAS 1 and 2 – Maintain 10 minutes 30 seconds at the 80th percentile
(based on assumptions using 2012 resource levels)

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>Response Time Target</th>
<th>Recommended 2013 Region of Waterloo Target</th>
<th>2011 Number Of Calls</th>
<th>2011 Compliance (To Target Time shown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Cardiac Arrest</td>
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<td>323</td>
<td>41.2%</td>
</tr>
<tr>
<td>CTAS 1</td>
<td>EMS Response in 8 minutes or less (Set by MOHLTC)</td>
<td>70% or better</td>
<td>323 (includes Sudden Cardiac Arrests)</td>
<td>66.6%</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>EMS Response in 10 minutes 30 seconds or less</td>
<td>80% or better</td>
<td>4,142</td>
<td>80.2%</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>EMS Response in 10 minutes 30 seconds or less</td>
<td>80% or better</td>
<td>12,536</td>
<td>74.5%</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>EMS Response in 10 minutes 30 seconds or less</td>
<td>80% or better</td>
<td>9,063</td>
<td>70.5%</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>EMS Response in 10 minutes 30 seconds or less</td>
<td>80% or better</td>
<td>892</td>
<td>68.2%</td>
</tr>
</tbody>
</table>
OPTION “D”
Excluding CTAS 1 and 2-
Status Quo until further deliberation possible: 10 minutes 30 seconds at the 90th Percentile (targets not achievable with current resources)

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>Response Time Target (From EMS Notified to Arrival at Scene)</th>
<th>Recommended 2013 Region of Waterloo Target</th>
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<td>CTAS 4</td>
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<tr>
<td>CTAS 5</td>
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<td>68.2%</td>
</tr>
</tbody>
</table>
APPENDIX C

Canadian Triage Acuity Scale (CTAS) National Guidelines

The Canadian Triage and Acuity Scale (CTAS) is a standardized method of grouping patients according to the severity of their condition and is comprised of the following categories:

- **CTAS I**: severely ill, requires resuscitation
- **CTAS II**: requires emergent care and rapid medical intervention
- **CTAS III**: requires urgent care
- **CTAS IV**: requires less-urgent care
- **CTAS V**: requires non-urgent care

- **CTAS I**: requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, arrest, major trauma or shock states).
- **CTAS II**: requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts (for example, head injury, chest pain or internal bleeding).
- **CTAS III**: requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as mild to moderate asthma, moderate trauma or vomiting and diarrhea in patients younger than 2 years.
- **CTAS IV**: requires less-urgent care and includes conditions related to patient age, distress or potential for deterioration or complications that would benefit from intervention, such as urinary symptoms, mild abdominal pain or earache.
- **CTAS V**: requires non-urgent care and includes conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system, such as sore throat, menses, conditions related to chronic problems or psychiatric complaints with no suicidal ideation or attempts.

**National Guidelines for the target time to be seen by a physician based on CTAS**

- **CTAS Level 1**: Patients need to be seen by a physician immediately 98% of the time.
- **CTAS Level 2**: Patients need to be seen by a physician within 15 minutes 95% of the time.
- **CTAS Level 3**: Patients need to be seen by a physician within 30 minutes 90% of the time.
- **CTAS Level 4**: Patients need to be seen by a physician within 60 minutes 85% of the time.
- **CTAS Level 5**: Patients need to be seen by a physician within 120 minutes 80% of the time.
The Waterloo Region Crime Prevention Council creates Research and Planning Sheets (or ‘RAP Sheets’ for short) as a tool to disseminate information to residents and community agencies within Waterloo Region. The most recent RAP Sheet examines fear of crime.

In 2009, the Waterloo Region Crime Prevention Council released Fear of Crime: Perceptions in Waterloo Region then in 2011 Changing Perceptions: 2011 Waterloo Region Area Survey was released. These two reports included sections tracking fear of crime within Waterloo Region.

The Fear of Crime & Victimization RAP sheet represents an attempt to distill some of the basic concepts behind the causes of fear of crime in a format that is accessible. The RAP sheet also contains some suggestions on how people can reduce fear of crime in their own community.

A copy of the RAP sheet is available online at: http://www.preventingcrime.ca/documents/FearofCrime0812FIN.pdf
Trends

• Waterloo Region is one of the safest communities in all of Canada. Recent statistics show that the national crime rate continues to fall, and the crime rate in Waterloo Region is well below national averages when it comes to the overall crime rate, crime severity, homicides and robberies (Statistics Canada, 2012).

• During the day, more than 9 in 10 people in Waterloo Region (95%) feel “very safe” in their homes and most other areas (WRPS Community Survey Highlights, 2011).

• Nearly 8 in 10 people in Waterloo Region (77%) perceive crime levels as remaining the same as previous years or decreasing (WRPS Community Survey Highlights, 2011).

• Fear of crime tends to rise with age for both men and women.

• Females are significantly more fearful than males.

What is Fear of Crime?

“Fear of crime” is challenging to understand and even more difficult to define. Actual crime is a weak predictor of fear of victimization. For instance, young males (age 15-24) are the most likely group in society to be a victim of crime, yet they are the least likely to fear crime. In contrast, women and those who are 60+ are more fearful of crime, but are at a comparatively low risk of victimization (Statistics Canada, 2009). In reality, many more people experience “fear of crime” than are actually victimized by a crime.

The more vulnerable a person feels, the more they will fear crime.

What Causes Fear?

If the crime rate decreases it does not necessarily mean that our fear of being victimized decreases. Even if the evidence tells us that our community is safe, several factors contribute to the human tendency to be fearful of crime nonetheless. These fears can be heightened in certain neighbourhoods, at certain times of day, and depend on whether we are alone or in a group. These fears can also be shaped by:

• Age
• Gender
• Household income
• Past victimization
• Social and physical disorder in a neighbourhood (i.e. sex trade, public drug use, panhandling, loitering, vandalism, graffiti).

www.preventingcrime.ca
The Role of the Media

The media plays a substantial role in determining the extent of our fear of crime. “Shock crimes” such as murder and other violent incidents get our attention and the headlines. The media’s extensive coverage of crime stories, often outside of our community, contributes to a perception that we are less safe. So while crime may make up a relatively small part of what happens in a community, it can take up a rather large part of a newscast or newspaper.

The more often we see, read and hear stories about robberies, assaults and even murders, the more likely we are to be fearful of crime. The impact local media has on fear of crime is greater than that of national media, especially for people who live in high crime areas or have recently been victimized (Chiricos, Padgett & Gertz, 2000).

Several studies also suggest that the media can increase stigmatization and fear of certain groups (youth, ethno-cultural communities) and of certain geographical locations or neighbourhoods. Misleading media coverage of specific groups and places can lead to harmful behaviour and measures of control even if these are not warranted in reality. The fear of being victimized by certain groups or in certain neighbourhoods can lead to unnecessary avoidance of people and places (ICPC, 2008).

“If the crime rate decreases it does not necessarily mean that our fear of being victimized decreases.”

The ‘Broken Windows’ Theory

The Broken Windows Theory suggests a broken window in a building, if left in disrepair, will soon lead to other windows in a building being broken. And that once one social norm is violated, it will encourage individuals to violate other social norms.

This theory can be extended into other areas of our community where we see disorderly behaviour such as littering, loitering or public intoxication. The more disorderly behaviour that is present, the more likely that it is to increase. And our fear of that area will also increase.

What Can You Do?

Fear of crime is real and it affects our quality of life. What can you do to reduce the fear?

- Follow statistics, not just headlines
- Get involved in your neighbourhood
- Organize a community clean up
- Get to know your neighbours - Just say hi!
- Share good news stories about your community
- Bring together residents, agencies, local government, businesses and police to create new approaches to reducing crime
- Don’t overgeneralize from one situation to another
- Become a Friend of Crime Prevention
<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Requestor</th>
<th>Request</th>
<th>Assigned Department</th>
<th>Anticipated Response Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-May-12</td>
<td>Council</td>
<td>Staff were directed to provide Council with a prioritized list of discretionary benefits and financial impacts prior to or as part of the 2013 Budget process, as required.</td>
<td>Social Services</td>
<td>Fall 2012</td>
</tr>
</tbody>
</table>