Appendix A

Paramedic Services Performance Measurement: Key Indicators and Trends

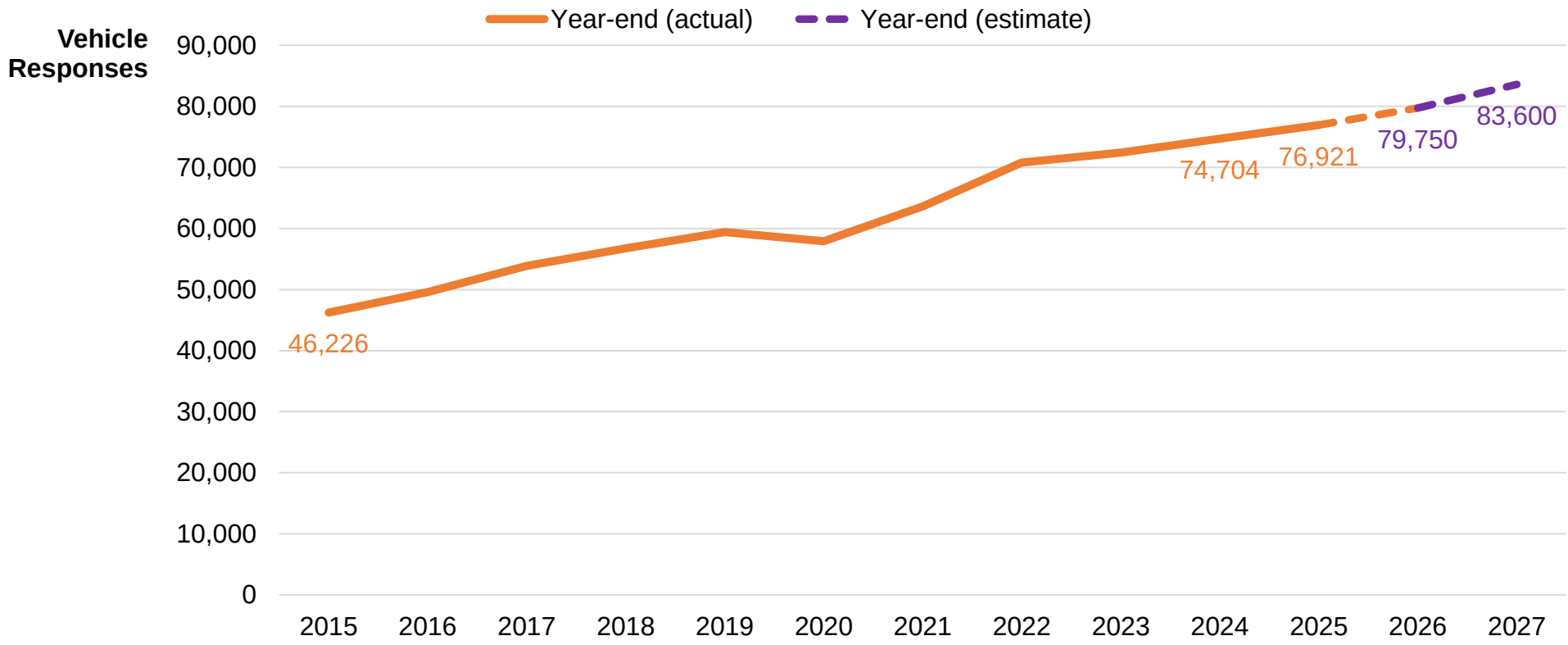
January – December 2025

Note: As of December 4, 2025, the Ministry of Health Cambridge Central Ambulance Communications Centre (CACC)transitioned from using the Dispatch Priority Card Index version 2 (DPCI II) to the Medical Priority Dispatch System (MPDS). MPDS offers improved accuracy in assessing patient acuity, allowing for a more tailored response based on resource availability and prioritizing immediate life-threatening calls. Although this change is anticipated to impact some key indicators, only minor effects have been noted so far and insufficient to alter 2025's overall results.

Actual and forecast number of vehicle responses by year

Region of Waterloo Paramedic Services, inside and outside of Waterloo Region, full-year actual 2015 to 2025, and full-year forecast 2026 and 2027

There were 76,921 vehicle responses in 2025 compared to 74,704 in 2024, an increase of 2,217 (3.0%).

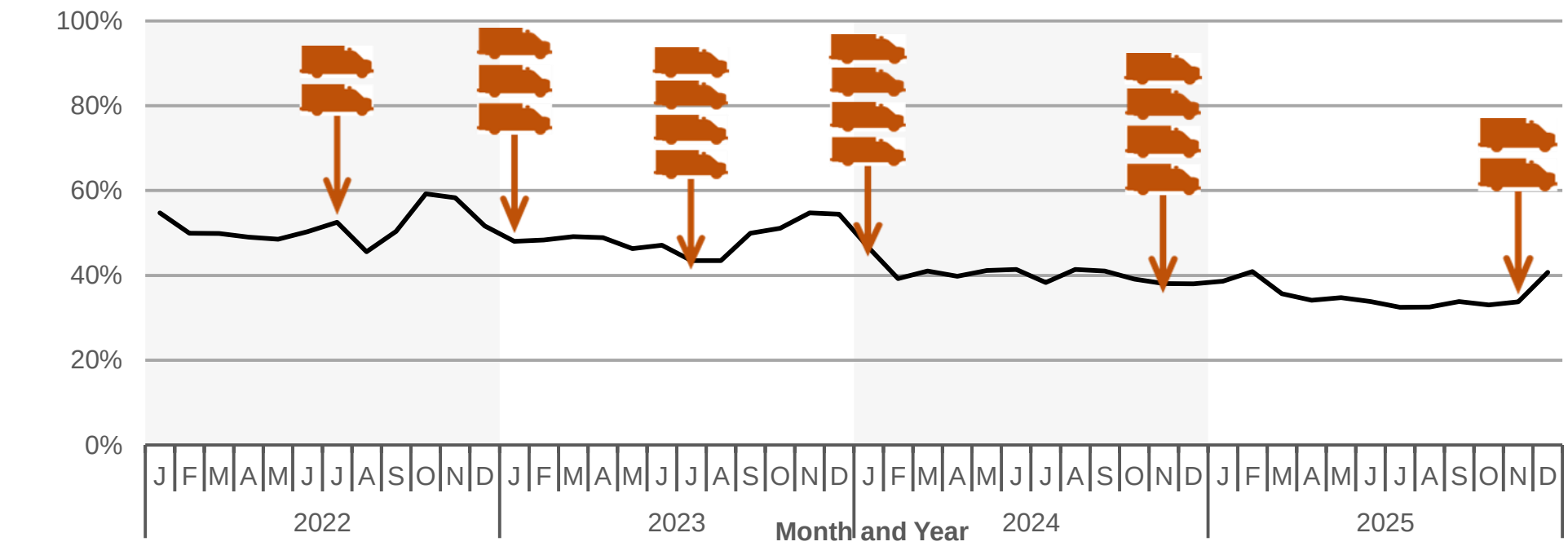


Source: Ambulance Dispatch and Reporting System (ADRS) (January 2026)

Unit Utilization (ambulance use) by month

Region of Waterloo Paramedic Services, January 2023 to December 2025

Unit utilization was 13 per cent lower in 2025 (35 per cent) compared 2024 (40 per cent).



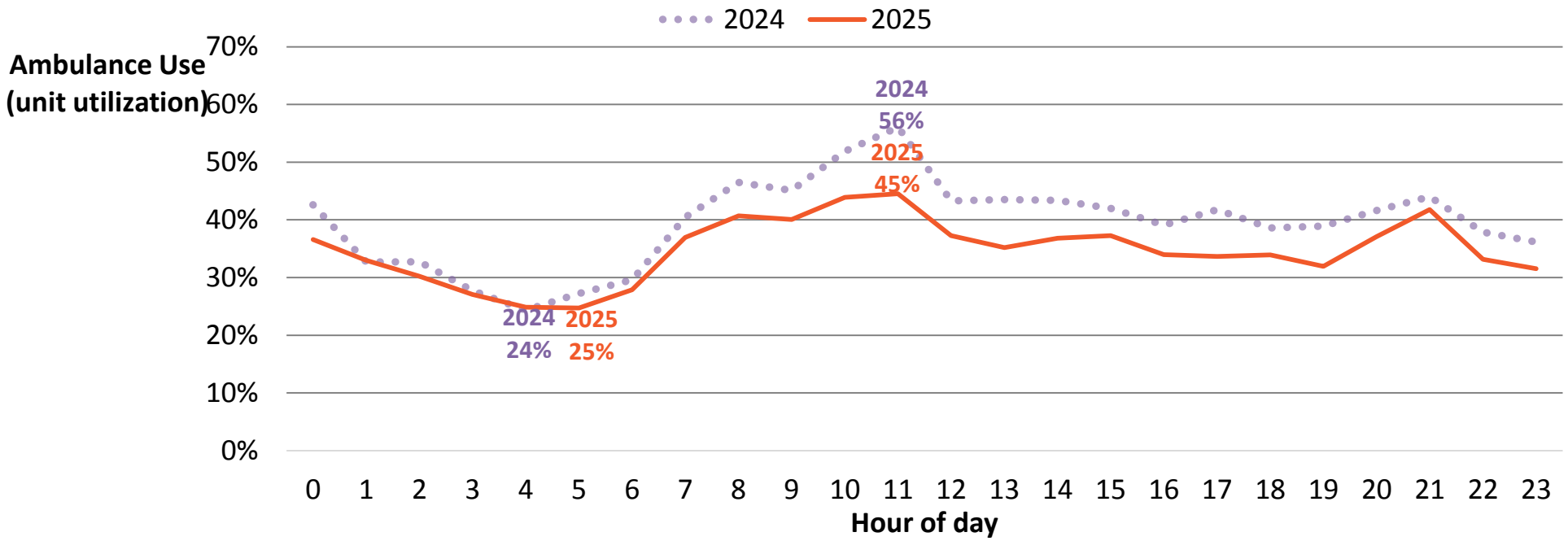
Notes: For unit utilization, a decreasing trend is considered positive, while an increasing trend is seen as a negative. As part of on-going quality improvement initiatives, ongoing and future data quality initiatives will result in changes to the indicator and could lead to differing results. When additional changes occur, historical data will be recalculated using the new methods and a note will be provided to explain the impact.

Sources: ADRS (January 2026) and TAMS (January 2026)

Unit Utilization (ambulance use) by hour of day

Region of Waterloo Paramedic Services, 2024 and 2025

Unit utilization was lower for all but two hours of the day (1am and 4am) in 2025 compared to 2024.



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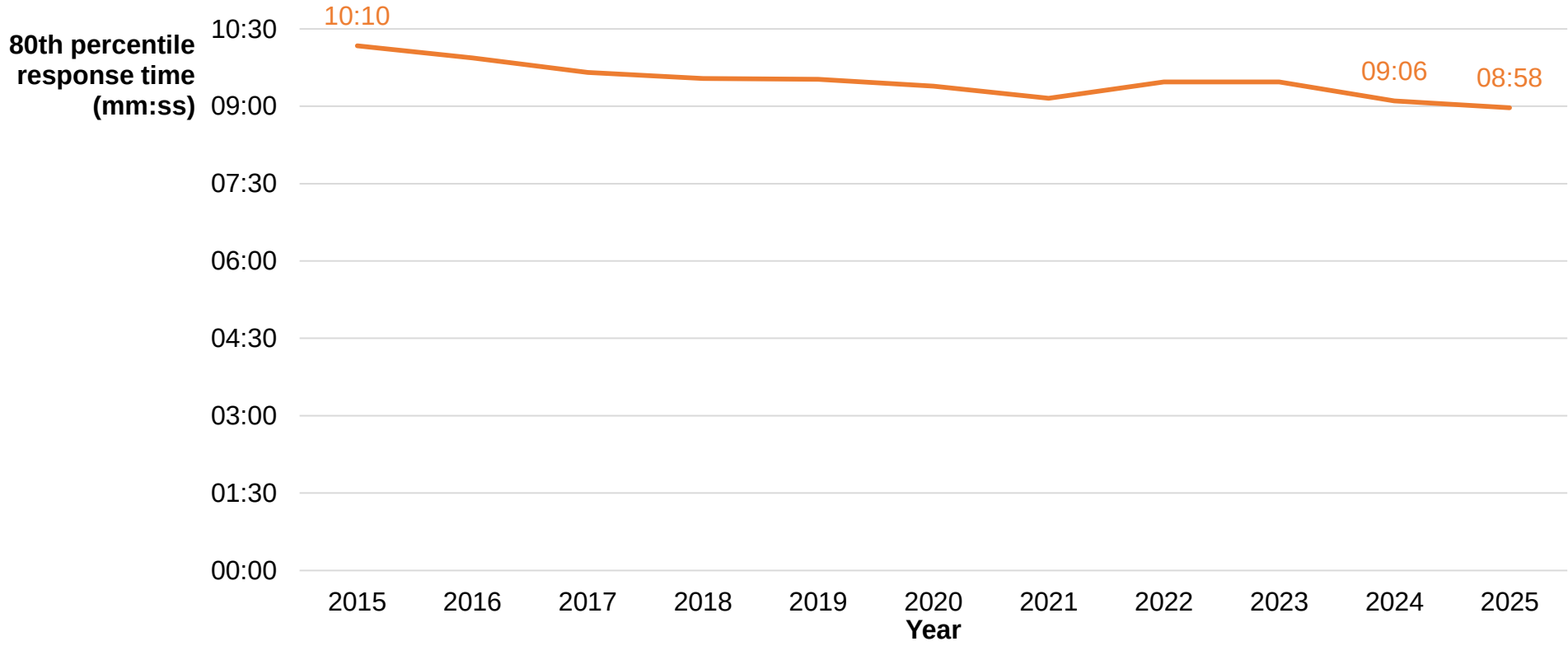
Sources: ADRS (January 2026) and TAMS (January 2026)

80th percentile response time to highest priority* emergency calls by year

Region of Waterloo Paramedic Services, inside Waterloo Region, 2015 to 2025

Response times improved (decreased) by 28 seconds from 2024 to 2025.

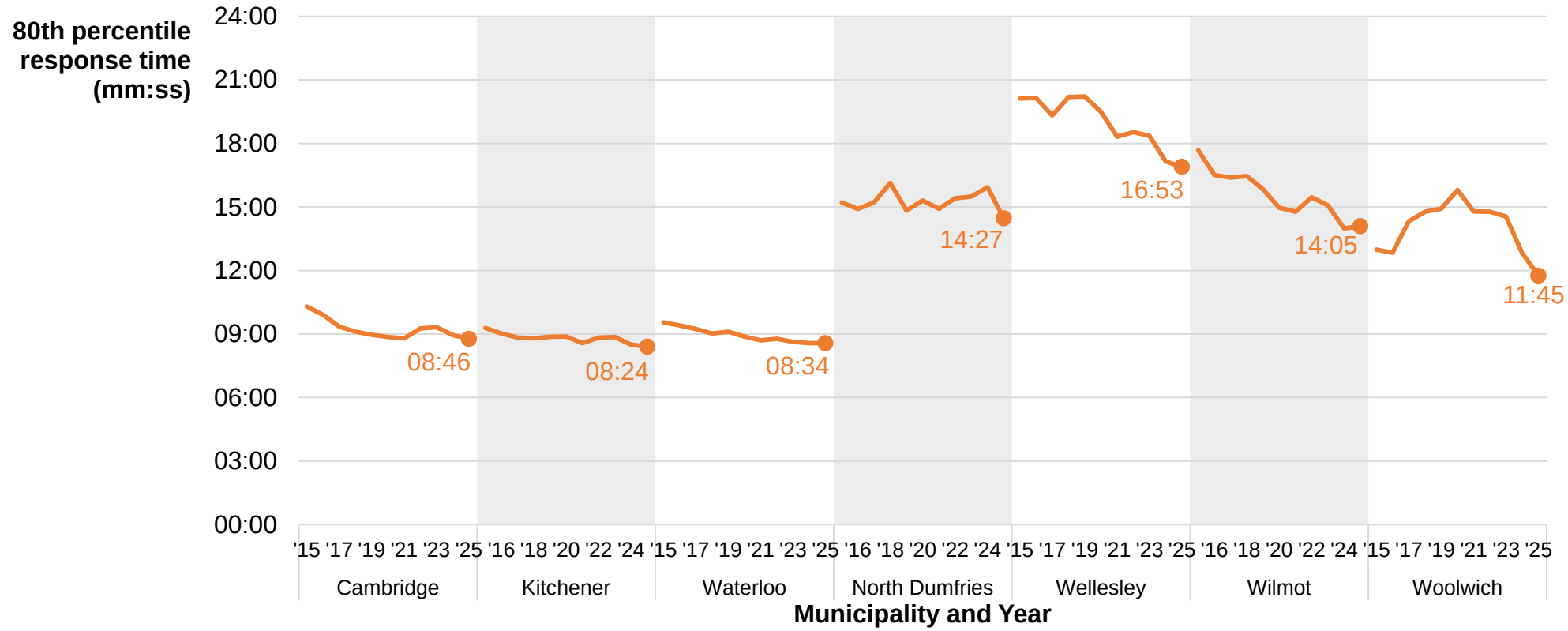


*Due to the implementation of the Medical Priority Dispatch System (MPDS) triage tool in the provincial dispatch centre, “highest priority” calls refers to code 4 calls from 01-Jan-2025 to 03-Dec-2025, and code purple and code red calls from 04-Dec-2025 to 31-Dec-2025.
Source: ADRS (January 2026)

80th percentile response time to emergency calls (code 4) by municipality and year

Region of Waterloo Paramedic Services, inside Waterloo Region, 2015 to 2025

Response times decreased or remained consistent across all municipalities.



Note: Response times are not intended to be measured at the municipal level.

Sources: ADRS (January 2026)

Compliance to 2025 response time performance plan, by Canadian Triage Acuity Score (CTAS)

Region of Waterloo Paramedic Services, 2024 and 2025

Response times improved across all acuity levels. Compliance results indicate that urgent calls are being given a more appropriate priority and attended to faster.

Sudden Cardiac Arrest (SCA):

- Target: six minutes or less for a defibrillator to arrive on scene 70 per cent of the time for 2024 and 2025.
- 2024 result: 64.1 per cent compliance,
    - Seventy per cent of the time SCA calls were responded to within 6 minutes 26 seconds.
- 2025 result: 73.8 per cent compliance,
    - Seventy per cent of the time SCA calls were responded to within 5 minutes 42 seconds.
- The six-minute time standard is set by the Ministry of Health. The 70 per cent compliance standard for SCA calls was chosen by Paramedic Services, and exceeds the Ministry mandated compliance target of 50 per cent.
- SCA results include data from local all fire departments.

CTAS 1 (resuscitation):

- Target: eight minutes or less 70 per cent of the time for 2024 and 2025.
- 2024 result: 73.4 per cent compliance,
    - Seventy per cent of the time CTAS 1 calls were responded to within 7 minutes 44 seconds.
- 2025 result: 74.3 per cent compliance,
    - Seventy per cent of the time CTAS 1 calls were responded to within 7 minutes 41 seconds.

CTAS 2 (emergent):

- Target: ten minutes or less 80 per cent of the time for 2024 and 2025.
- 2024 result: 79.9 per cent compliance,
    - Eighty per cent of the time CTAS 2 calls were responded to within 10 minutes 02 seconds.

- 2025 result: 80.3 per cent compliance,
    - Eighty per cent of the time CTAS 2 calls were responded to within 9 minutes 57 seconds.

For CTAS 3, 4, and 5 calls, response time targets were lowered in 2025 (per cent compliance targets remained the same) to better reflect the appropriateness of the call priority, manage public expectations for less urgent calls, and prioritize resources for higher acuity calls (Sudden Cardiac Arrest, CTAS 1 and 2). This adjustment has resulted in a significant increases in compliance for the CTAS 3, 4, and 5 targets.

CTAS 3 (urgent):

- Target: eleven minutes or less 80 per cent of the time for 2024;
  fifteen minutes or less 80 per cent of the time for 2025.
- 2024 result: 80.0 per cent compliance,
    - Eighty per cent of the time CTAS 3 calls were responded to within 11 minutes 00 seconds.
- 2025 result: 92.3 per cent compliance,
    - Eighty per cent of the time CTAS 3 calls were responded to within 10 minutes 58 seconds.

CTAS 4 (less urgent):

- Target: twelve minutes or less 80 per cent of the time for 2024;
  twenty minutes or less 80 per cent of the time for 2025.
- 2024 result: 81.2 per cent compliance,
    - Eighty per cent of the time CTAS 4 calls were responded to within 11 minutes 44 seconds.
- 2025 result: 96.0 per cent compliance,
    - Eighty per cent of the time CTAS 4 calls were responded to within 11 minutes 44 seconds.

CTAS 5 (non-urgent):

- Target: twelve minutes or less 80 per cent of the time for 2024;
  twenty-five minutes or less 80 per cent of the time for 2025.
- 2024 result: 78.2 per cent compliance,

    - Eighty per cent of the time CTAS 5 calls were responded to within 12 minutes 15 seconds.
- 2025 result: 98.0 per cent,
    - Eighty per cent of the time CTAS 5 calls were responded to within 12 minutes 12 seconds.

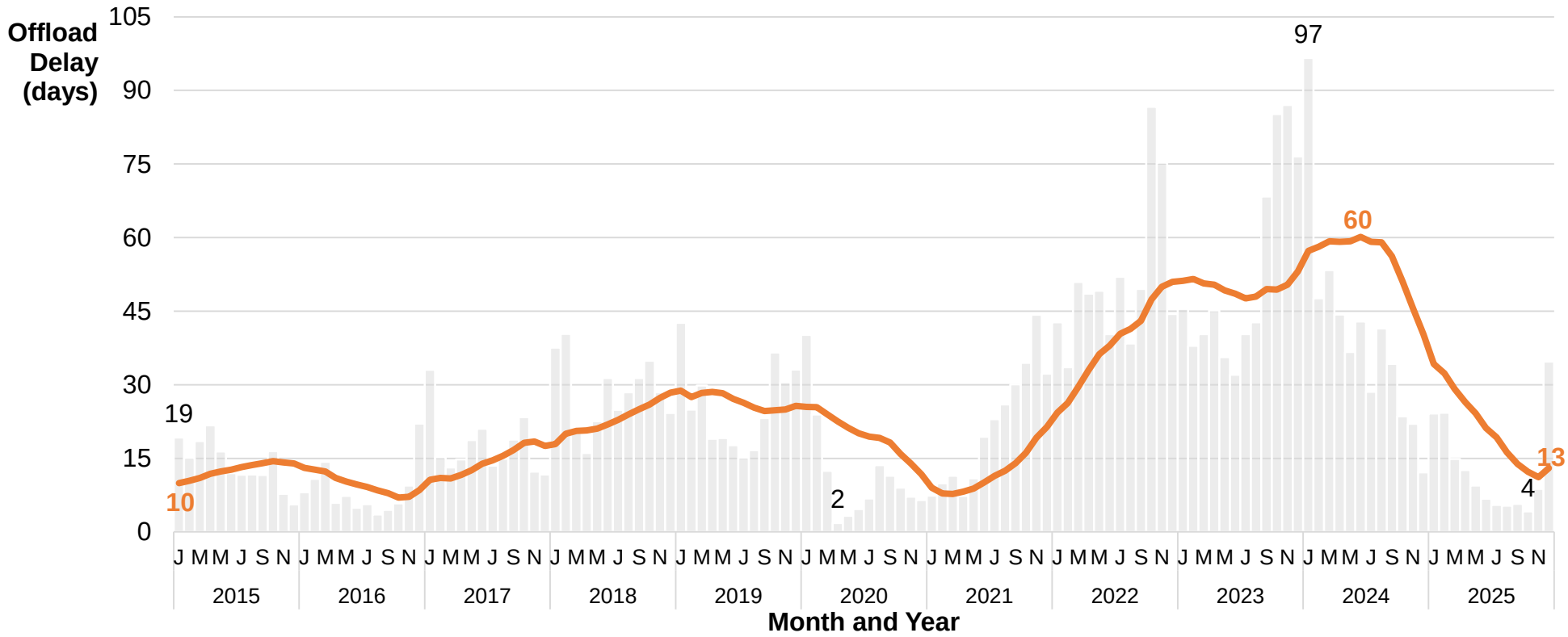
Compliance values should exceed the target while response time percentiles should be lower than the target. Compliance results indicate that urgent calls were given a more appropriate priority and attended to faster. Setting faster times for more urgent calls, and progressively slower times for less urgent calls, is a standard approach. Response times vary according to population, road density, system capacity, and road conditions. Drive times are longer in rural areas. To be more reflective of the SCA indicator definition of any defibrillator arriving on scene, only the SCA indicator includes fire department data.

Source: ADRS and TabletPCR (January 2026); Local Fire Department dispatch data (January 2026)

Monthly total and 12-month moving average of ambulance days lost to offload delay, by month

Region of Waterloo Paramedic Services at local hospitals, 2015 to 2025

Since January 2024, offload delay has trended down significantly. October 2025 had the lowest monthly total of offload delay since May 2021. As of December 2025, Paramedic Services had lost an average of 13 days per month to offload delay over the past year.

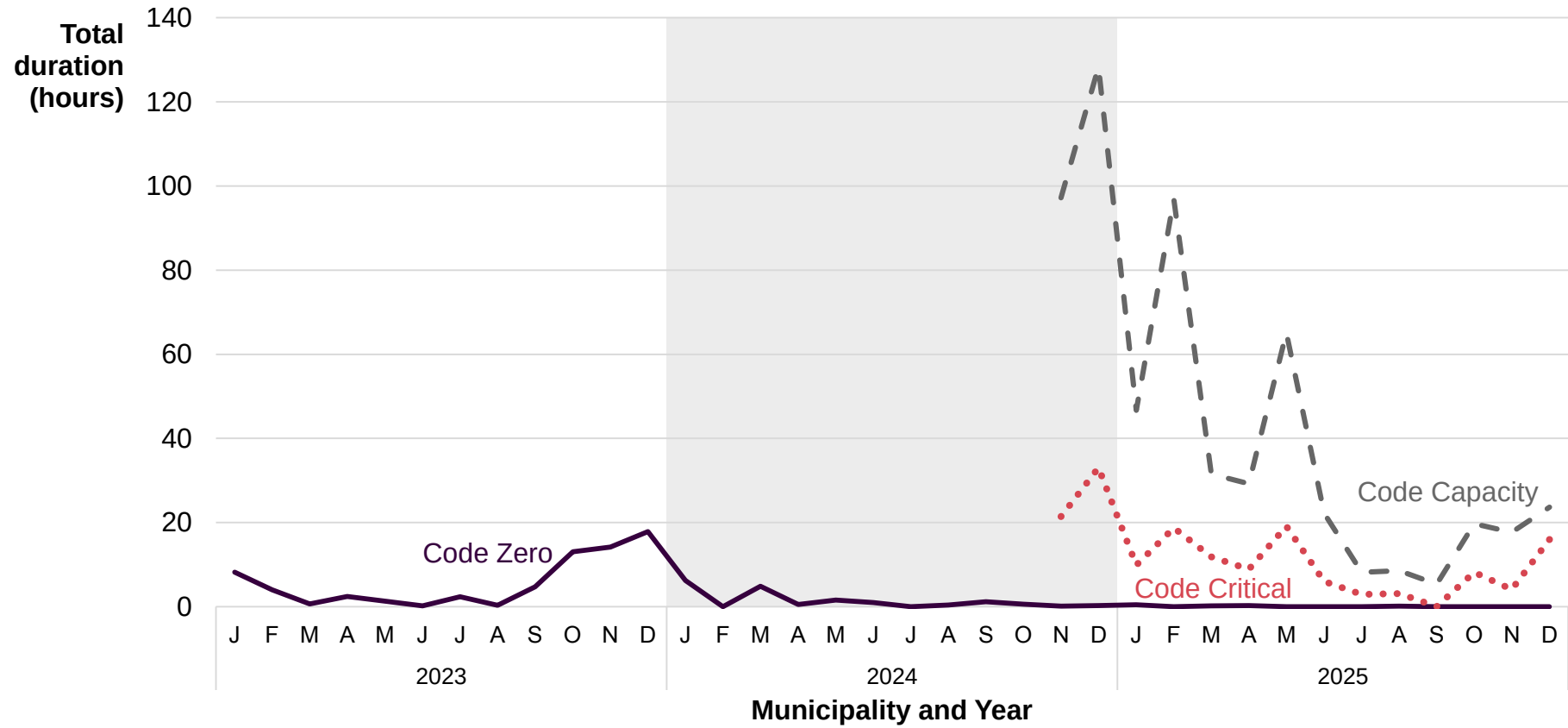


Source: TabletPCR (January 2026)

Total duration spent in Code Zero, Code Critical, and Code Capacity, by month

Region of Waterloo Paramedic Services, January 2023 to December 2025

Time spent in Code Zero remained consistently low. There were no Code Zero event between September and December 2025. Time spent in Code Critical and Code Capacity largely trended down for much of the year.



Source: CACC (January 2026)

Glossary

ADRS: Ambulance Dispatch Reporting System

CACC: Central Ambulance Communication Centre

Code 1 (Deferrable): A routine call that may be delayed without detriment to the patient (e.g. a non-scheduled transfer; a minor injury).

Code 2 (Scheduled): A call which must be done at a specific time, for example because of special treatment or diagnostic facility requirement (e.g. inter-hospital transfers or a scheduled meet with an air ambulance).

Code 3 (Prompt): A call that should be performed without delay (e.g. serious injury or illness).

Code 4 (Urgent): A call that must be performed immediately where the patients 'life or limb' may be at risk (e.g. Vital Signs Absent patient or unconscious head injury).

Code Capacity: 0800 hrs – 2000 hrs: 12 ambulances available or fewer; 2000 hrs – 0800 hrs: 7 ambulances available or fewer. Indicates low to medium risk as resource availability is reduced but the system is managing effectively. This status allows for escalation protocols to be implemented to help prevent entering Code Critical status.

Code Critical: 5 ambulances available or fewer. Indicates high risk due to significantly reduced resource availability. This status allows for escalation protocols to help reduce the likelihood of entering Code Zero.

Code Zero: When the Region of Waterloo Paramedic Services is at a level where no ambulances are available to respond to the next emergency call and no out of town services are immediately available to assist.

CTAS Level: The 'Canadian Triage & Acuity Scale' is used to assign a level of acuity to a patient. Acuity refers to the gravity of the situation – the potential for death and/or irreversible illness. CTAS is a tool that more accurately defines the patient's need for care. Assignment of the CTAS level is to be based upon not only the presenting complaint identified on the initial assessment made by the paramedic, but also on their examination findings, and response to treatment.

Dispatch Priority Card Index version 2 (DPCI II): DPCI was developed by the Ministry of Health. Multiple versions of DPCI have been in use in Ontario ambulance dispatch centres since the early 1990s. The current version, DPCI II, has four priority levels; two for emergency

responses (Code 4 – Urgent, Code 3 – Prompt), and two for non-emergency responses (Code 2 – Scheduled, Code 1 – Deferrable). Code 4 calls are considered the highest priority, authorize the use of lights and sirens, and may initiate a tiered response from police and/or fire. The DPCI II algorithm lacks specificity and results in a high number of patients being improperly prioritized as emergent, but who present to paramedics as non-emergent. This over-prioritization of calls as high priority unnecessarily depletes paramedic resources. As of December 2025, DPCI II is no longer used in Waterloo Region, and is in the process of being phased out across Ontario, in favour of the much more specific Medical Priority Dispatch System (MPDS).

Dispatch Priority Code: The priority code number that is assigned to the call by the dispatcher. It identifies the priority under which the ambulance responds to the call location (e.g. an urgent response would be entered as Code 4 under the old DPCI II triage tool, and as Code Purple or Code Red under the new MPDS triage tool).

Emergency Calls: Based on dispatch priority only. The highest acuity emergency calls are categorized as Code 4 (Urgent) or Code 3 (prompt) under the old DCPI triage tool, and as Code Purple and Code Red under the new MPDS triage tool.

Medical Priority Dispatch System (MPDS): MPDS is an internationally recognised and broadly used algorithm for triaging incoming calls that is frequently reviewed and updated. MPDS has medical director / physician oversight and has more than 40 problem types, and five priority levels. The priority levels are: Purple – Emergent and Immediately life-threatening; Red – Emergent and potentially life-threatening; Orange – Urgent and potentially serious, immediate threat to life unlikely; Yellow – Not urgent, not serious, immediate threat to life very unlikely; and Green – Not urgent, not serious, Immediate threat to life very unlikely, may be deferred without detrimental impact to patient outcome). The MPDS priorities mirror the patient acuity levels of the Canadian Triage Acuity System (CTAS). MPDS is considered a more accurate algorithm in determining patient acuity resulting in a more appropriate resourcing of calls than DPCI II. The specificity and accuracy of the triage tool allows for a more flexible and appropriate response based on resource availability and helps to ensure there is sufficient capacity to respond immediately to life threatening calls**.**

Offload Delay: Offload delay occurs when the time between when the ambulance crew arrives with a patient(s) at the hospital to the time when the patient(s)' care has been transferred to the hospital staff exceeds 30 minutes (i.e. total offload time minus 30min). Offload delay can impact the resources required and availability to respond to calls.

Response Time: Response time means the time measured from the time a notice is received to the earlier of either the arrival on-scene of a person equipped to provide any type of defibrillation to sudden cardiac arrest patients or the arrival on-scene of the ambulance crew.

Return Priority Code: The priority code number that is assigned to the call by the ambulance crew. It identifies the priority under which the patient is transported (e.g. a prompt return to a medical facility would be entered as a Code 3).

T1: The time point when a call is entered into the queue at the Central Ambulance Communications Centre and is available for dispatch.

T2: The time point when ambulance/response unit is notified by the Central Ambulance Communications Centre of a call.

T4: The time point when an ambulance/response unit arrives at the dispatched call's location/scene. This is not the time point when a paramedic is at the patient's side.

T6: The time point when an ambulance arrives at its destination (e.g. hospital).

TabletPCR: An internal tool used to track information and data relevant to calls and patient care reporting.

Unit Utilization: Percentage of total available staff time used to actively respond to calls. Note that when UU exceeds a value of 40 per cent, it becomes difficult to ensure an ambulance will be available for the next call in a reasonable time.

Vehicle response: A vehicle response is generated when an ambulance or emergency response unit is dispatched to a call; there can be more than one vehicle response per call (multiple ambulances/emergency response units assigned to the same call; for example, multi-casualty incidents).

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