College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Council Meeting

December 9, 2020

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

NOTICE OF MEETING OF COUNCIL

A meeting of the College of Midwives of Ontario will take place on Wednesday, December 9, 2020 from 9:30 AM to 2:50 PM by videoconference.

This meeting is open to the public. Any individuals wanting to observe the meeting should contact the College at cmo@cmo.on.ca or 416.640.2252 ext. 227 for access details.

Kelly Dobbin,
Registrar & CEO

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

CMO Council Meetings – Guidelines for Observers

- The Council meetings held by videoconference may be observed by the public, please contact the college for information on how to attend.
- Those attending the Council meetings as observers do not participate in the meeting.
- Observers are required mute their microphone during the videoconference.
- If a portion of the meeting is closed to the public, an announcement will be made to move in-camera. Observers do not participate. If known in advance, in-camera items are noted on the agenda. The agenda is posted to the CMO website two weeks prior to the scheduled Council meeting.
- Observers can access the Council package materials from the College website approximately two weeks prior to the scheduled Council Meeting.

If you have any questions regarding the Council meeting or would like to register as an observer, please contact the College at cmo@cmo.on.ca or by phone at 416-640-2252, ext 227.

COUNCIL AGENDA

Wednesday, December 9, 2020 | 09:30 am to 2:50 pm
Microsoft TeamShare Videoconference

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
1.	Call to Order, Land Acknowledgment	C. Ramlogan Salanga	9:30	INFORMATION		-
2.	Conflict of Interest	C. Ramlogan Salanga	9:35	DISCUSSION	*signed forms appended to end of meeting book	-
3.	Proposed Agenda	C. Ramlogan Salanga	9:36	MOTION	3.0 Agenda 3.1 Council Actions	4
4.	Consent Agenda - Draft Minutes of September 30, 2020 Council Meeting Q2 Reports for: - Inquiries, Complaints and Reports Committee Report - Registration Committee - Quality Assurance Committee - Discipline Committee - Fitness to Practise Committee - Client Relations Committee	C. Ramlogan Salanga	9:38	MOTION	4.0. Draft Minutes 4.1 ICRC report 4.2 RC report 4.3 QAC report 4.4 DC report 4.5 FTP report 4.6 CRC report	7
5.	Chair Report	C. Ramlogan Salanga	9:40	MOTION	5.0 Chair Report	31
6.	Executive Committee Report	C. Ramlogan Salanga	10:00	MOTION	6.0 Executive Committee Report 6.1 Q2 SOP	33
	I. Council Annual Evaluation Presentation			INFORMATION	-	-
	II. Committee Appointments & Composition			MOTION	6.2 Proposed Committee Composition	37
	III. Comprehensive Assessment of Auditor Report			MOTION	6.3 Assessment Report	38

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
	IV. Financial Policy	C. Doornekamp	10:40	MOTION	6.4 Briefing Note 6.5 Draft policy	40
BREAK 11:10 AM						
	V. Revised Registrar Review Plan	S. Goodwin	11:40	DISCUSSION	6.6 Briefing Note 6.7 S Goodwin Presentation Slides 6.8 Appendix A Table of Proposed Changes	46
7	Registrar's Report	K. Dobbin	12:10	MOTION	7.0 Registrar's Report	46
	Governance Policies			MOTION	7.1 Briefing Note 7.2 Revised GP 10 7.3 Revised GP 11 4.4 Revised GP 12	55
8	By-laws	K. Dobbin	12:40	MOTION	8.0 Briefing Note 8.1 Revised By-laws	60
9	Strategic Plan	C. Ramlogan Salanga	12:45	MOTION	9.0 Briefing Note 9.1 Framework 9.2 Strategic plan 9.3 Risk Matrix	64
BREAK 1:00						
10	Quality Assurance Committee: Standards Review	L. Martin	1:30	MOTION	10.0 Briefing Note 10.1 Scope of Practice 10.2 Revised Professional Standards 10.3 Guideline on Ending the Midwifery-Client Relationship	87
11	Registration Committee: Clinical Currency Recommendations	I. Milot	2:10	DISCUSSION	11.0 Briefing Note 11.1 Regulatory Impact Assessment Statement	140
12	Housekeeping	C. Ramlogan Salanga	2:45	INFORMATION	-	-
13	Adjournment	C. Ramlogan Salanga	2:50	MOTION	-	-

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
	Next Meetings: March 23-24, 2021 June 15-16, 2021 October 5-6, 2021 December 7-8, 2021			INFORMATION		

COUNCIL ACTIONS

Every agenda item brought to Council has an associated action to be taken by Council in the context of regulating in the public interest. These actions are:

INFORMATION - Agenda item contains information that would be of benefit to Council in understanding their role, processes or any other information pertinent to the regulatory environment of health colleges.

DISCUSSION – Agenda item is being brought forward for discussion only. Discussions may guide staff or committees in the development of future actions or proposals.

MOTION – A motion is formal decision or action of Council. A motion can be made to approve, accept, appoint, adjourn or to take another form of action.

MINUTES OF COUNCIL MEETING

Held on September 30, 2020 | 9:30 am to 12:30 pm
Videoconference Microsoft TeamShare

Chair:	Claire Ramlogan-Salanga, RM
Present:	Jan Teevan, RM; Lilly Martin, RM; Edan Thomas, RM; Lisa Nussey, RM; Maureen Silverman, RM; Isabelle Milot, RM; Claudette Leduc, RM; Marianna Kaminska; Judith Murray; Don Strickland; Pete Aarssen; Sarah Baker
Regrets:	None
Staff:	Kelly Dobbin; Carolyn Doornekamp; Marina Solakhyan; Nila Halycia; Nada Gale; Johanna Geraci
Observers	Deborah Bonser (Association of Ontario Midwives); Sarah Kibaalya (Ministry of Health); Karen McKenzie, RM
Recorder	Zahra Grant

1. Call to Order, Welcome and Land Acknowledgement

   Claire Ramlogan-Salanga Chair, called the meeting to order at 9:32 am and welcomed all present. Introduction of all Council members and staff were made to welcome two new Council members Karen McKenzie, RM as an acclaimed professional member and Sarah Baker who is a public appointee.

   A land acknowledgement recognizing the traditional territory of Indigenous people of the lands on which we currently live and work was shared by the Chair along with an anecdote honouring Phyllis Webstad, the legacy of residential schooling in Canada and its continued impact as we work toward truth and reconciliation.

2. Declaration of Conflict of Interests

   No conflicts of interest were declared.

3. Proposed Agenda

   The agenda was approved as presented.

   Moved: Jan Teevan
   Seconded: Pete Aarssen
   CARRIED

4. Consent Agenda

It was noted for the Council that there was an error in meeting materials regarding the Chair listing on the ICRC, Discipline and Fitness to Practise reports. The materials posted the website have been revised to accurately reflect the correct Chair.

MOTION: THAT THE CONSENT AGENDA CONSISTING OF:

- Draft Minutes of June 24, 2020 Council Meeting
- Inquiries, Complaints and Reports Committee Report
- Registration Committee Report
- Discipline Committee Report
- Fitness to Practise Committee Report
- Client Relations Committee Report
- Quality Assurance Committee Report

Moved: Maureen Silverman
Seconded: Isabelle Milot
CARRIED

5. Council Chair Report

The Chair, Claire Ramlogan-Salanga introduced her report providing a summary and highlights of activities since the last report.

The Strategic Planning Working Group held its third planning meeting on September 23, 2020. The Chair introduced Marina Solakhyan, Director of Regulatory Affairs to present to Council an overview of the strategic planning process in the context of being a risk-based regulator. The 2017-2020 strategic planning cycle saw the College overhaul its regulatory programs from a reactive model of regulation to a risk-based model of regulation meaning that strategic goals, programs and day-to-day activities are now guided by focusing activity and attention on issues and potential risks that pose the greatest threat to our duty to protect the public. Goals of the strategic plan and activities will be built around mitigating identified risks.

The Council will spend a day in December review and finalize the strategic plan.

MOTION: That the Chair's report be approved as presented

Moved: Lilly Martin
Seconded: Claudette Leduc
CARRIED

6. Registrar's Report

The Registrar, Kelly Dobbin introduced her report and opened the floor to any questions.

An update was provided regarding the Drug Regulation that was formally submitted by the College December 2019. The submission of the College was based on the direction of the Ministry to make amendments from the current regulation that lists specific drugs and substances to include instead categories of drugs and substances in accordance with the

American Health Formulary System (AHFS). Prior to this direction the College had initially proposed broad access to drugs and substances within the midwifery scope of practice as there is concern that it is difficult to predict how often new categories will be created or how often the categories included in the proposed regulation would require change. Some of these anticipated problems have come to fruition, as it has come to the College's attention that there is a AHFS category dealing with non-hormonal contraceptives that was missed in the College submission because the online AHFS Clinical Drug Information (CDI) database used to develop the draft did not previously include this class information when the proposed changes to the regulation were being developed. This situation highlights initial concerns about using the AHFS classification system that is designed to respond to industry needs in the United States, and not designed for a drug regulation that governs midwifery professionals' access to Canadian drugs and substances. The Registrar has had a conversation with Allison Henry, Director, Health Workforce Regulatory Oversight at the Ministry of Health about concerns regarding this approach to regulation and will keep Council informed of developments.

An update was provided to Council regarding the College Performance Measurement Framework (separate from the College's own organizational specific performance measurement framework that was approved by Council June 2019) that is to be implemented by the Ministry of Health. In accordance to correspondence from the Ministry on September 1, 2020 all Colleges are expected to measure against the standards for the calendar year 2020, and to report back to the Ministry and publicly post in a standardized manner by March 31, 2021. The standards have not yet been finalized so were not shared with Council however, based on staff review the College meets the majority of the best practices established by the framework and do not anticipate any issues with gathering any of the requested data.

A final update was provided regarding developments in the regulatory sector to actively address issues of anti-Black and anti-Indigenous racism. The Registrar is working with other College representatives through a newly formed HPRO working group to build a framework/toolkit for health regulators to address equity, diversity and inclusion in regulatory policy, governance policy, human resource policy, and to assist with building capacity among staff with expert support.

MOTION: That the Registrar's Report be accepted as presented.

Moved: Lisa Nussey
Seconded: Lilly Martin
CARRIED

7. Executive Committee Report

Claire Ramlogan-Salanga, Chair introduced the Executive Report advising Council of activities of the committee since the last report.

An update was provided to Council that a third-party consultant Sam Goodwin of Goodwin Consulting was hired to work with Council to review, revise and administer the Annual Performance Evaluation of the Registrar-CEO.

The Q1 statement of operations was reviewed in detail by the committee and a copy of the approved statements was presented to Council for information. Carolyn Doornekamp, Director

of Operations provided additional clarity and answer questions. The College is in a good cash flow position and there were no concerns to report.

The committee in the role of privacy working group reviewed the College's Privacy Code which had to be updated in response to all College data being moved and stored on Canadian-based servers for information storage and is making the recommendation to Council to approve the revisions.

Lastly, the committee proposed recommendations for committee composition to appoint incoming professional member Karen McKenzie, newly appointed public member Sarah Baker as well as former public member Sally Lewis, who has applied and is eligible for appointment.

The Chair also took a moment to recognize the contributions and service of Lisa Nussey, professional member of Council whose three-year term would end at the conclusion of the meeting.

MOTIONS:

i. That the Executive Committee Report be approved as presented.
ii. That the revisions to the Privacy Code be approved as presented.
iii. That Sarah Baker be appointed Registration, Discipline and Fitness to Practise Committees.
iv. That Karen McKenzie, upon approval of Council slate be appointed to Client Relations, Discipline and Fitness to Practise committees.
v. That Sally Lewis be appointed to Investigations, Complaints and Reports, Discipline and Fitness to Practice committees as a public non-Council committee member.

Moved: Jan Teevan
Seconded: Claudette Leduc
CARRIED

8. Quality Assurance Committee Presentation

Lilly Martin, Chair of the Quality Assurance committee gave a presentation to Council summarizing the inaugural launch of the College's new Quality Assurance Peer and Practice Assessment program. Seventy-three members who were randomly selected, participated in distance assessments led by peer assessors and all were found to meet the criteria and standards established by the program. Based on the criteria established by the program no in-person assessments were required. Both members who participated as well as the peer assessors who conducted the assessments had an opportunity to provide feedback on the process. Responses were overwhelmingly positive but there is also indication that the perception of the program could be improved to get members to better understand the assessment process as a proactive form of regulation and not an effort to police midwives in any way. The committee envisions the program not only as fulfilling the requirements of the Code in assessing the members' knowledge, skill and judgment are satisfactory in accordance with the professional standards established by the profession but also an opportunity for professional mentorship and development. The program will run another cycle in 2021 to establish more clear evidence and feedback before the committee looks to make any changes. Overall, the

first launch was a great success. The presentation was for information only and no action or decision was made by Council.

9. Election of Executive Committee

The positions for Chair, Vice-Chair (public), Vice-Chair (professional) and public member at large were acclaimed by Claire Ramlogan-Salanga, Don Strickland, Edan Thomas and Marianna Kaminska respectively. Two candidates, Maureen Silverman and Claudette Leduc were eligible for the professional member at large position and an election was held.

MOTION: That the Council accepts the acclamation of Claire Ramlogan-Salanga as Chair; that the Council accepts the acclamation of Edan Thomas as Vice Chair (Professional); and that the Council accept the acclamation of Donald Strickland as Vice Chair (Public); Marianna Kaminska as Executive Member at Large (Public), and Claudette Leduc as Executive Member at Large (Professional).

Moved: Pete Aarssen
Seconded: Lisa Nussey
CARRIED

10. Approval of Annual Slate of Council

MOTION: That the following slate be approved as the 2018-2019 College of Midwives of Ontario's Council:

Professional Elected Members: Claire Ramlogan-Salanga; Lilly Martin; Jan Teevan; Edan Thomas; Maureen Silverman; Isabelle Milot; Claudette Leduc; Karen McKenzie.

Appointed Public Members: Marianna Kaminska; Judith Murray; Donald Strickland; Pete Aarssen; Sarah Baker

Moved: Claudette Leduc
Seconded: Lisa Nussey
CARRIED

11. ADJOURNEMENT

MOTION: THAT THE MEETING BE ADJOURNED AT 12:19 pm
Moved: Judith Murray
Seconded: Lisa Nussey
CARRIED

INQUIRIES, COMPLAINTS & REPORTS COMMITTEE

REPORT TO COUNCIL – Q2
July 1, 2020-September 30, 2020

General

Committee Members

Chair	Edan Thomas, RM
Professional	Maureen Silverman RM; Lilly Martin, RM; Jan Teevan; Claudette Leduc, RM, Edan Thomas, RM
Public	Judith Murray, Susan Lewis
Non-Council	Christi Johnston, RM, Samantha Heiydt, Jillian Evans

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held*	15	10	–	–	25
Number of Committee Meetings Held*	0	0	–	–	0
Number of Trainings*	0	0	–	–	0

Notes:
Q2: Of the 10 meetings held, 8 occurred by teleconference, 1 occurred electronically and 1 oral caution was administered by videoconference due to COVID-19
YTD: Of the 25 meetings held, 15 occurred by teleconference, 9 occurred electronically, and 1 oral caution was administered by videoconference due to COVID-19

Caseload Work of the ICRC

	Complaints	Reports	Total
Open files as at July 1, 2020 (Files carried over)	37	13	50
New files (July 1, 2020 to September 30, 2020)	12*	1	13
Closed files (July 1, 2020 to September 30, 2020)	10	5	15
Open files as at September 30, 2020	39	9	48

Notes:

Q2: Twelve new complaint files were a result of receiving seven complaints. Two complaints involved more than one midwife.

Source of New Matters

Source of New Matters	Complaints (12)	Reports (1)	YTD Total Complaints (27)	YTD Total Reports (7)
Client	9	–	20	–
Family Member	–	–	3	–
Health Care Provider	2	–	3	–
Information received by Mandatory / Self Report	–	1	–	5
Information received from another source	–	–	–	2
Another Midwife	1	–	1	

Outcomes/Completed Cases

Number of Resolved Cases and Outcomes	Complaints		Reports	
	Q2 (10)	YTD (19)	Q2 (5)	YTD (6)
Complaints referred to ADR	1	1	N/A	
Complaints Withdrawn	0	1	N/A	
Frivolous and Vexatious	0	0	N/A	
No Action	5	12	2	2
Advice & Recommendations	2	3	0	0
Specified Continuing Education or Remediation Program (SCERP)	2	2	2	2
Oral Caution	0	0	0	0
SCERP AND Oral Caution	0	0	1	2
Referral to Discipline Committee	1	1	0	0
Referral to Fitness to Practise Committee	0	0	0	0
Acknowledgement & Undertaking	0	0	0	0
Undertaking to Restrict Practise	0	0	0	0
Undertaking to Resign and Never Reapply	0	0	0	0

Note: where decisions contain more than one outcome or multiple issues, both will be captured. Accordingly, the total number of decisions may not equal the total number of outcomes or cases.

Year to Date Percentage of ICRC decisions made pursuant to section 26(1) of the Health Professions Procedural Code:	Complaints (18)	Reports (6)
Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee (s. 26.1.1 of the Code)	6%	0%
Refer the member to a panel of the ICRC under s. 58 for incapacity proceedings (s. 26.1.2 of the Code)	0%	0%

Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned(s. 26.1.3 of the Code)	0%	33%
Take action it considers appropriate that is not inconsistent with the health profession Act, Code, the regulations or by-laws. (s. 26.1.4 of the Code)	94%	67%

Timelines

Closed cases	Complaints		Reports	
	Q2 (10)	YTD (18)	Q2 (5)	YTD (6)
Number of files closed <150 days	2	3	2	2
Number of files closed between 150 days and 210 days	1	1	0	0
Number of files closed >150 days	8	15	3	4
Shortest: (reported in number of days)	91	90	99	99
Longest: (reported in number of days)	814	814	683	683
Average: (reported in number of days)	391	382	479	356
90th percentile disposal*: (reported in number of days)	672	672	233	233

Notes:
Time is calculated from receipt of complaint until the date of the final decision and reasons.

This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.

Note: Several complaint matter involving several members involved a lengthy and complex investigation. These numbers are expected to decrease throughout Q3-Q4.

Alternative Dispute Resolution

Current Stats at at September 30, 2020	Total
Open files with ADR as at July 1, 2020 (Files carried over)	2
New files referred to ADR (July 1, 2020 to September 30, 2020)	0
Closed files with in 60 days (July 1, 2020 to September 30, 2020)	0
Closed files with in 120 days (July 1, 2020 to September 30, 2020)	0
Files returned to ICRC due to timeframe (July 1, 2020 to September 30, 2020)	0
Files returned to ICRC due to unsuccessful mediation (July 1, 2020 to September 30, 2020)	0
Files returned to ICRC as Registrar did not ratify the agreement (July 1, 2020 to September 30, 2020)	0
Open files as at September 30, 2020	2

Other useful information (July 1, 2020 to September 30, 2020:	Total
Total Number of Complaints Received	12
Number of complaints that were not ADR eligible	10
Number of Complaints that were ADR eligible	2
Number of Complaints ELIGIBLE that proceeded to ADR upon consent of all parties	0
Number of Members who agreed to participate in ADR	2
Number of Complainants who agreed to participate in ADR	0

Appeals

Complaint Matters	Total
Open HPARB appeals as at July 1, 2020 (Appeals carried over)	2
New HPARB appeals (July 1, 2020 to September 30, 2020)	3
Completed HPARB appeals (July 1, 2020 to September 30, 2020)	0
Open HPARB appeals as at September 30, 2020*	5

Note: The five appeals are representative of two complaint matters involving five members.

Respectfully Submitted,

Edan Thomas, RM

REGISTRATION COMMITTEE

REPORT TO COUNCIL - Q2

July 1, 2020 - September 30, 2020

General

Committee Members

Chair	Isabelle Milot, RM
Professional	Claudette Leduc, RM;
Public	John Stasiw (until August 16, 2020); Peter Aarssen
Non-Council	Alexandra Nikitakis, RM; Christi Johnston, RM; Jillian Evans; Samantha Heiydt

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held*	5	3	-	-	8
Number of Committee Meetings Held*	2	1	-	-	3
Number of Trainings*	0	0	-	-	0

** Of the 11 meetings held to date, 11 occurred by videoconference using Microsoft Teams.*

In Q2, the Registration Committee addressed the following items:

REGISTRATION REGULATION PROJECT – REGULATORY IMPACT ASSESSMENTS

As part of the Registration Regulation Project Plan, the Registration Committee is asked to review key topics that require policy decisions that will inform the development of the revised Registration Regulation. Each topic is outlined in a regulatory impact assessment tool, which is an assessment of the expected impact of each regulatory policy initiative that must be done before any regulatory measure is introduced or revised, in accordance with the College's policy development process.

The Committee reviewed the updated regulatory impact assessments and preliminary recommendations on clinical currency and new registrant conditions. The Committee identified additional questions and staff is conducting final research in order to propose recommendations for a policy framework to address clinical currency and new registrant conditions in the revised Registration Regulation. Staff is continuing work on this topic, as well as entry-to-practise requirements for review at upcoming

Registration Committee meetings. Once recommendations are approved by the Registration Committee, they will be brought forward to Council for review.

INACTIVE TO GENERAL CLASS CHANGE – PANEL PROCESS STREAMLINING

Section 15(4) of the Registration Regulation outlines the requirements for members who hold inactive certificates and who wish to be reissued a general certificate of registration. Where a member does not meet a requirement, the Registration Regulation requires that the member successfully complete a requalification program that has been approved by a panel of the Registration Committee for that purpose.

The College staff presented the Committee with a possible approach to streamlining the inactive to general class change process where a panel referral is required. The goal of streamlining the process is to enhance efficiency and transparency, helping to reduce the processing time for a member who requires a requalification program. The Committee discussed and reviewed the materials presented by the staff and agreed to move forward with the presented approach. Staff will work with legal counsel to finalize a draft policy and propose changes to the risk assessment tool for approval by the Registration Committee.

Committee, panel, membership changes and statistics follow:

Members by Class of Registration (as of September 30, 2020)	Total	%
	Q2 (1042)	Q2
General	737	70
General with new registrant conditions	90	9
Supervised practice	10	1
Inactive	205	20
Transitional	0	0

New Members by Class of Registration	Total		%	
	Q2 (18)	YTD (58)	Q2	YTD
General	0	1	0	2
General with new registrant conditions	16	46	89	79
Supervised practice	2	11	11	19
Inactive	0	0	0	0
Transitional	0	0	0	0

New Members by Route of Entry	Total		%	
	Q2 (18)	YTD (58)	Q2	YTD
Laurentian University graduates	7	20	39	34.5
McMaster University graduates	4	20	22	34.5
Ryerson University graduates	4	12	22	21
International Midwifery Pre-registration Program (IMPP) graduates	2	4	11	7
Out of province certificate holders (midwife applicants) from other Canadian regulated midwifery jurisdictions	1	2	6	3
Former members	0	0	0	0

Panel Referrals	Total	
	Q2	YTD
Total Number of referrals to a panel of the Registration Committee	5	14

Panels Held by Category	Total	
	Q2 (5)	YTD (14)
Application for registration[1]	0	1*
Class change – Inactive to General[2]	5	13
Active practice requirements shortfall[3]	0	0
Re-issuance of a Supervised Practice certificate of registration[4]	0	0
Reinstatement within one year following revocation[5]	0	0
Variation of terms, conditions and limitations[6]	0	0

**Decision not yet rendered –additional information required. Another panel meeting will be held.*

Panel Outcomes by Category		
Panel Outcomes By Application for Registration[1]	Total	
	General	Supervised Practice
	Q2 (0)	YTD (0)
Application approved – Registrar directed to issue certificate of registration	0	0
Application approved – Registrar directed to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel	0	0
Application approved - Registrar directed to issue a certificate of registration if the applicant successfully completes additional training specified by the panel	0	0
Application approved – Registrar directed to impose terms, conditions and limitations on certificate	0	0
Application not approved – Registrar directed to refuse to issue certificate	0	0
Panel Outcomes By Class change – Inactive to General[2]	Total	
	Q2 (5)	YTD (13)
Requalification program approved – General certificate re-issued	5	13
Requalification program approved with supervision required – Supervised Practice certificate issued	0	0
Panel Outcomes By Active Practice Requirements Shortfall[3]	Total	

	Q2 (0)	YTD (0)
Exception granted – extenuating circumstances demonstrated	0	0
Shortfall plan required	0	0
Shortfall plan and undertaking imposing terms, conditions and limitations related to the plan	0	0
Panel Outcomes By Re-issuance of a Supervised Practice certificate of registration[4]	Total	
	Q2 (0)	YTD (0)
Re-issuance approved – supervised practice extended	0	0
Re-issuance not approved	0	0
Panel Outcomes By Reinstatement within one year following revocation[5]	Total	
	Q2 (0)	YTD (0)
Requalification program approved – no supervised practice required	0	0
Requalification program approved –supervised practice required	0	0
Panel Outcomes By Variation of terms, conditions and limitations[6]	Total	
	Q2 (0)	YTD (0)
Application refused	0	0
Registrar directed to remove any term, condition or limitation imposed on the certificate of registration	0	0
Registrar directed to modify terms, conditions or limitations on the certificate of registration	0	0

Timelines: from referral to a panel to a written decision	Total	
	Q2 (5)	YTD (13)
Files closed within 30 days	3	10
Files closed within 60 days	2	3
Files closed beyond 60 days	0	0
Shortest: (reported in number of days)	23	11
Longest: (reported in number of days)	35	40
Average: (reported in number of days)	29	27

Registration Decisions appealed to the Health Professions Appeal and Review Board (HPARB)	Total
	Q2 (1)
Open HPARB appeals as at July 1, 2020 (Appeals carried over)	1
New HPARB appeals (July 1, 2020 to September 30, 2020)	0
Completed HPARB appeals (July 1, 2020 to September 30, 2020)	1*
Open HPARB appeals as at September 30, 2020	0

**Applicant withdrew their request for a review of their application for registration with the College and the Board accepted the withdrawal.*

Of those appeals completed, the number of registration decision appeals that:	Total	
	Q2 (0)	YTD (0)
Confirmed the decision	N/A	0
Required the College to issue a certificate of registration to the applicant upon successful completion of any examinations or training the Registration Committee may specify	N/A	0
Required the Committee to issue a certificate of registration to the applicant, with any terms, conditions and limitations the HPARB considers appropriate	N/A	0
Were referred back for further consideration	N/A	0

Attrition	Total		%	
	Q2	YTD	Q2	YTD
Attrition[7]	19	21	1.8	2

Respectfully Submitted,

Isabelle Milot, RM

Notes:

1. *Applications for registration can include first time (initial) applications and applications for re-registration from former members. If the former member resigned within five years prior to the date of re-application, the Registration Regulation requires them to complete a requalification program that has been approved by the Registration Committee.*

2. *Under the Registration Regulation, members who wish to be re-issued a general certificate of registration and who do not meet one or more of the non-exemptible requirements for a general certificate, with the exception of having to repeat the midwifery education program and the qualifying exam, are required to complete a requalification program that has been approved by a panel of the Registration Committee. Often members will be referred because they do not meet the current clinical experience and active practice requirements for a general certificate.*

3. *It is a condition on every general certificate of registration that the member shall carry on active practice as outlined in the Registration Regulation. Where a member fails to meet these conditions (i.e. has not attended sufficient births in various settings in a specific timeframe), the member is referred to a panel of the Registration Committee to determine if an exception may be granted or if a shortfall plan is required.*

4. *Under the Registration Regulation, a Supervised Practice certificate of registration may only be granted for a period of up to one year. Therefore, if a member has not successfully completed their Plan for Supervised Practice and Evaluation within 12 months of issuance of a supervised practice certificate, the member may request an extension and the certificate may only be re-issued if the Registration Committee approves of it being reissued.*

5. *Where a former member wishes to be reinstated within one year following revocation, under the Registration Regulation, the former member is required to complete a requalification program that has been approved by the Registration Committee.*

6. *Under the Health Professions Procedural Code, Schedule 2 of the Regulated Health Professionals Act, 1991, a member may apply to the Registration Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of a registration proceeding.*

7. *Attrition rate includes the number of midwives who left the profession (e.g. resignation) and former members' certificates that have been suspended/revoked/expired. It does not include inactive members. The rate of attrition is expressed as a percentage.*

QUALITY ASSURANCE COMMITTEE

REPORT TO COUNCIL – Q2
July 1, 2020 - September 30, 2020

Committee Members

Chair	Lilly Martin, RM
Professional	Jan Teevan, RM; Isabelle Milot, RM
Public	Marianna Kaminska; Don Strickland
Non-Council	None

Committee Meetings

August 26, 2020

Panel Meetings

N/A

Trainings

N/A

Items

Exemption Panel Process Approval
The committee approved a process for the approval of exemption requests by staff without requiring a panel. This process will apply to members practising in Expanded Midwifery Care Models who have applied for exemption because the circumstances of their practice model make meeting a QAP requirement impossible.

Attachments:

None

Respectfully submitted,

Lilly Martin, RM

DISCIPLINE COMMITTEE

REPORT TO COUNCIL – Q2

July 1, 2020 - September 30, 2020

Committee Members

Chair	Judith Murray
Professional	Edan Thomas, RM, Maureen Silverman RM, Lisa Nussey, RM Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM
Public	Marianna Kaminska, Peter Aarssen, Donald Stickland, Susan Lewis & John Stasiw
Non-Council	n/a

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Prehearing Conferences Held	0	1	–	–	0
Number of Hearing Days	0	1	–	–	1
Number of Trainings	1	–	–	–	1

Caseload Work of the ICRC

	Q2	YTD
Open files as at July 1, 2020 (Files carried over)	1	NA
Number of new referrals by the ICRC (July 1, 2020 to September 30, 2020)	1	1
Closed files (July 1, 2020 to September 30, 2020)	1	1
Open files as at September 30, 2020	1	NA

Statistics on Closed Cases

Types of Hearings	Q2(1)	YTD
Number of Uncontested Hearings	1	1
Number of hearings that resulted in findings of professional conduct	1	1

Findings of Professional Misconduct	Q2(1)	YTD
Practicing the profession while the registrant is in a conflict of interest	1	1
Engaging in conduct that would reasonably be regarded as conduct unbecoming a midwife	1	1

Engaging in conduct relevant to the practice of the profession that would reasonably be regarded by registrants as unprofessional	1	1

Penalties	Q2(1)	YTD
Reprimand	1	1
Terms, conditions and limitations of the Registrant's certificate of registration requiring the Member to complete remediation	1	1
Costs Award	1	1

Note: One discipline case may result in more than one finding of professional misconduct and/or penalty component.

Amount of time from referral to the written decision	YTD (days)
Range	294
Average	294

Summary of Discipline Committee Decision(s)

Sandra Knight v. CMO

On July 22, 2020, a panel of the Discipline Committee of the College of Midwives of Ontario found that Sandra Knight (the Member) engaged in professional misconduct by practising the profession while the member is in a conflict of interest; engaging in conduct that would reasonably be regarded by members as conduct unbecoming a midwife; and engaging in conduct or performing an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

Publication Ban

The Panel made an order that no person shall publish, broadcast or in any manner disclose the name of the Client or the baby referred to during the hearing or in documents filed at the hearing, held July 22, 2020, or any information that would disclose the identity of the Client or the baby. The publication ban applies to the exhibits filed and to the Panel's decision and reasons.

Please note that this summary has been drafted to comply with the publication ban ordered by the Discipline Committee and therefore some facts that could identify the Client or the baby have been omitted.

Facts

The Member admitted that she engaged in professional misconduct and the Member and the College jointly agreed to the facts that were presented to the panel.

The allegations in this case involved a blurring of professional and personal boundaries.

The Client contacted the Practice through the Practice's online intake form. The Client advised that she had recently learned that she was pregnant. The Client indicated that she wanted to terminate the pregnancy, but she was advised by other health care practitioners that she would not be able to do so. The Client was in a vulnerable position.

The Member contacted the Client and arranged to meet her at a coffee shop. They met on October 12, 2018. The Member informed the client she was not there as a midwife but rather, a woman wanting to help another woman in a time of need. The Client and the Member spoke for approximately 5 hours. During the course of this meeting, the Member discussed various care and treatment options, including midwifery, obstetric care and a Caesarean section. The Member also offered to have a non-professional relationship with the Client.

After this meeting, the Member documented in a narrative note that she offered to stay on call for the Client as a midwife in the event anything urgent occurred since the Client had not had prenatal care since early September.

The Member admits that it was unprofessional to meet the Client at a coffee shop and to discuss the Client's pregnancy and care options in these circumstances.

On October 13, 2018, the Client contacted the Member and complained of pain. The Member advised her to go to the hospital, but the Client refused to go due to past negative experiences. The Member then offered to pick her up and take her to the hospital, and the Client agreed.

While at the hospital, the Member introduced the Client to the other midwife at the practice who would act as the primary midwife if the Client decided to enter midwifery care. The Client indicated that she would like to become a patient of that midwife. That midwife was assisting another patient in active labour and was therefore unable to provide care to the Client at that time.

The Member provided midwifery care to the Client including:

- taking the Client's history;
- completing documentation relating to the Client's care, including the Ontario Perinatal Record;
- ordering lab work;
- prescribing medication to the Client; and
- speaking to the obstetrician about the Client delivering the baby by planned Caesarean section.

On October 15, 2018, the Member documented in the Client's midwifery chart that the Member would have a non-professional relationship with the Client and that the Member would no longer be involved clinically in the Client's care. Thereafter, the Client was cared for by a different midwife at the Practice.

The Member acknowledges that it was unprofessional to offer to have a non-professional relationship with a person in a vulnerable position who was requesting pregnancy-related care from the Practice and to later provide care, even if limited, to that Client.

Findings of Professional Misconduct

The Panel found that the agreed facts supported the findings of professional misconduct.

The Panel determined that the Member was a practising midwife at the time of the events and as such the Member problematically blurred the line between acting as an individual and acting as a midwife in a professional capacity. Firstly, had it not been for the Member being a midwife and working within a midwifery practice at the time, the Member would never have had access to the Client nor would they have been aware of the Client at all. In this respect, when the Member contacted the Client, the Client might have reasonably interpreted that the Member was acting as a midwife responding to her email and not as an individual. The Panel found this problematic and felt that the Member could have reasonably anticipated that this involvement could cross boundaries since their involvement with the Client came through their practice in the first place. The Panel also felt that the Member themselves understood that this could be problematic by initially attempting to clarify to the Client that they were not acting as a midwife.

The Panel agreed that the Member acted unprofessionally in choosing to meet the Client at a coffee shop on October 12, 2018, rather than in their clinic or a more professional setting. While the Member believed that this more casual and public setting was for the Client's comfort and that this would also reinforce the idea that the Member was acting as an individual rather than as a midwife, the discussion that took place in the coffee shop was of a professional and private nature and should have been conducted in a suitable environment to protect the Client's privacy and health information. In discussing health care options with the Client at this time the Panel concluded that the Member blurred the lines between being a private individual who only wanted to help, and being a member of a healthcare profession.

The Member's offer to have a non-professional relationship with the Client put the Member in a conflict of interest right away and would reasonably be regarded by the membership and the public at large as unprofessional. Although the Client stated that they did not feel pressured by the Member's conduct, the appearance to the public may be one of the Member taking advantage of a vulnerable client. The Panel was concerned that these actions led to the perception by the public that midwives are unprofessional or untrustworthy.

With respect to the care provided by the Member to the Client on October 13, 2018, the Panel concluded that this was a conflict of interest and thus constituted professional misconduct. The Panel determined that when the Member agreed to be on call for the Client subsequent to their meeting at the coffee shop, the Member was already in conflict of interest as midwifery community standard is that midwives are on call for people who are already in

their professional care. Thus, the Member offering to be on call for the Client in this case would be perceived by the professional community and midwifery clients as the Member having taken on the professional role for this Client while both parties were contemplating a non-professional relationship as well. It would have been more appropriate for the Member at this time to have provided the Client with another midwife from the practice. It was this on-call provision that led to the Member providing care to this Client on October 13th, 2018. Once the Member met the Client at the hospital and the Client decided to come into midwifery care, the Member should have recused herself and called in another midwife from the practice since the midwife who would ultimately take over care was unavailable at that time.

The fact that the Member had access to the Client's chart and documented in that chart on more than one occasion is problematic. An individual without a professional relationship with this Client would not have had access to the private healthcare information of the Client, nor would they be charting on the record.

The Panel did believe that the Member was trying to act in an altruistic and caring manner and was not trying to take advantage of the situation. The Panel acknowledged that once the Client had decided to officially come into midwifery care and had decided to have a non-professional relationship with the Member, the Member did take steps to remove themselves from the Client's care and to ensure that the Client was taken care of by others within their practice. However, while this was appropriate to do, the Panel found that the Member should have been more aware of the potential conflicts of interest and the blurring of the boundaries that could and in fact did take place.

Penalty

The Panel accepted the parties' Joint Submission as to Penalty and accordingly made the following order:

1. Ms. Knight is required to appear before a panel of the Discipline Committee to be reprimanded, with the fact of the reprimand to appear on the public register of the College;
2. The Registrar is directed to impose the following terms, conditions and limitations on Ms. Knight's certificate of registration:
    a. Within six months of the date of the Discipline Committee's Order, Ms. Knight is required to successfully complete, at her own expense and to the Registrar's satisfaction, an individualized ethics and professionalism course that is pre-approved by the Registrar; and
    b. Within two months of the date of the completion of the above-noted ethics and professionalism course, Ms. Knight is required to prepare and submit a 1,500-word paper, to the satisfaction of the Registrar, in which Ms. Knight demonstrates her reflection on the importance of establishing and maintaining professional boundaries with persons in a vulnerable position; and
3. Ms. Knight is required to pay to the College costs in the amount of $2,500 within 12 months of the date of the Discipline Committee's Order.

The Panel concluded that the proposed penalty was reasonable and in the public interest. The reprimand, individualized ethics and professionalism course, and reflective paper serve the goal of specific deterrence and are rehabilitative in nature. In addition, the reprimand being posted on the public register of the Member protects the public interest and serves as a general deterrent to the membership.

The Panel considered that the Member had no prior discipline issues at the College; the Member cooperated with the College; the Member has acknowledged her behaviour amounted to professional misconduct and accepted responsibility for her actions; and from the Agreed Statement of Facts, her intentions were perceived by the Panel as altruistic.

- Decision and Reasons of the Discipline Committee dated August 5, 2020.

Respectfully Submitted,
Judith Murray

FITNESS TO PRACTISE COMMITTEE

REPORT TO COUNCIL – Q2

July 1, 2020 - September 30, 2020

Committee Members

Chair	Judith Murray
Professional	Edan Thomas, RM, Maureen Silverman RM, Lisa Nussey, RM Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM
Public	Marianna Kaminska, Peter Aarssen, Donald Stickland, Susan Lewis & John Stasiw
Non-Council	n/a

Activities of the Panel

The Committee has not met since the last report to Council.

No referrals from the Inquiries, Complaints and Reports Committee (ICRC) were received since the Committee last reported to Council.

Respectfully Submitted,

Judith Murray

CLIENT RELATIONS COMMITTEE

REPORT TO COUNCIL– Q2
July 1, 2020 - September 30, 2020

Committee Members

Chair	Marianna Kaminska
Professional	Karen McKenzie, RM (as of September 30, 2020)
Public	Pete Aarssen
Non-Council	Alexandra Nikitakis, RM

Committee Meetings

N/A

Panel Meetings/Hearings

N/A

Trainings

N/A

Items

N/A

Attachments:

N/A

Respectfully Submitted,

Marianna Kaminska, Chair

CHAIR'S REPORT

REPORT TO COUNCIL – December 9, 2020
Prepared by: Claire Ramlogan Salanga, RM

1. General Highlights

As we say goodbye to 2020, I have reflected on the challenges this year has presented. From the initial announcement of the pandemic in March to the current second wave, as well as the unjust events surrounding the murder of Mr. George Floyd, we as a society are being forced to take a deeper look at our priorities. These major events have exposed the inequities that exist in many facets of Canadian culture. For all of the negativity that has encompassed us this year, I am certain we will find a positive way forward, together. At the College of Midwives of Ontario, the Registrar-CEO, Directors, and Staff have worked tirelessly to acknowledge, and address identified risks posed by the pandemic, and are developing ways to incorporate an equity, diversity, and inclusion lens to examine and enhance their daily work. As Chair of Council, I would like to commend the CMO team for their outstanding work during this challenging year.

2. Governance

The discourse that surrounds the use of online platforms as a way of conducting business and communicating with others has been analyzed by many experts over the past year. One thought provoking argument proposes that dominant cultural standards can be reinforced through the use of netiquette rules and as a consequence of this maintenance of 'status quo' behaviour, cultural variation can be stifled. Therefore, it is my goal as Chair of Council to find a balance between being guided by standard netiquette rules but also creating spaces to support individuality and human connection. Interestingly, this same sentiment was also echoed in October's post-Council feedback survey. Despite the overwhelming positive comments from members, there were also requests to innovate our current online meetings to somehow mimic the synergy of our previous in-person meetings.

For many organizations the reality is that due to the second wave of the pandemic, meetings will remain online; this will also be the case for our Council meetings, indefinitely. That being said, moving forward we will be trying new and innovative approaches to help humanise the on-line interface. I am hopeful that if we all willing to participate, we can eventually learn what will work best for our group. Council peer reviews that were conducted in early October confirmed my thoughts that our Council members continue to be happy, engaged and fully committed to serving on Council. I am looking forward to another year as Chair and the challenges of creating an online space that supports our group's dynamics.

3. Stakeholder Engagement (e.g. stakeholder meetings, conferences)

1. AOM/CMO Liaison meeting Oct 2, 2020
2. CMRC Board meetings Oct 22 & 23, 2020

3. SPWG meeting #4 & #5 Nov 2 & Dec 2, 2020
4. CMRC EDI Committee Nov 12, 2020
5. System Partner Meeting with MOH Nov 26, 2020
6. Ex-Officio:
    ICRC Committee meeting Nov 17, 2020
    QAC Committee meeting Nov 23, 2020
    Registration Committee meeting Nov 27, 2020

EXECUTIVE COMMITTEE

REPORT TO COUNCIL December 9, 2020

Committee Members

Chair	Claire Ramlogan-Salanga, RM
Professional	Edan Thomas, RM (VC); Claudette Leduc, RM
Public	Don Stickland (VC); Marianna Kaminska

Committee Meetings

November 10, 2020

Panel Meetings/Hearings

N/A

Trainings

N/A

Items

Q2 Statement of Operations

The Q2 financial statements were reviewed in detail by the committee and was approved on behalf of Council. A copy of approved financial statement is attached.

Financial Policy

The committee reviewed a draft of the *Internally Restricted and Unrestricted Net Asset Policy*, a policy developed by staff to address the College's existing net assets. The policy is being brought to Council with the recommendation of approval. A briefing note and draft policy are attached.

Registrar's Evaluation

The committee met with Sam Goodwin, the consultant who will administer the annual assessment of the Registrar. An overview of the process and steps was shared with the committee. Mr. Goodwin will also be presenting to Council at its December 9, 2020 meeting.

Assessment of the External Auditor

The committee completed the Comprehensive Assessment of the External Auditor. This is the first year the Comprehensive Assessment has been conducted by the committee, as only the annual assessment has been done by the committee since the introduction of the assessment

tool in 2016. A draft of the report is attached, and the committee is making the recommendation the Council reappoint Hilborn, LLP as the external financial auditor of the College.

Council Evaluations

The committee reviewed the responses to the 2020 Council Evaluation. Based on the eleven responses received, Council is functioning well, and Council members are engaged with the work of the College. Of particular interest were the responses to where Council could improve. As has been previously discussed at Council, diverse representation on Council and committees was identified as an area for improvement.

An interesting response received from members of Council was with regard to how members of Council relate to each other. This has been year of transition and change amid the ongoing COVID19 pandemic and a big change has been Council meetings moving from being held in-person at the College to remote meetings by videoconference. Numerous Council members expressed finding it is hard to relate and get to know each other because the informal connections that would form organically in an in-person setting isn't as easy to do while online. These informal connections are an important part of creating collegiality and strong dynamic working relationships between members of Council and the Council Chair will be proposing a new process to remote meetings to help facilitate this growth at the December 9th meeting.

The committee also reviewed the results of the Council competency matrix, where Council members responded through self-evaluation their level of knowledge and expertise on an essential list of competencies, personal attributes and skills. Every year, the results of the competency matrix provides a skillset unique to the current composition of Council members and is used to inform the planning and development of Council training days throughout the year. This year's competency matrix identified policy development, public relations and communications, and government and public sector relations as areas where three or more Council members indicated a 'basic' level of understanding. These areas of interest have been used in consideration of the proposed training days planned for the 2021 year which will be presented to Council at the December 9th meeting.

Committee Appointments & Composition

The committee did a review of all eligible appointments to propose committee composition for the upcoming terms. Five new eligible professional non-Council appointments have been received, as well as the two current professional non-Council appointments have applied for re-appointment and continue to be eligible. The College's three current public non-Council appointees have also expressed interest in re-appointment and continue to be eligible. This gave a total of ten eligible candidates for non-Council committee appointments. Creating opportunities for professional and public engagement on College committees is a goal of the College and the committee recommends all eligible applications for appointment. In order to accommodate the increase in committee members, the committee decided to limit appointment of Council members to one or two committees, in addition to everyone's appointment to Discipline and Fitness to Practise, and did their best to accommodate the first or second choice of preferred committee appointments as expressed by Council members on their annual expression of interest form. It was also decided that where possible, members of Executive will not Chair a statutory committee. The committee is excited to propose its first non-Council public member

as a Chair of the Investigations, Complaints and Reports Committee. A full mock-up of the proposed 2020-2021 committee Chairs and composition is attached for Council approval.

Motions:

The following motions are being proposed to Council:

I. That the Executive Committee Report be approved as presented

II. That the eligible non-Council committee candidates:

Professional
- Christi Johnston, RM
- Alexandra Nikitakis, RM
- Maryam Rahimi-Chatri, RM
- Sabrina Blaise, RM
- Sarah Kirkland, RM
- Kristen Wilkenson, RM
- Jessica Raison, RM

Public
- Samantha Heiydt
- Jill Evans
- Sally Lewis

be approved for appointment and that the proposed committee composition be approved as presented.

III. That HIlborn, LLP be renewed as auditor for an annual assessment for the following year.

Attachments:

1. Q2 Statement of Operations
2. Draft Comprehensive Assessment of External Auditor
3. Proposed 2020-2021 Committee Composition
4. Briefing Note – Net Asset Policy
5. Internally Restricted and Unrestricted Net Asset Policy, October 2020

Respectfully Submitted,

Claire Ramlogan-Salanga, RM, Chair

The College of Midwives of Ontario

Q2 Statement of Operations (Fiscal April 1, 2020 - March 31, 2021)

April 1, 2020 -September 30, 2020

	F21 Projected Revenue	F21 Projected Revenue to end of Q2	Q2 Revenue F21	Q2 Revenue F20	Percentage Variance Against Budget
REVENUE					
Membership Fees	$ 2,384,797	$ 1,192,398	$ 1,203,727	$ 970,563	50%
Administration & Other	$ 107,316	$ 53,658	$ 34,330	$ 97,368	32%
Project Funding - Birth Centres	$ 67,121	$ 33,561	$ 33,561	$ 33,065	50%
TOTAL REVENUE	**$ 2,559,233**	**$ 1,279,617**	**$ 1,271,618**	**$ 1,100,996**	**50%**

	F21 Budget	F21 Budget to end of Q2	Q2 Spending F21	Q2 Spending F20	Percentage Variance Against Budget
EXPENSES					
Salaries & Benefits	$ 1,479,847	$ 739,924	$ 621,475	$ 605,888	42%
Professional Fees	$ 116,068	$ 58,034	$ 25,698	$ 15,986	22%
Council and Committee	$ 150,696	$ 75,348	$ 39,844	$ 25,136	26%
Office & General	$ 155,764	$ 77,882	$ 38,496	$ 43,141	25%
Information Technology, Security & Data	$ 145,400	$ 72,700	$ 52,748	$ 45,209	36%
Rent & Utilities	$ 196,764	$ 98,382	$ 96,699	$ 96,719	49%
Conferences, Meeting Attendance & Membership Fees	$ 82,975	$ 41,488	$ 60,360	$ 53,898	73%
Panel & Programs	$ 325,919	$ 162,960	$ 27,794	$ 13,731	9%
Birth Centre Assessment & Support	$ 67,121	$ 33,561	$ 29,168	$ 24,620	43%
Capital Expenditures	$ 43,043	$ 21,522	$ 19,819	$ 18,785	46%
TOTAL EXPENDITURES	**$ 2,763,597**	**$ 1,381,798**	**$ 1,012,102**	**$ 943,113**	**37%**
PROJECTED LOSS	**$ (204,364)**				

ADDITIONAL NOTES

1 An accrual was set aside at the end of the previous fiscal to bring outstanding Professional Conduct matters to their conclusion. Tracking of the spending in this area against the accrual recorded is as follows:

Total Accrual	$ 233,050
Accrual Budget to end of Q2	$ 116,525
Accrual Spending to end of Q2	$ 61,035

Proposed Committee Composition 2020-2021

2020-2021 Slate of Council Members	Executive Committee	ICRC	QAC	Discipline/FTP	Registration	Client Relations
Elected/Appointed	Elected September 30, 2020					
Council Members **Professional Members** 1. Claire Ramlogan-Salanga 2. Edan Thomas 3. Lilly Martin 4. Jan Teevan 5. Maureen Silverman 6. Isabelle Milot 7. Claudette Leduc 8. Karen McKenzie **Public Members** 9. Marianna Kaminska 10. Judith Murray 11. Donald Strickland 12. Peter Aarssen 13. Sarah Baker 14. Vacant 15. Vacant **Non-Council Members** **Professional** 1. Christi Johnston 2. Alexandra Nikitakis 3. Maryam Rahimi-Chatri 4. Sabrina Blaise 5. Sarah Kirkland 6. Kristen Wilkenson 7. Jessica Raison **Public** 1. Samantha Heiydt 2. Jill Evans 3. Sally Lewis	**Chair:** Claire Edan, VC Don, VC Claudette Marianna	**Chair:**Sally (NC) Edan Claudette Maureen Lilly Judith Sarah B **Non- Council** Christi Sarah K Jessica Samantha Jill	**Chair:** Lilly Jan Isabelle Don **Non- Council** Sabrina Kristen Sally	**Chair:** Judith Jan Edan Maureen Lilly Karen Isabelle Claudette Marianna Don Pete Sarah B **Non-Council** Sally	**Chair:** Isabelle Jan Karen Sarah B Pete **Non-Council** Alexandra Maryam Samantha Jill	**Chair:** Peter Marianna Karen Maureen

COMPREHENSIVE ASSESSMENT REPORT TO COUNCIL

Reporting year:	April 1 2019-March 31 2020
Summary observations:	The Executive committee felt that the audit process was overall a very positive one given the change in format due to Covid-19 pandemic. Committee members engaged in a virtual audit overview which allowed them to meet with audit team members and earlier on the year we were able to participate in financial training (Council training day). In addition to attending the auditor presentation at virtual Council, the Executive committee also had the opportunity to speak separately with Blair (Manager), Peter (lead senior auditor) to ensure a high- quality audit occurred. Auditing processes were fully explained and questions were candidly answered. The auditor again appears to have a very professional and positive working relationship with the Director of Operations as well as with the Executive committee members. Both the Engagement letter and the Final Opinion letter gave a detailed explanation of the audit process, with the rendering of a clean Opinion on the financial statements of the College. Having completed the Comprehensive Report for the first time, and the Annual Report for 3 years, Executive is confident the Tool is useful and detailed. We look forward to engaging with the auditing team in the future.
Recommendation to Council – renew auditor or go to tender (FOR APPROVAL BY COUNCIL):	Renew auditor
Recommended audit structure for the following year (FOR APPROVAL BY COUNCIL):	☐ Comprehensive Assessment ☑ Annual Assessment
Any recommended changes to the assessment process for	None

future:	
Recommendations made to the auditor: (In the event that the auditor is to be renewed)	None

BRIEFING NOTE FOR COUNCIL

Subject: Internally Restricted and Unrestricted Net Asset Policy and setting aside the restriction for Investigations and Hearings

Summary

A draft *Internally Restricted and Unrestricted Net Asset Policy* to address its existing net assets is presented to Council. The policy acknowledges that the College is still budgeting annual deficits. This draft policy is being presented to Council after first being discussed at the Executive Committee. The Executive Committee reviewed the policy and approved the policy in principle to be brought forward to Council for approval.

Background

The College, up until 2013-14 fiscal, had only $14,404 in net assets. The College was also financially dependent on the Ministry of Health for a portion of its operating budget through annual grants. With a small membership and therefore limited revenue, the College needed, since its inception in the early 1990s, annual financial support in order to fulfil its mandate to protect the public.

The College's financial independence was identified as a strategic priority in the College's 2014-17 Strategic Plan. In early 2014, the College submitted the first long-term plan to the Ministry that would bring the College to financial self-sufficiency. Although the Ministry did not at that time approve the plan, it did recognize the importance of working with the College toward its financial independence, and as a sign of good faith, allowed the College to retain unspent funds from the annual operating grant (previously unspent funds were returned annually). These funds allowed the College to work toward its financial self-sufficiency by securing net assets. The College also raised membership fees in order to increase revenues and reduce the number of years that deficit budgets were projected.

2019-20 was the first fiscal year the College did not receive a Ministry grant for its operations. The College by this time had secured net assets in sufficient amount that it could, in combination with membership fee increases, chart an independent financial plan forward.

Making Restrictions

The College has, for some time, had a restriction for counselling and therapy (relating to *Bill 87, The Protecting Patients Act, 2017*). It is considered good practice for Colleges to earmark funds for this purpose.

It is normal practice to internally restrict funds for Investigations and Hearings at regulatory colleges. Investigations and Hearings have variable costs and can have cost overruns that cannot always be fully mitigated. The College itself experienced this with a case in 2012-14 that had costs well above 1 million.

Restrictions for other purposes should be limited, and the policy has laid out strict guidelines for additional restrictions.

The College's Current Net Assets

The College currently has $1,587,023 in unrestricted net assets and $16,000 in internally restricted assets for counselling and therapy. Until recently, our financial auditor did not advise restricting further assets, as the College was still running deficit budgets. That said we have agreed the College is now in a financial position to consider such a restriction.

Creating an Internally Restricted and Unrestricted Net Asset Policy is complicated at this time by the fact that the College still projects a few years ahead in which the College will run budget deficits (to be offset by the College's existing net assets). These deficits were expected as the College's revenue climbs to the level of the College's expenses. In its current long-term planning, the College has projected its breakeven year to be 2025-26.

At the time of approval of the 2020-21 budget deficit projections were as follows:

Year	Estimated Loss/Gain at Close of Fiscal	Revised Unrestricted Net Asset Number at Close of Fiscal
2020-21	-$204,364	$1,382,659
2021-22	-$154,544	$1,228,115
2022-23	-$105,856	$1,122,259
2023-24	-$54,055	$1,068,204
2024-25	-$886	$1,067,338

It should be noted that Council only approves a one-year operating budget. A new budget will be submitted for 2021-22. At the time of that submission, it will be clearer how either the College's new 5-year Strategic Plan or altered expense projections will affect the above deficit projections. After receipt of the 2020-21 financial statements, the College will be able to determine if its current assets continue to fall within the unrestricted net asset range established in the Internally Restricted and Unrestricted Net Asset Policy.

Assuming that Council approves the policy and the new Investigations and Hearings restriction, it is important to understand if the College's current financial position satisfies the policy's guidance regarding unrestricted net assets. The College has a current budget of $2,763,567. As a reminder, the policy states the College should hold 3 to 6 months of unrestricted net assets (in this case 690,891 - $1,381,178).

To calculate our current unrestricted net assets, assuming the Council were to make the Investigations and Hearings Restriction, the calculation would be:

current unrestricted – projected deficits – new restriction = unrestricted net assets
1,587,023- $519,705 - $300,000 = $767,318

At the present time the College's unrestricted assets would be of sufficient amount to match the policy.

Key Considerations

The Canadian Revenue Agency's current administrative position suggests that not-for-profits should have three to six months of operating expenses set aside as unrestricted net assets. Restrictions established should have specific purposes. Not-for-profit organizations should abide by this guidance in order to follow best practices. Holding large amounts of net assets in excess of what is recommended could threaten the not-for-profit status of the organization and could be seen as unfair to members who create revenue for the organization through their membership fees.

The attached policy was created after researching best practices and reviewing like organizations' policies. The policy was written and then shared with our external financial auditor for guidance.

Blair MacKenzie from Hilborn LLP reviewed the policy and recommended small changes (which were incorporated) before the policy's presentation. Blair has been involved with various round tables with the Canadian Revenue Agency regarding not-for-profit organizations so is well positioned to provide appropriate guidance to the College. Blair clarified the current administrative position of the Canadian Revenue Agency and reviewed our policy through that lens. He also reviewed our current Investment Policy and found it satisfactory as well.

Recommendations

Council is asked to:

1) Approve the Internally Restricted and Unrestricted Net Asset Policy
2) Internally restrict $300,000 for the Investigations and Hearings Internal Restriction as detailed in the policy

Implementation Date

December 9, 2020 (Council meeting)

Legislative and Other References

N/A

Attachments

Internally Restricted and Unrestricted Net Asset Policy

Submitted by:

Carolyn Doornekamp, Director of Operations

INTERNALLY RESTRICTED AND UNRESTRICTED NET ASSET POLICY

Purpose

To establish internally restricted and unrestricted net assets to provide for the long-term financial stability of the College and to thereby fulfill the mandate of the College to protect the public.

Policy Statement

The College maintains internally restricted and unrestricted net assets in order to cover variable and/or unforeseen expenses.

Internally Restricted Net Assets

Standing internal restrictions are related to professional conduct matters. The College makes best efforts to anticipate the costs associated with professional conduct matters based on past experience and current caseload. However, in the event that the College incurs costs beyond the normal scope of such matters, Council has internally restricted net assets to fund expenses related to these matters as follows:

(1) Investigations and Hearings Internal Restriction
   (a) The Investigations and Hearings Internal Restriction is designed to cover unforeseen expenses such as investigations, discipline hearings, and fitness to practise hearings.
   (b) The amount to be maintained is $300,000.
   (c) In any fiscal year in which the expenses of the activities set out in (a) above exceed the budget, net assets may be transferred from this internal restriction to unrestricted net assets to cover the cost overrun.

(2) Therapy and Counselling Internal Restriction
   (a) The Therapy and Counselling Internal Restriction is designed to cover unforeseen expenses of the program for Funding for Therapy and Counselling.
   (b) The amount to be maintained is $16,000.
   (c) In any fiscal year in which the expenses of the activities set out in (a) above exceed the budget, net assets may be transferred from this internal restriction to unrestricted net assets to cover the cost overrun.

A draw-down of internally restricted net assets related to professional conduct below the established threshold should include, wherever possible, a plan for replenishing the net assets to the established threshold.

Additionally, at the request of Council, other internal restrictions can be set but only for capital projects or strategic initiatives that are specifically identified.

Internal restrictions for strategic initiatives or capital projects should be tied to specific projects or initiatives, approved by a Council motion, and a plan to use the net assets in their entirety within a set timeframe should accompany the restriction. If net assets remain after projects or initiatives reach completion, they will be reallocated to unrestricted net assets.

Unrestricted Net Assets

In addition to internally restricted net assets the College will maintain unrestricted net assets which may be used before internally restricted net assets, to cover other variable and/or unforeseen expenses.

When the College budgets a deficit in its financial planning, the unrestricted net assets should be an amount within 3 and 6 months of the annual operating expense budget, plus net assets in the amount of the deficit.

When the College does not project a deficit in its financial planning, the unrestricted net assets should be an amount within 3 and 6 months of the annual operating expense budget.

In the event that unrestricted net assets (as presented through audited financial statements) fall outside the established range, a plan for returning unrestricted net assets to the range should be implemented by Council.

Accountability

Council is responsible for establishing all restrictions of net assets, and authorizing transfers to and from restrictions. Council is responsible for approving this policy and any alterations to this policy.

The Registrar-CEO has the responsibility of ensuring compliance with this policy.

The Executive Committee will regularly receive reports on net assets and report to Council as it deems necessary but always in situations when the net assets fluctuate outside of what has been established in this policy.

Policy Review Schedule

The Executive Committee will review this policy every three years, or sooner if conditions warrant, and present to Council for their approval any alterations to the policy the Committee deems necessary, or the policy as it stands for renewed approval.

Approved by
Approval date
Implementation Date
Last reviewed and revised

FOR DISCUSSION

BRIEFING NOTE FOR COUNCIL

Subject: Revised Annual Registrar-CEO Performance Evaluation

Background

As per the Executive Committee Terms of Reference, the Executive is responsible for conducting the evaluation of the Registrar-CEO's performance on behalf of Council. The Registrar-CEO undergoes a performance evaluation on an annual basis.

In 2019, the Committee implemented a revised performance evaluation tool and manual. The new tool was used to evaluate the Registrar-CEO's performance in 2019 and there was some feedback from Council members regarding the tool and process. Council requested that the tool be reviewed by a governance consultant to ensure that it was in line with best practices.

Accordingly, the Registrar-CEO reached out to a governance consultant to request a quote for this service, but it was later decided by the Executive to consider expanding the project to also have a consultant administer the performance review on an annual basis. With the proposed project being expanded, this required the College to engage in a procurement process, in accordance with its procurement policy. Sam Goodwin, of Goodwin Consulting was the successful bidder for the project. Mr. Goodwin has a collaborative work style, valuing open and frequent communication between the Registrar-CEO, Chair, and Council. Mr. Goodwin has completed his review of the tool and process, which included individual interviews with the Registrar-CEO and current and former Executive members, and has made his recommendations to the Executive Committee. The Executive Committee supports his recommendations and has invited him to present to Council on December 9th, 2020.

Attachments:

1. Report to CMO Executive (PowerPoint slides)
2. Appendix A – Table of Proposed Changes

Submitted by:

Claire Ramlogan-Salanga, Chair

Report to Executive Committee

College of Midwives

CEO Performance Evaluation Review Recommendations

November 4, 2020

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Purpose of the Project

To provide advice about potential enhancements to the CEO performance evaluation process and tools, and to outline the specific roles and activities that the external facilitator will carry out in the 2020-21 process, as well as the proposed timeline.

Approach

- Interview current and former Executive Committee members, and the CEO to identify any issues, concerns, and opportunities related to the current approach
- Review and assess current policies and practices
- Confirm opportunities – translate into recommendations
- Discussions about recommendations with the Chair, Executive Committee, and CEO

Overview

- CMO has a well-researched, comprehensive set of tools and approaches.
- Overall, satisfaction with the current approach is high, and the relationship with the CEO is strong, transparent, and trust based.
- There are a few opportunities to strengthen the current approach – to address challenges that Council members can face and to encourage more comments, while providing them with more information and insights on which to base their evaluation.
- There is also an opportunity to leverage some other processes related to staff and stakeholder input in order to give Council good ongoing assurance of performance in these areas.
- Also, Council may wish to consider updating and focusing the CEO's performance criteria – to have them in place for the 2021-22 CEO evaluation.

No formal policy changes at this stage – use the upcoming evaluation for 2020-21 as a test

From the interviews

- No major issues or concerns.
- Biggest challenge as a Council member is answering some of the questions – how to answer, what to base the answers on, where to find the information, etc.
- There is a desire to have more comments and insights from Council members in the survey responses.
- There are some concerns about the staff survey – sensitivity and confidentiality with a small staff group.
- Confidence in the current CEO is high because the relationship is well-established. But it was noted that a new CEO might be different. If Council doesn't have that strong trust, or it takes time to build, how can it be sure of performance?

Recommendations

“Current” to “Proposed” format

More detail is available in Appendix A

No formal policy changes at this stage – use the upcoming evaluation for 2020-21 as a test and then revise policies

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Theme: Supporting Council members to assess the CEO's performance

Action: A new CEO Year-End Summary Report specifically for the CEO performance evaluation

Current

- CEO presents an overview of the operational plan results at the December Council meeting – focus is on the operational plan, the categories of which do not align with the performance criteria.
- Council members draw on their recollections, notes, and other documents that have been previously distributed, as they complete the survey.

Proposed

1. The CEO will still present an overview of the operational plan results at the December Council meeting
2. In addition – and specifically for Council to use for the performance evaluation – the CEO will prepare a Year-End Summary Report that provides the CEO's "take" on the year, highs and lows, key successes and accomplishments, etc. aligned to the performance criteria.
3. Executive Committee will review the draft Year-End Summary Report before it goes out to Council to ensure (and provide Council with the assurance of) overall accuracy and completeness.

Theme: Supporting Council members to assess the CEO's performance

Action: A package of key resources to assist Council members in completing the CEO evaluation

Current

- To complete the survey, Council members draw on their notes, recollections, and other documents that have been previously distributed throughout the year.

Proposed

1. Council members will receive a package of resources to assist them in responding to the survey, the key component of which will be the proposed CEO Year-End Summary Report (the main tool for them to use).

2. In addition to this report, the package will include:

    - The overview of the operational plan that the CEO presented at the December Council meeting.
    - Copies of Quarterly Reports presented throughout the year.
    - The report to Council on the results and outcomes of the Organizational Effectiveness Survey.
    - The report to Council on the results of the proposed Stakeholder Engagement survey.

Theme: Supporting Council members to assess the CEO's performance

Action: Provide real-time support to Council members and follow-up

Current

- Council members complete the surveys and the results are compiled by the Chair of Council.

Proposed

1. The expectation is 100% participation by Council members. As part of the survey, they will disclose their identities to the external facilitator for follow-up purposes. Only the facilitator will have access to individual survey input.
2. The external facilitator will be available to answer any questions Council members have as they complete the survey.
3. In addition to their survey input, a Council member might wish to follow-up with the external facilitator directly to provide additional comments and will be able to ask for a conversation.
4. Everyone's communication style is different. Some people might have no difficulty completing the numeric evaluation but would prefer to communicate their comments verbally to the external facilitator – which will be possible at any time during the process.
5. The external facilitator will monitor the survey responses and contact Council members directly to draw out comments and "dig into" any concerns or issues:
    - For example, a Council member might indicate "Needs Improvement" but not provide any comments. The external facilitator will contact them to bring out additional detail.

Theme: Supporting Council members to assess the CEO's performance

Action: Explore and validate themes from the Council member evaluations

Current

- Council members complete the surveys and results are compiled by the Chair of Council.

Proposed

1. Once the Council surveys are completed, the external facilitator will conduct interviews with 4 selected Council members, determined at the beginning of the process in consultation with the Executive Committee.

2. The purpose of the interview will be to explore and validate any themes, issues, or opportunities arising from the survey results.

Theme: Obtaining meaningful staff input

Action: Leveraging the annual Organizational Effectiveness Survey process

Current

- Staff are asked to complete a survey about the CEO's performance at the end of each strategic cycle – every 3-4 years.
- Staff also participate in an Organizational Effectiveness Survey (similar to a "staff engagement survey" each year, which covers much of the same ground.
- The results of the Org Effectiveness survey are shared with the staff and as a group they meet to discuss and identify opportunities to enhance the working environment.
- The Org Effectiveness survey results and outcomes are shared with Executive Committee, but to date have not been shared with Council.

Proposed

1. The results of the Org Effectiveness (OE) Survey can provide Council with good ongoing insight into the CMO working environment.
2. With some minor modifications, this survey would take the place of the Staff Survey in the CEO evaluation process.
3. Each year, the CEO would present the Org Effectiveness survey results and outcomes to Council at the December Council meeting.
4. Council members would draw on the survey results in responding to the CEO performance evaluation survey.
5. The two Directors would participate directly in the CEO evaluation process through a confidential interview with the external facilitator.
6. Staff will still have access to the Whistleblower policy and the right to reach out to the Chair as safety valves related to very significant issues or concerns.

Theme: Obtaining meaningful stakeholder input

Action: A Stakeholder Engagement Survey, and the option for direct outreach to individual stakeholders

Current

- Stakeholder input is obtained at the end of the Strategic Cycle (every 3-4 years).
- Executive Committee identifies the stakeholders to be interviewed and Committee members conduct the interviews.
- The results are shared with Executive Committee members and are part of their discussions about the CEO's performance.

Proposed

1. Management is considering developing a Stakeholder Engagement survey process – with the idea that the survey would be conducted each year.
2. A Stakeholder Engagement survey will give Council good, ongoing insight into stakeholder views and experiences in their engagement with CMO, under the CEO's direction.
3. The results and outcomes of this survey would be presented to Council each year and would also be one of the resources that Council members draw on as they complete the CEO performance evaluation survey.
4. In addition, in any given year (but at a minimum, once every three years), Executive may decide to seek additional stakeholder input, depending on the events and experiences of the past year.
    - The external stakeholders would be selected in consultation with the CEO.
    - The additional stakeholders would be given the choice of a survey or interview. The external facilitator will collect the input and include it in the analysis for Executive Committee.

Theme: supporting Executive Committee to evaluate the CEO

Action: A facilitator's report that integrates all of the input and sets the stage for the Exec-CEO discussion

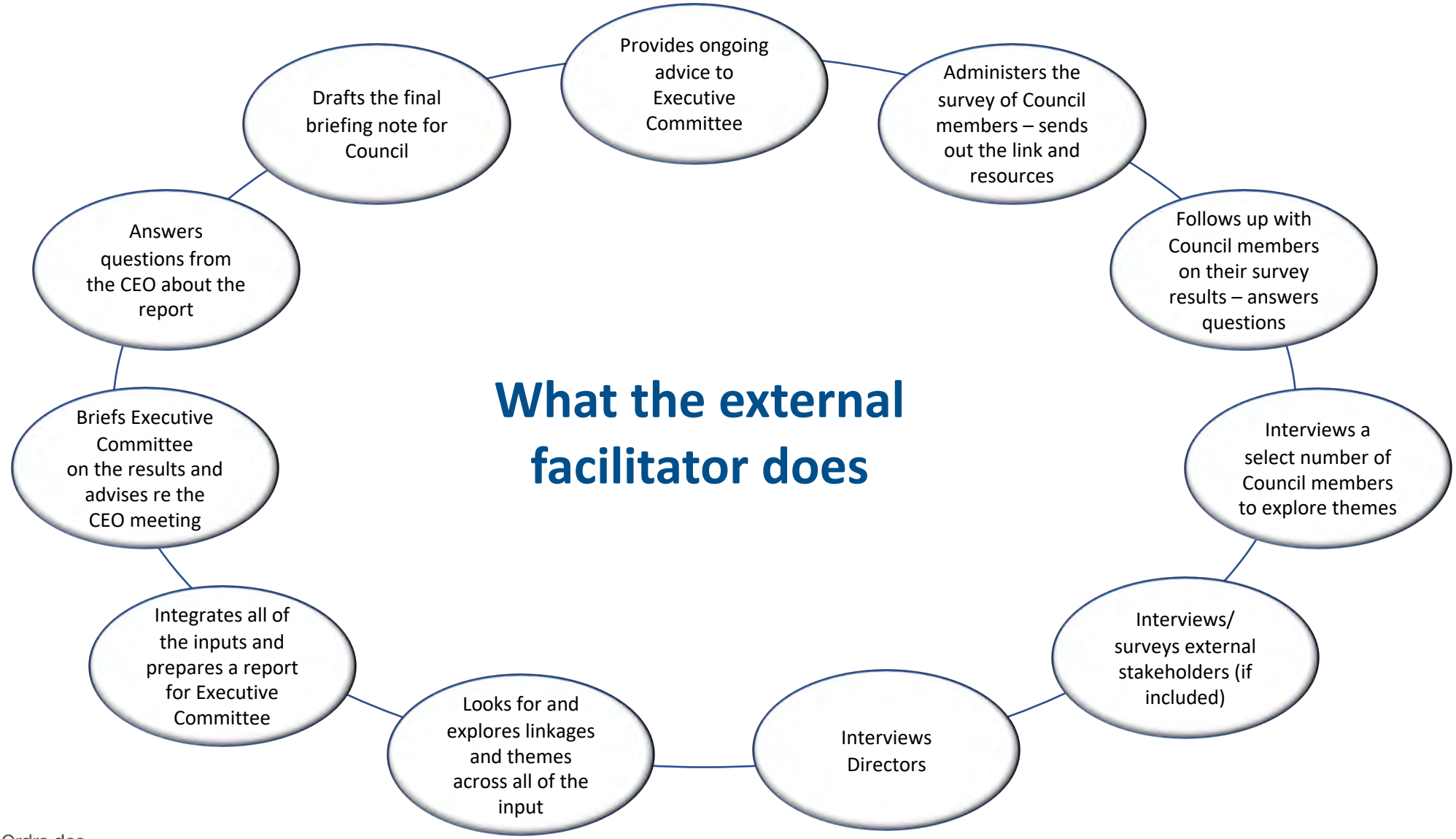
Current

- Chair collects and compiles the inputs and shares with Executive Committee.

Proposed

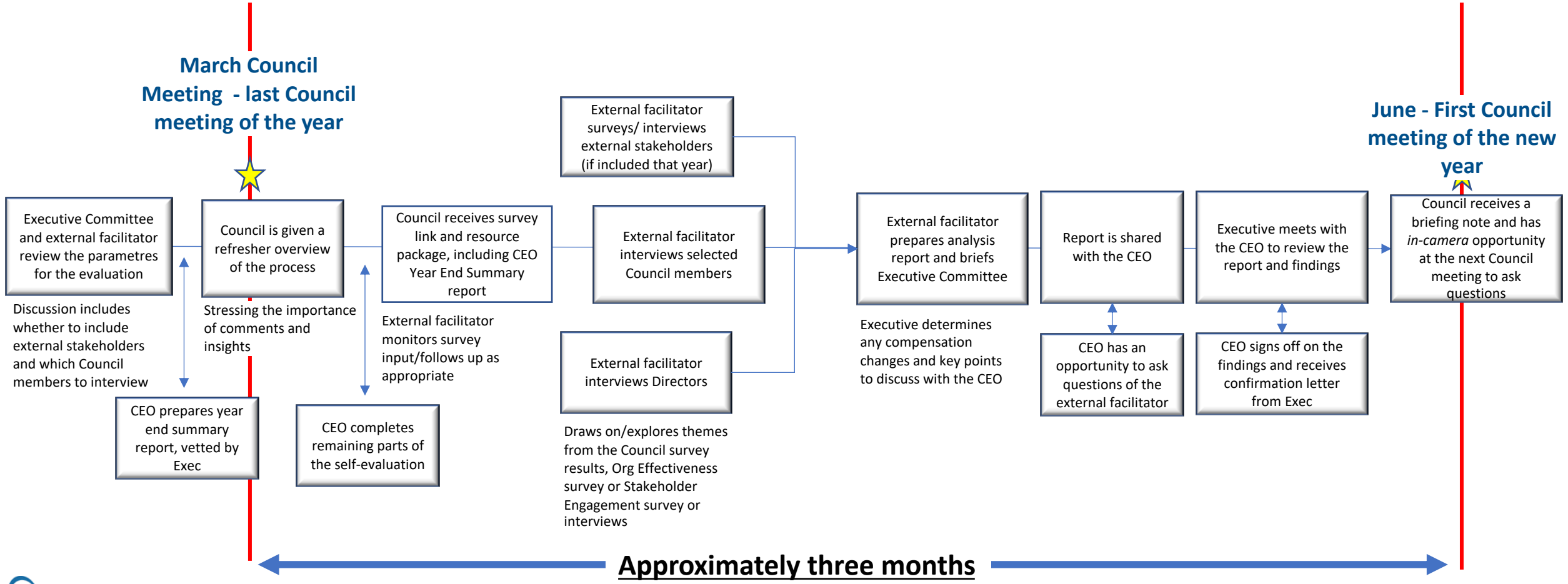
1. The external facilitator prepares a report for Executive Committee, bringing together all of the evaluation inputs, and including analysis of linkages, issues, opportunities, etc.
    - The report is non-identifying. Comments or insights will not attributed to individuals.
    - The report's focus is primarily on common themes and patterns, as opposed to one-off or individual perspectives.
2. The external facilitator meets/briefs Executive Committee on the results, answers questions, explores themes, and assists them in preparing for their meeting with the CEO (notes, questions, etc.)
3. Once Executive Committee has reached a consensus, the report (potentially with revisions) is shared with the CEO, who has an opportunity to ask questions of the external facilitator before meeting with Executive.

What the external facilitator does



Future annual process flow/timeline

(in future, will be April 1 to March 31, given transition to fiscal year)



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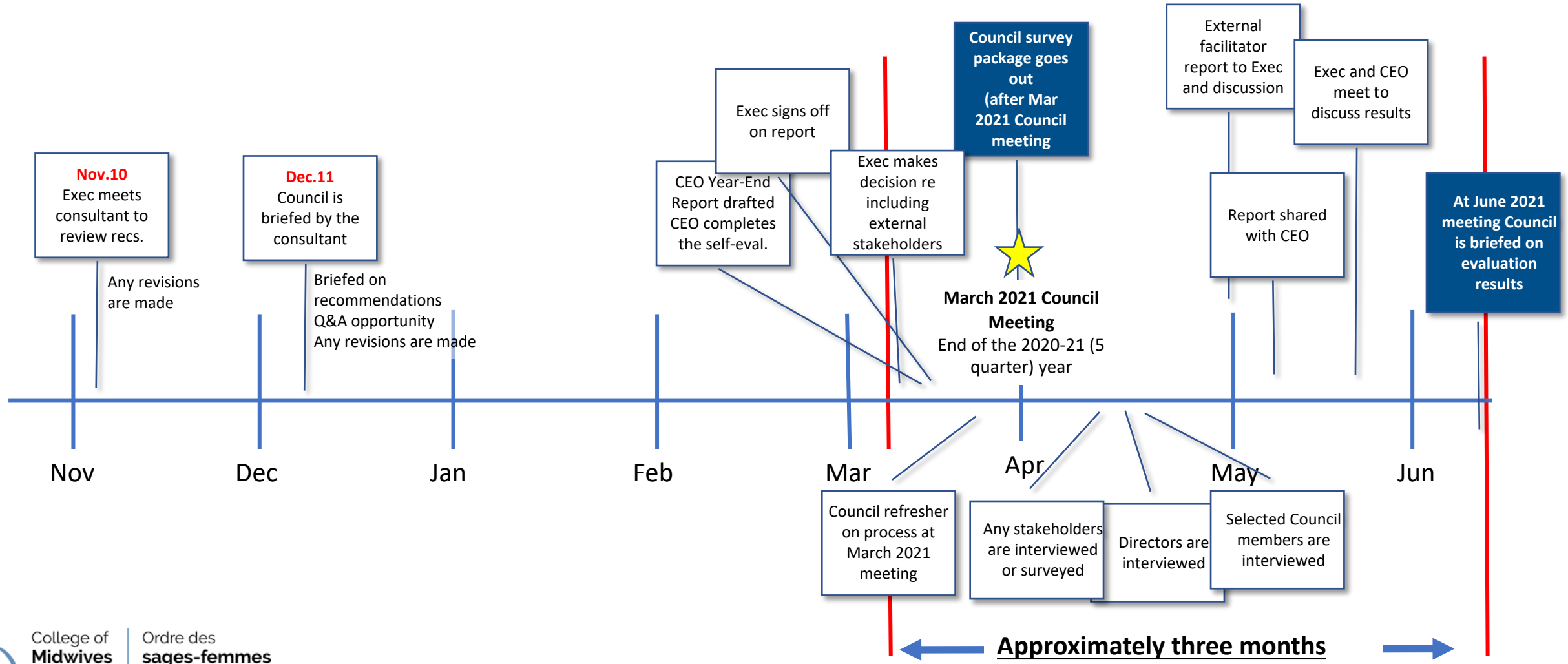
Actual Timeline for **this year**: 2020-21

(will be a **five-quarter** year – **Jan. 1, 2020 to Mar. 31, 2021** – transitioning to the new fiscal year for 2021-22 beginning on April 1, 2021)



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One more recommendation... for the 2021-22 evaluation

- Revisit the CEO performance evaluation criteria in time for the 2021-22 business year
- CEO, with support from the external facilitator, to develop proposed changes for Executive Committee and Council review/sign-off.
    - Less emphasis on technical regulatory requirements (should be “givens”).
    - Potential to put more focus on:
        - ✓ Strategic leadership and vision
        - ✓ Achievement of strategic plan goals and objectives
        - ✓ Council relations (as a component of Governance)

Appendix A – Table of Proposed Changes

Current	Proposed
1. Annual Process Launch	
Exec meeting before last Council meeting to start the process	No change – decide whether/which stakeholders to interview and which Council members to interview
2. Year End Summary for Council	
CEO presents overview of operational plan results at the last Council meeting of the yea	No change
	CEO prepares a separate Year-End Summary Report for Council specific to the performance evaluation – a confidential document that is the key tool for Council members to reference as they prepare for and complete the survey.
3. Council Survey	
Council survey is sent out after the last Council meeting of the year	Council members receive the following from the external facilitator after that last Council meeting of the year: • Survey instrument and instructions. • The CEO's Year-End Summary Report. • Copies of quarterly reports. • Results of/actions arising from the Org Effectiveness Survey.
	Council members have the option to provide direct feedback to the external facilitator, in addition to completing the survey (or instead of a survey, if there are issues related to processing information) and can ask questions of the facilitator as they complete the survey.
	External facilitator receives the survey results directly from Council members – follows up on any anomalies, noteworthy comments, etc.
	External facilitator interviews a selected number of Council members (4) following receipt of the survey results.

4. CEO Self-Evaluation	
CEO completes self-evaluation – submits to President	CEO completes the remaining parts of the self-evaluation: • Numerical assessment. • Professional goals. • Registrar-CEO feedback. Sends to the external facilitator.
5. Stakeholder Input	
Exec members conduct interviews with stakeholders at end of strategic cycle – every 3-4 years	Proposed stakeholder engagement survey to provide Council with ongoing insight into CEO performance re external stakeholders. Results are presented at a regular Council meeting before the end of the year.
	Exec may decide to seek direct stakeholder input in any given year given situational circumstances (including the results of the stakeholder engagement survey) – but at a minimum once every three years.
	Exec seeks input from the CEO re appropriate stakeholders to involve.
	Stakeholders given the opportunity to be interviewed by the external facilitator or to complete a survey – results received by external facilitator.
6. Staff Input	
Staff surveyed re CEO performance – send results to President (every 3-4 years)	Council to be briefed by the CEO on the results and outcomes of the Organizational Effectiveness survey at a regular Council meeting (before the end of the year).
	Council receives results of Organizational Effectiveness Survey as background when completing the CEO performance evaluation survey
	External facilitator interviews Directors
7. Analysis of Evaluation Inputs	
Council President compiles results and shares with Executive Committee	External facilitator prepares analysis for Executive Committee of: • Council survey results. • Council member interviews. • CEO self-evaluation. • Results of Org Effectiveness Survey. • Director interviews. • Stakeholder engagement survey results. • Direct Stakeholder input (if any).

8. Executive Committee Discussion of Results	
Executive meets to review and discuss the results compiled by the President	External facilitator meets with Executive: • Presents the analysis. • Facilitates discussion to reach consensus on the evaluation. • Facilitates discussion of CEO's proposed professional goals. • Identifies key discussion points for meeting with CEO.
9. Meeting to Discuss Results with CEO	
Executive shares evaluation report with the CEO prior to meeting with her.	No change
	CEO has an opportunity to ask questions of the external facilitator.
Executive meets with the CEO to: • Go through the results together. • Answer questions. • Ensure alignment/exchange views. • Identify any concerns or points of contention. • Discuss the CEO's proposed professional goals for the year.	No change
Executive communicates compensation changes to the CEO.	No change
CEO signals their agreement with the results of the assessment – signs the document, which is stored in the personnel file.	No change
President provides CEO with a letter confirming the results of the review and any compensation changes.	No change (External facilitator to draft)
10. In-Camera Briefing for Council	
Executive reports to Council on the results of the evaluation at the next Council meeting	External facilitator prepares confidential briefing note for Council summarizing the results of the review – draft for sign-off by Executive.
	Council receives the confidential briefing note in advance of the next Council meeting.
	At the Council meeting, Council members have an opportunity to ask any questions, request clarifications from Executive

REGISTRAR-CEO QUARTERLY REPORT

REPORT TO COUNCIL – December 9, 2020
Submitted by Kelly Dobbin

The Registrar-CEO is accountable for performance in three main areas:

1. Achievement of Council's strategic objectives as set out in the College's Strategic Plan
2. Compliance with the Registrar-CEO Expectations as set out in approved Governance Polices
3. Fulfillment of the duties and responsibilities of the Registrar in accordance with the *Regulated Health Professions Act, 1991*, other relevant legislation, and the by-laws of the College of Midwives of Ontario.

The Registrar-CEO Quarterly Report assures Council that the College operates effectively and that the Registrar performs in accordance with the expected duties outlined above.

1. Regulatory Highlights

Regulations

As Council is aware, the College formally submitted proposed changes to the Designated Drugs Regulation 884/93 under the *Midwifery Act, 1991* in December 2019. The Ministry completed its own consultation on their Regulatory Registry this summer, and they recently shared the feedback they received with us. The College has responded to the Ministry and we do not anticipate that further changes to the regulation will be required in response to the feedback. However, we are still awaiting confirmation that the need to add Class 32:00 Nonhormonal Contraceptives as well as our concerns with using the American Health Formulary System (AHFS) as the category framework in our regulation will be addressed.

In July 2017, the College made a formal submission to the Ministry to make changes to the General Regulation 335/12 made under the *Midwifery Act*, specifically to amend Part I, Quality Assurance, and request that Part II, Notice of Open Meetings and Hearings, be rescinded because it was outdated and redundant. The Ministry had anticipated making these proposed changes on July 1, 2020, however, due to the pandemic, all Ministry deadlines were delayed. We are pleased to report that the proposed regulation changes have been signed by the College and are now in queue for cabinet approval. Once they are approved the changes will be enacted upon filing.

We have no new news to report on regarding the Professional Misconduct Regulation 388/09, that was formally submitted in 2017.

Work to review and revise the Registration Regulation under the Midwifery Act, 1991, has been underway for some time. The Registration Committee has met a few times throughout 2021 and made its preliminary recommendations regarding clinical currency (to be reviewed and discussed

at the December Council), new registrant conditions, classes of registration and other areas that will inform the development of the revised Registration Regulation. The first draft of the proposed Registration Regulation will be brought to Council for review at its March meeting.

By-laws

With the Ministry supporting the decision of Council to rescind Part II, Notice of Open Hearings, of the General Regulation, the College agreed to add this information to its General By-law to clarify what must be included in a notice of a Council meeting; and that information concerning a hearing by a panel of the Discipline Committee will be given to every person who requests it. In March 2020, Council approved to have the proposed changes circulated for a 60-day public consultation. The consultation was delayed due to the pandemic but was launched in mid-August to members, stakeholders and the public to provide feedback before the October 10, 2020 deadline. No feedback was received. Council is now being asked to approve the proposed Bylaw changes at its December meeting.

Performance Measurement

As Council may recall, the Ministry recently introduced a College Performance Measurement Framework (CPMF), separate from our own Performance Measurement Framework that was approved by Council in June 2019. All Colleges are expected to measure against the Standards (defined as best practices as opposed to minimum expectations) for the calendar year 2020, and to report in a standardized manner by March 31, 2021. All Colleges were recently asked to provide narrative reports to the Ministry in regard to the proposed Domain 3: System Partner. The System Partner domain is defined by the following draft Standards:

- The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.
- The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.
- The College responds in a timely and effective manner to changing public expectations.

The College has submitted its narrative report outlining best practices in these areas. We are scheduled to meet with the Ministry on November 26th to review our submission. A verbal update will be provided to Council at the December meeting.

Programs

In accordance with the *Independent Health Facilities Act* (IHFA), and at the request of the Director of the Independent Health Facilities Branch of the Ministry of Health, the College conducts general and emergent assessments of the two Ontario Midwife-Led Birth Centres (MLBC). The regularly occurring (every 5 years) general assessment of the Toronto Birth Centre is nearly complete, with the onsite assessment having taken place on November 13th. Council should expect a presentation by staff on the general assessment program in March 2021. Emergent assessments can arise outside of the regularly scheduled general assessments at the request of the Ministry. No emergent assessments have been conducted since the last report.

The Registration renewal and quality assurance reporting period closed on October 1, 2020. Due to the pandemic, continuing competency requirements were amended for 2020 to allow midwives to renew their registration and continue practising while ensuring that the public is adequately protected. We continue to monitor the developments and will make other changes as needed.

As part of the College's Quality Assurance Program, the College will be conducting its annual Peer & Practice Assessment Program in 2021. Approximately 10% of members in the General class and Supervised Practice class will be selected for assessment, and those who have been selected will be notified by email in January 2021.

In November, staff conducted two surveys: the practice environment survey and transition to practice as a new midwife survey. The survey about midwifery practice environments was conducted to understand if the College's standards that apply to practice owners are enough or if there is a need for additional standards or guidance to support positive environments. The survey about transitioning to independent practice as a midwife (sent to all midwives who have been in practice for 5 years or less) was conducted to understand more about how midwives transition to practice as supervised midwives or new registrants and what changes might be required to support new midwives develop confidence and engagement in the profession. The findings will also inform our ongoing work on the Registration Regulation. Both surveys closed on November 8th. As per our usual practice, the information collected from the surveys will be analyzed and incorporated into a report that will be shared on our website at a later date.

Standards Review – Phase 2 is now complete and final recommendations will be brought to Council at its December meeting. A number of standards, including the Consultation and Transfer of Care standard will be rescinded, once a guiding document on the midwifery scope of practice is implemented.

Relevant changes were made to the Guide on Compliance with *Personal Health Information Protection Act* (PHIPA) to incorporate amendments made to the Act in 2019. The updated guide is available on the website.

2. Governance

Council & Committee

The newly constituted Executive Committee met on November 10th, 2020 via web conference. Executive members received an orientation related to their Terms of Reference and their associated duties with respect to officer roles, quorum and decision-making, as well as responsibilities in governance, risk, finance, and auditor oversight. The Executive Committee also acts as the body responsible for receiving grievances outlined in the Staff Operations Manual that involve the Registrar, as set out in the Conflict of Interest, Workplace Violence and Harassment, and Disclosure of Wrongdoing (Whistleblower) policies. In addition, for matters related to information or privacy breaches that cannot be satisfactorily resolved by the Information Officer, the Executive Committee acts as the Privacy Working Group to attempt to find a resolution. Lastly, it is the responsibility of the Executive Committee to administer the Registrar's Performance Review on an annual basis. The Executive Committee Terms of Reference and their Assessment

Tools (Assessment of the Auditor and Registrar-CEO Performance Review Manual & Tools) as well as the Staff Operations Manual are available to all Council members at all times in BoardEffect.

The Inquiries, Complaints and Reports Committee (ICRC) held a 2-hour video meeting on November 17, 2020. A large component of this meeting was dedicated to training provided by Erica Richler of Steineke, Maciura, LeBlanc (SML). The refresher training including deliberation and decision-making skills is aimed at assisting the ICRC in dealing effectively with the increased volume of matters before them this year.

Each year, the Executive Committee reviews and makes Committee member and Chair recommendations to Council. The Executive Committee also reviews the applications for non-Council committee members (both public and professional). A recent call for applications was made with the hope to increase diversity of thought, race, abilities, practice model and practice location on committee membership. Under the Executive Committee's report, Council is asked to review and approve recommendations for the 2021 committee appointments and composition.

Policies

A staff review of the Ministry's College Performance Measurement Framework (CPMF) has resulted in the request of Council to make a minor addition to its Governance Policy GP10 to align with best practice. In addition, with the proposed changes around timing of delivery of the Registrar's performance review and the proposed start and length of the new strategic plan, we are recommending minor changes to GP12 and GP11. Accordingly, the Registrar is bringing forward these minor amendments directly to Council as opposed to the Executive Committee (please refer to attachments).

3. Risk Management

Privacy and Security Systems

The College takes privacy and security seriously and has robust systems in place to protect against accidental or intentional (nefarious) breaches. Any time confidential files are shared between the College and registrants, complainants, lawyers, experts, or investigators, we send those files using encrypted document sharing programs. We use a secure virtual boardroom for committee-accessed meeting materials, including registrant-related panel meetings that can include client health records and other highly confidential information. Panel members will use Microsoft SharePoint when providing feedback on confidential decision drafts. Password protected documents sent by email are never used in circumstances where confidential information affects the privacy of clients or registrants. The College's IT and Security Policies add further protection against breaches.

During November the College replaced aging computers that had been in use for over five years. The new units were distributed with robust end point protection installed. Additionally, a new password management software was implemented at the College and staff received training on

the software in mid-November. The new software and end point protection reinforce the College's information technology and security systems.

4. Financial Management

Financial Policies

A draft Internally Restricted and Unrestricted Net Asset Policy is presented to Council for approval. The College is now in a financial position to identify appropriate internal restrictions and set guidelines for unrestricted assets that align with the administrative position of Revenue Canada for not-for-profit organizations. Members can be assured, through this policy, that the College is setting aside appropriate assets not in excess of those required for the organization.

Statement of Operations

The second quarter statement of operations, presented in this Council package, indicates that the College's spending this year thus far is well within what was budgeted. The College team continues to look for cost savings and efficiencies as it progresses through the year.

Budget

The 2021/2022 Budget will come forward to Council in March 2021 for approval, after the Executive Committee reviews it. It should be noted that since we are launching a new 5-Year Strategic Plan on April 1, 2021, the College is also preparing a 5-year costed strategic plan for Council's approval. This costed plan outlines projected annual spending on planned initiatives over 5 years. The budget will also take into consideration the restriction of net assets if Council approves the financial policy before them.

5. Human Resource Management and Staff Leadership

Working During the Pandemic

The College continues to operate a virtual office. During September and early October an option was offered to the staff team to work onsite under the College's Office Re-entry Plan for Optional Work on Premises. The option to work onsite was removed on October 9 as the case numbers climbed. Staff connect often through videoconference in order to maintain connectivity and encourage information sharing. No schedule is currently set for a return to premises.

Performance Reviews

Annual performance reviews of all staff are currently being delivered in accordance with our performance review procedures. Staff are able to provide an evaluation of their supervisors through this process, and that feedback is incorporated into the supervisor evaluations.

Organizational Culture

The annual Organizational Effectiveness survey is underway. The survey identifies areas of success and areas for improvement and allows the College to continually work on its organizational culture. Results are reviewed in detail by the Staff HR committee and highlights and planned initiatives are then presented to the entire staff team as well as Council (in March).

Staff Training and Professional Development

On October 22, 2020, professional conduct staff attended a virtual training session on sexual abuse awareness and trauma informed responses with Joanna Birenbaum and Dr Lori Haskell. The College of Physiotherapists generously provided this training via YouTube livestream. Additionally, a member of our Professional Conduct team attended CLEAR's National Certified Investigator & Inspector Training.

The staff team was invited to attend this year's Canadian Network of Agencies and Regulators annual conference. The majority of the team chose to participate and attended the virtual sessions offered over the last few months.

The College contracted Human Factors North to conduct a virtual training session on ergonomics when working remotely. The session, conducted in October, was well received by the staff team.

The College renewed our contract with KnowBe4 to provide the team with training on the security risks posed by phishing attempts. Mock phishing attempts happen throughout the year, and trigger training opportunities.

Diversity, Equity and Inclusion

An anonymous Diversity, Equity and Inclusion survey was circulated to staff in the early fall. The survey was designed in collaboration with the staff Human Resources Advisory Group. Results of the survey went back to the group for discussion, and then a presentation on the results of the survey took place at a staff meeting in October. The results of the survey were positive.

Before the end of fiscal the College intends to offer staff a group training on Diversity, Equity and Inclusion to both help identify any thus far unidentified areas that could be improved upon and increase staff knowledge in this area.

6. Stakeholder and Media Relations

The College engages with other health regulatory colleges and other stakeholders, in a meaningful way and on a regular basis. We recognize that we cannot effectively fulfill our mandate of regulating in the public interest without thoughtful engagement with stakeholders. We believe that we do better working with others, and that maintaining quality relationships with our stakeholders will enable us to achieve better regulatory outcomes. We recognize the limits of our own statutory powers and responsibilities. Our focus is always on the needs of the clients and the public and by building a comprehensive stakeholder engagement we will ensure that issues are

dealt with by the most appropriate organization rather than simply falling outside our remit. More information on our Stakeholder Engagement Strategy can be found on our website.

Communications

Over the last few months, the College closed two consultations that were launched in the previous quarter about changes to the College's General By-law and for Phase 2 of the standards review. The deadline to provide feedback to the consultation about Phase 2 of the Standards Review was extended by a week, in order to allow for more feedback to be submitted. Email reminders were sent out to members, stakeholders, and the public advising of this deadline change and reminding them to provide feedback.

Shortly after these consultations were closed, the College launched two surveys. One survey for all members about practice environments and another for members who had been registered for five years or less about transitioning to practice as new registrants. These surveys were closed in early November.

The Health Profession Regulators of Ontario (HPRO)'s Communications Committee continues to publish articles in the Zoomer newsletter. Articles were timely with topics about how health professionals are keeping their patients and clients safe during the pandemic.

Ministry of Health

The Registrar continues to attend weekly meetings with the Ministry's Emergency Operations Centre to receive updates related to COVID-19, including worldwide, national and provincial case numbers as well as discussion of all Chief Medical Officer of Health Directives, Provincial Orders and guidance documents. When appropriate, this information is communicated to our staff and registrants.

Regulatory Sector

Staff attend regular Health Profession Regulators of Ontario (HPRO) meetings to share information related to emerging issues such as the pandemic, communications, Anti-BIPOC Racism, and the College Performance Measurement Framework (CPMF).

The Registrar continues to serve as an Executive Committee member (Treasurer) of the Canadian Midwifery Regulators Council (CMRC) and as a member of the CMRC's Canadian Midwifery Registration Exam (CMRE) Committee. Both committees meet regularly throughout the year by videoconference.

Midwifery Sector

The College engages regularly with all midwifery regulators in Canada, a total of nine provinces and three territories (only PEI remains unregulated) through its membership with the Canadian Midwifery Regulators Council (CMRC). Its mission is "to encourage excellence among Canadian midwifery regulatory authorities through collaboration, harmonization and best practice". It achieves this by maintaining and administering the national Canadian Midwifery Registration

Examination (CMRE), participating in the accreditation process of Canadian Baccalaureate Midwifery Education Programs, setting Canadian competencies for midwives, and developing consistent registration and professional practice standards and/or procedures which is the focus of its standing committees.

The College's Registrar is a Director and elected Treasurer of the CMRC, and Council Chair participates at Board meetings and on the Equity, Diversity and Inclusion working group. College staff serve on several committees and working groups, including Registration Affairs and Professional Practice.

Some significant achievements this past year included the substantial review and revision of the Canadian Competencies for Midwives which outline the knowledge, skills and abilities expected of entry-level midwives in Canada. The foundational national competencies were established nearly two decades ago and, with its revised governance and organizational structure, the CMRC was able to undertake this necessary work again. College staff participated on the advisory committee and were responsible for working closely with Yardstick Assessment Strategies in its drafting and validation. The Competencies are expected to be approved this year and a project to revise the blueprint for the CMRE will then be undertaken and completed in 2021.

The CMRE Committee worked on behalf of the CMRC to manage the challenges that were faced due to COVID-19. The committee, on which the Registrar is an active member, made the necessary decision to postpone the in-person writing of the national exam that was set to be delivered in May 2020. This decision was well-coordinated with all provincial/territorial regulatory bodies as each were impacted differently due to their specific legislation, regulations or by-laws that governed the exam requirement for applicants. The committee continued to meet regularly throughout the year to determine if the exam could be delivered online and remotely and yet still be valid and secure. Messaging to all regulators and exam candidates was consistent and frequent. In the end, the committee made the decision to increase the number of locations the exam was to be delivered (to minimize large gatherings) and, in some locations, administered the exam in private hotel rooms to ensure safety of candidates. The exam was successfully delivered on October 29th across Canada. The committee continues to explore its options for online exams, which has been a proposed project for several years but is waiting for federal funding to assist with implementation.

Another noteworthy accomplishment is the working relationship the CMRC has with the Canadian Association of Midwifery Education (CAMEd). The Accreditation Council of CAMEd is responsible for accrediting Midwifery Education Programs in Canada, a newly established process. The College Registrar is the individual appointed to represent the CMRC on that Council. Two Ontario universities have successfully achieved accreditation and the third program is undergoing its assessment now. College staff participated in two onsite visits and one that was delivered remotely to ensure regulatory expectations were met and to assure the CMRC that the process is fair, impartial, objective and transparent. Once all Midwifery Education Programs have had the opportunity to be assessed, the CMRC will recognize those that achieved accreditation, allowing provincial and territorial regulators to rely on this process for their own jurisdictional recognition processes. This process results in achieving consistent program standards and a fair and transparent system for recognition.

Attachments:

1. Briefing Note: Governance Policy amendments
2. Governance Process Policy 10 (proposed amendments)
3. Governance Process Policy 11 (proposed amendments)
4. Governance Process Policy 12 (proposed amendments)

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Governance Policy amendments

Background

A staff review of the Ministry's College Performance Measurement Framework (CPMF) has resulted in the request of Council to make a minor addition to its Governance Policy GP10 to align with best practice. In addition, with the proposed changes around the timing of delivery of the Registrar's performance review and the proposed start and length of the new strategic plan, we are recommending minor changes to GP12 and GP11. Accordingly, the Registrar is bringing forward these minor amendments directly to Council, as opposed to the Executive Committee.

Key Considerations

1. Governance Policy GP10 - Governance Evaluation.

While Council reliably conducts an annual evaluation of its own performance, it is recommended that it also undergoes a third-party assessment of its effectiveness at least once every three years. This policy change will be easy to meet as Council can engage Goodwin Consulting to assist with this work.

2. Governance Policy GP11 – Commitment to Strategic Planning

The current governance policy requires Council to develop a strategic plan at least every three years. Council has already approved the extension of our current strategic plan to four years and the Strategic Planning Working Group is now recommending a five-year strategic cycle. It is recommended that we amend this policy to state that Council will develop a strategic plan every three to five years.

3. Governance Policy GP12 – Council's Annual Planning Cycle

The College previously used calendar years as the start and end dates for its strategic plans. The current strategic plan will end on March 30th, 2021 and, going forward, all strategic plans will be closely linked to our fiscal years, therefore the delivery of the final operational plan report should be moved to the 3rd meeting of the year (typically March) to align with this timing. In addition, since the Registrar's performance review should also align with the strategic/fiscal year, it is recommended that we change the timing of the delivery and report to Council to the 4th meeting of the year (typically June).

Recommendations

The following motion is submitted for approval:

To approve the proposed changes to GP10, GP11 and GP12.

Implementation Date

Immediately upon approval

Legislative and Other References

None

Attachments

Governance Policy 10 (proposed amendments)
Governance Policy 11 (proposed amendments)
Governance Policy 12 (proposed amendments)

Submitted by:

Kelly Dobbin, Registrar-CEO

Policy Type:	**Governance Process**
Policy Title:	**Governance Evaluation**
Reference:	**GP10**
Date approved:	**December 9, 2020; June 24, 2020; October 13, 2016; November 21, 2014**

Council will evaluate its effectiveness on an annual basis.

Accordingly,

1. Council will evaluate its own performance on the responsibilities highlighted in the Governance Process Policies and Council Registrar-CEO Linkage policies.
2. The Executive Committee will recommend an evaluation process to Council for their approval.
3. A third-party assessment of Council's effectiveness will be conducted at least once every three years.

Policy Type:	**Governance Process**
Policy Title:	**Commitment to Strategic Planning**
Reference:	**GP11**
Date approved:	**December 9, 2020; June 24, 2020; October 13, 2016; November 21, 2014**

It is the policy of the College to ensure the existence of a timely and appropriate strategic plan, prepared in concert with Council and staff and monitored regularly and consistently.

Accordingly,

1. At least every three to five years, Council will dedicate a portion of its resources to the development of a strategic plan.
2. All members of Council together with the Registrar (and other staff as appropriate) participate in a strategic planning process agreed to by Council.

Policy Type:	**Governance Process**
Policy Title:	**Council's Annual Planning Cycle**
Reference:	**GP12**
Date approved:	**December 9, 2020; June 24, 2020; October 13, 2016; November 19, 2015; November 21, 2014**

Council adopts an annual planning cycle to optimize its effectiveness in governing, directing and fulfilling its regulatory function.

Accordingly,

1. Council meets, in person, a minimum of three (3) times each year in compliance with the By-laws, however, Council will meet four (4) times each year. Under extraordinary circumstances, or when additional meeting may be required, meetings may be held by teleconference or by other electronic means.
2. At each meeting, Council will:
    a. Review the Registrar's monitoring report, including the most recent quarterly financial report
    b. Review reports for Committees as appropriate
3. Prior to its first meeting, Council conducts its Orientation of Council Members
4. At each meeting, Council will perform the following additional functions, in accordance with the following schedule:
    a. Meeting #1 (post-elections)
        i. Annual Conflict of interest declaration, and Confidentiality and Code of Conduct agreements.
        ii. Approval of slate of Council members
        iii. Annual election of Executive Committee
    b. Meeting #2
        i. Approval of Committee membership and composition
        ii. Annual Council Evaluation report and Education Plan
    c. Meeting #3
        i. Report to Council on Annual Operational Plan
        ii. Approval of Annual Budget
        iii. Approval of Annual Operational Plan
    d. Meeting #4
        i. Annual Report
        ii. Report to Council on Registrar's Performance Review
        iii. Review and approval of financial conditions (Auditor's Report and Audited Financial Statements).
5. Council will review its governance policies at least once every three to five years.

Moved down [1]: <#>Report to Council on Annual Operational Plan¶

Moved (insertion) [1]

Moved down [2]: <#>Report to Council on Registrar's Performance Review¶

Moved (insertion) [2]

BRIEFING NOTE FOR COUNCIL

Subject: Amendments to the General By-law

Background

In July 2017, the College made a submission to the Ministry to request that Part II of the General Regulation made under the Midwifery Act called Notice of Open Meetings and Hearings be rescinded. This submission also requested amendments to the College's Quality Assurance Program.

Many of the provisions included in the regulation were outdated and required revisions. For example, s. 14.2 of the regulation required that the College publish notice of every Council meeting "no less than 14 days before the date of the meeting in a daily newspaper of general circulation throughout Ontario". Other provisions included in the regulation required that the College provide certain types of information relating to a hearing by a panel of the Discipline Committee upon request.

The College was informed by the Ministry that they would be willing to rescind Part II of the regulation on the condition that the College agrees to add this information to its General By-law to clarify what must be included in a notice of a Council meeting; and that information concerning a hearing by a panel of the Discipline Committee will be given to every person who requests it.

In March 2020, Council approved to have the proposed changes circulated for a 60-day public consultation. The consultation was delayed due to the pandemic but was launched in mid-August to members, stakeholders and the public to provide feedback before the October 10, 2020 deadline. No feedback was received.

Key Considerations

The below comparison table outlines what information currently exists in the General regulation and proposed sections to be added to the General By-law. Once approved these new sections will be added to Article 7 of the General By-law: *Meetings of Council and Committees.*

Existing provisions in the General Regulation	Proposed provisions to the added to Article 7 of the General By-law
Council Meetings Notice requirement	Notice of Council Meetings

14. (1) The Registrar shall ensure that notice of every council meeting that is required to be open to the public under the Act is given in accordance with this section. O. Reg. 335/12, s. 14 (1).	1. The Registrar shall ensure that notice of every council meeting that is required to be open to the public is posted on the College's website at least 14 days before a regular Council meeting and as soon as reasonably possible before a special Council meeting.
(2) The notice shall be published no less than 14 days before the date of the meeting in a daily newspaper of general circulation throughout Ontario. O. Reg. 335/12, s. 14 (2).	*Repeal*
(3) The notice shall be in English and French. O. Reg. 335/12, s. 14 (3).	2. The notice shall be provided in English and French.
(4) The notice shall include the intended date, time and place of the meeting and a statement of the purpose of the meeting. O. Reg. 335/12, s. 14 (4).	3. The notice shall include the intended date, time, and place of the meeting
(5) The Registrar shall give a copy of the notice to every person who requests it. O. Reg. 335/12, s. 14 (5).	4. The Registrar shall give a copy of the notice to every person who requests it.
Discipline Committee Hearings **Provision of information**	**Provision of Information Regarding Discipline Committee Hearings**
15. (1) The Registrar shall ensure that information concerning a hearing by a panel of the Discipline Committee respecting allegations of professional misconduct or incompetence by a member is given to every person who requests it, (a) at least 30 days before the intended date of the hearing, if possible; or (b) for requests made less than 30 days before the meeting, as soon as reasonably possible after the request is made. O. Reg. 335/12, s. 15 (1).	1. The Registrar shall ensure that information concerning a hearing by a panel of the Discipline Committee respecting allegations of professional misconduct or incompetence by a member is given to every person who requests it, a. at least 30 days before the intended date of the hearing, if possible; or b. for requests made less than 30 days before the meeting, as soon as reasonably possible after the request is made.
(2) The information shall be available in English and French. O. Reg. 335/12, s. 15 (2).	2. The information shall be available in English or French as requested.
(3) The information shall include, (a) the name of the member against whom the allegations have been made;	3. The information shall include, a. the name of the member against whom the allegations have been made

(b) the member's principal place of practice; (c) the intended date, time and place of the hearing; and (d) a statement of the purpose of the hearing. O. Reg. 335/12, s. 15 (3).	b. the member's principal place of practice; c. the intended date, time and place of the hearing; and d. a statement of the purpose of the hearing e. a notation that the hearing is open to the public. If the panel makes an order that the public be excluded from a hearing or any part of it, a notation to that effect.

Recommendations

That Council approve the proposed changes to the General By-law.

Implementation Date

Immediately upon approval

Legislative and Other References

General Regulation under the *Midwifery Act, 1991*

Attachments

1. Proposed By-law- clean copy

Submitted by:

Kelly Dobbin, Registrar-CEO

[to be added to Article 7 of the General Bylaw – Meetings of Council and Committees]

Notice of Council Meetings

1. The Registrar shall ensure that notice of every council meeting that is required to be open to the public posted on the College's website at least 14 days before a regular Council meeting and as soon as reasonably possible days before a special Council meeting.
   a) The notice shall be provided in English and French; and
   b) The notice shall include the intended date, time and place of the meeting.
2. The Registrar shall give a copy of the notice to every person who requests it.

Provision of Information Regarding Discipline Committee Hearings

1. The Registrar shall ensure that information concerning a hearing by a panel of the Discipline Committee respecting allegations of professional misconduct or incompetence by a member is given to every person who requests it,
   a) at least 30 days before the intended date of the hearing, if possible; or
   b) for requests made less than 30 days before the meeting, as soon as reasonably possible after the request is made.
2. The information shall be available in English or French as requested.
3. The information shall include,
   c) the name of the member against whom the allegations have been made
   d) the member's principal place of practice;
   e) the intended date, time and place of the hearing;
   f) a statement of the purpose of the hearing; and
   g) a notation that the hearing is open to the public. If the panel makes an order that the public be excluded from a hearing or any part of it, a notation to that effect.

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Strategic Plan 2021-2026

Background

At its December 2019 meeting, Council set up a Strategic Planning Working Group (Working Group) to lead Council in setting the overall strategic direction of the College beginning April 1, 2021. The Working Group is comprised of two professional members, two public members (one public member's term ended in June), and the Council Chair. The Registrar and the Director of Regulatory Affairs supported the work of the Working Group.

Under the authority delegated to it by the Council, the Working Group was responsible for the oversight of the strategic planning process, that included the following deliverables:

1. Review of the College's strategic framework, including the vision, mission, regulatory outcomes, and the guiding principles
2. Development of a Strategic Plan by:
    a. Reviewing the College's Register and risk assessment matrix
    b. Developing mitigating strategies based on the risks identified in the risk matrix
    c. Synthesizing the results and recommending
        i. Strategic priorities for the next 3-5 years
        ii. How the College will achieve its priorities
        iii. How the College will measure its success
3. Organizing and leading a Council Strategic Planning Day, scheduled for December 8th, 2020 to finalize the strategic plan.

The Working Group met five times throughout 2020 and presented regular reports to Council, including the results of risk assessment and the emerging themes that would inform the new strategy.

Key Considerations

1. Strategic Framework

Strategic Framework is a high-level statement that describes the College's vision, mission, regulatory outcomes key priorities over the next few years. It also includes our guiding principles – the values that underpin our work as an organization and our relationships with external stakeholders, including the public and midwives.

Vision and Mission Statements

The College's vision and mission statements (provided below) were developed in 2016 as part of the Strategic Plan 2017-2020. Both statements were reviewed by the Working Group and no changes are recommended.

Our Vision: Inspiring trust & confidence in midwifery by leading in regulatory excellence.

Our Mission: Regulating midwifery in the public interest.

Guiding Principles

The College's guiding principles were developed in 2016 as part of the Strategic Plan 2017-2020. They were reviewed by the Working Group and the following changes are recommended. The changes seek to incorporate the principle of equity, diversity and inclusion into the existing guiding principles.

Current Version	Proposed Version
Accountability We make fair, consistent and defensible decisions	Accountability We make fair, consistent and defensible decisions, incorporating diverse and inclusive views
	Equity We identify, remove and prevent systemic inequities
Transparency We act openly to enhance accountability	Transparency We act openly and honestly to enhance accountability
Integrity We act with respect, fairness and honesty	Integrity We act with humility and respect and apply a lens of social justice to our work
Proportionality We allocate resources proportionate to the risk posed to our regulatory outcomes	Proportionality We allocate resources proportionate to the risk posed to our regulatory outcomes
Innovation We translate opportunity into organizational value	Innovation We translate opportunity into organizational value

Regulatory Outcomes

The College's regulatory outcomes were initially developed in 2016 as part of the 2017-2020 Strategic Plan. These outcomes are compatible with the duty and the objectives of the College as set out in the *Regulated Health Professions Act, 1991,* and specify the desired results that we intend to achieve in fulfilling our public protection mandate.

The regulatory outcomes were reviewed by the Working Group and the following changes are recommended:

#	Current version	Proposed version
1	Clients and the public can be confident that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care.	No change proposed
2	Clients and the public can be confident that midwives practise the profession with honesty and integrity and regard their responsibility to the client as paramount.	No change proposed
3	Clients and the public can be confident that midwives maintain boundaries between professional and non-professional relationships.	Rescind. Any boundary violation is an ethical issue and is adequately captured under outcome #2.
4	Clients are safeguarded from sexual abuse from midwives.	Rescind. Sexual abuse is an integrity issue and is adequately captured under outcome #2.
5	Clients can expect midwives to facilitate their choice and autonomy in decision-making.	Rescind. This is adequately captured under outcome #1. Informed choice is a standard of the profession and so *possessing and maintaining knowledge, skills and behaviours relevant to their professional practice* involves maintaining the standards of the profession.
6	Clients and the public can be confident that midwives demonstrate accountability by complying with legislative and regulatory requirements.	No change proposed

7	Clients and the public can expect midwives to practise free of a condition that prevents them from providing safe care.	Rescind. This is adequately captured under outcomes #1 and #2.
8	Clients and the public trust that the College of Midwives of Ontario regulates in the public interest.	No change proposed.

2. Strategic Priorities

As a regulatory body, it is imperative for the College to ensure that its regulatory activities remain focused on risks to the public. Risk-based regulation, the College's adopted model of regulation, is an international standard for regulators in many industries, including in the area of professional regulation, where the regulator has finite resources and so cannot detect and eliminate risk completely. It is premised on the idea that no matter what safeguards are put in place, zero risk is impossible to achieve. The risk-based approach allows a regulator to proactively reduce the risks posed by targeting its activities at the greatest areas of need. This approach ensures that regulatory activities and resources are prioritized and applied proportionately. Part of being a risk-based regulator means that strategic goals and subsequently proposed programs and day-to-day activities are guided by focusing activity and attention on issues that were identified as high priority risks for the organization.

How do we identify risks?

In 2017, as part of implementing risk-based regulation, the College created a Risk Register in order to ensure consistency in the way in which risks are identified and to have a comprehensive picture of our risk exposures across all core areas of regulatory activity. The Risk Register was not designed to be exhaustive. It is a living document that evolves as new risks emerge and as the regulatory/operating environment changes.

The College Risk Register groups all identified risks into the following three categories:

1. External Risks: Risks arising from external developments that are outside of College control
2. Midwife practice risks: Risks that an individual midwife practises or acts in a way that may negatively impact midwifery clients or the public interest.
3. Organizational Risks: Risks arising from the College's internal systems and processes.

How do we assess risks and create a risk assessment matrix?

A risk assessment matrix is an important part of the College's risk management decision-making process. The goal is to rank the risks to determine priority. Assessment is about two things: the likelihood that the event will happen and how severe is the outcome of the event. Likelihood and impact both receive a score using a similar scale. The risk level is then calculated from the two scores. For example, a risk with high likelihood and high impact will rank higher than a risk with low likelihood and medium impact. This exercise

leads to a list of risks ranked according to their combined score of likelihood and impact which then leads to identifying mitigating strategies and deciding what action to take. It is the risk tolerance of the organization that will ultimately determine the type and extent of action taken.

What did our 2020 risk assessment show?

The following risks 1-6 were identified as high priority through this exercise. Risk #7 is a newly identified and overarching risk that also needs managing at this time. The College's Risk Assessment Matrix is attached for your reference.

#	High Priority Risks	Level
1	Risks arising from changes in the midwifery environment that may affect midwifery practice.	
2	Risks arising from a lack of adequate training, including bridging and remedial opportunities for midwives with identified gaps and deficiencies in professional knowledge.	
3	Risk that a midwife does not maintain the knowledge and clinical skills necessary to provide safe and effective care to clients	
4	Risk that a midwife fails to meet legislative or regulatory requirements	
5	Risk that the College grants eligibility to (re)enter practice to an individual who does not have the knowledge & skills to practice safely, ethically and competently	
6	Risk arising from a lack of data and records mismanagement	
7.	Risk arising from increased expectations of information, openness in decision-making and demonstrating our value as the regulator	

Based on the above, the following priorities have been identified by the Working Group for the College's Strategic Plan 2021-2026. As noted above, part of being a risk-based regulator means that strategic priorities must be focused on the issues that were identified as high priority risks for the organization.

Strategic Priority 1: Regulation that enables the midwifery profession to evolve

Develop a responsive regulatory framework, without relying on legislative change, that promotes high standards of care and enables midwives to deliver good practice regardless of midwifery practice model, individual practice environment, or practice setting.

Strategic Priority 2: Effective use of data to identify and act on existing and emerging risks

Make better use of data about midwifery practice to identify, analyze and understand trends and areas of risk to the public to be able to maintain an effective system of regulation.

Strategic Priority 3: Building engagement and fostering trust with the public and the profession

Deliver services and demonstrate our role and value as the regulator through greater engagement, openness and accessibility so that the public and the profession have confidence that we fulfill our public protection mandate effectively, efficiently and fairly.

The attached draft of the Strategic Plan describes in detail the key initiatives through which the College will achieve its strategic priorities and will measure its success.

3. Next Steps

With approval of the Strategic Plan 2021-2026, the Working Group will dissolve. Staff will continue the required work to implement the strategy including:

1. Develop a costed strategic plan 2021-2026 for Council approval in March 2021
2. Create the public facing documents, including the Strategic Framework and the Strategic Plan

Recommendations

The following motions are submitted for approval:

1. That Council approve the strategic framework 2021-2026, including the revised regulatory outcomes and guiding principles to come into effect April 1, 2021.
2. That Council approve the next College Strategic Plan 2021-2026 to come into effect April 1, 2021.

Implementation Date

April 1, 2021

Legislative and Other References

None

Attachments

1. Draft Strategic Framework 2021-2016
2. Draft Strategic Plan 2021-2026
3. Risk Assessment Matrix (2020)

Submitted by: Strategic Planning Working Group

STRATEGIC FRAMEWORK – 2021-2026

The 2021-2016 Strategic Framework is a high-level statement of the College's vision, mission, outcomes and key priorities over the next five years. It also identifies our guiding principles – the shared values that underpin our work as an organization and our relationships with the public, members and stakeholders.

Our Strategic Framework paves the way forward for the organization. It builds a stronger sense of common purpose and direction and a shared understanding of what we will achieve as an organization.

Our Vision

A leader in regulatory excellence, inspiring trust and confidence

Our Mission

Regulating midwifery in the public interest

Outcomes We Are Expected to Achieve

1. Clients and the public can be confident that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care.

2. Clients and the public can be confident that midwives practise the profession with honesty and integrity, and regard their responsibility to the client as paramount.

3. Clients and the public can be confident that midwives demonstrate accountability by complying with legislative and regulatory requirements.

4. Clients and the public trust that the College of Midwives of Ontario regulates in the public interest.

Our Strategic Priorities

1. Regulation that enables the midwifery profession to evolve
2. Effective use of data to identify and act on existing and emerging risks
3. Building engagement and fostering trust with the public and the profession

Our Guiding Principles

Accountability: We make fair, consistent and defensible decisions, incorporating diverse and inclusive views.

Equity: We identify, remove and prevent systemic inequities.

Transparency: We act openly and honestly to enhance accountability.

Integrity: We act with humility and respect and apply a lens of social justice to our work.

Proportionality: We allocate resources proportionate to the risk posed to our regulatory outcomes.

Innovation: We translate opportunity into organizational value.

WORKING WITH MIDWIVES, WORKING FOR THE PUBLIC

STRATEGIC PLAN
2021-2026

INTRODUCTION

Our mandate and core regulatory functions remain unchanged, but the landscape in which we operate and society's expectations of midwives and of us as the midwifery regulator are changing. Midwifery practice is changing to adapt to an evolving health care system and to meet client needs. Navigating this landscape requires organizations to become increasingly informed by data to stay relevant, impactful and successful. Regulators, including the College of Midwives of Ontario, are under increased scrutiny to increase accessibility of information and openness in decision-making and to measure and publicly report on their regulatory performance, so that the public, midwives and our partner organizations understand our role and our value as the regulator.

Over the past four years, we have started a major transformation of our organization, moving from what was essentially a reactive model of regulation towards a risk-based model of regulation, one that seeks to understand risks better and to act quickly upon emerging concerns before they can negatively affect the public. Part of being a risk-based regulator means that strategic goals and subsequently proposed programs and our day-to-day activities are guided by focusing activity and attention on issues and potential risks that pose the greatest threat to our duty to protect the public.

We have made substantial progress during the past four years, and we are determined to maintain this momentum and launch into our new strategy cycle by responding to new challenges that, if not mitigated, have the potential to adversely impact our regulatory objectives and outcomes.

1. **A need for greater agility in our regulatory processes to enable the evolution of the midwifery profession**

   Midwives' careers are becoming more diverse. They are able to work in a wider range of environments than when the profession was first regulated. These changes require a renewed effort on our part to minimize the burden that some of our regulatory processes place on midwives whose contexts of practice do not allow them to meet our current requirements. This does not mean that the requirements we set should be lowered in ways that may compromise good midwifery practice and adversely impact client care. It does mean, however, that if we are to provide effective regulation, we must understand the context in which midwives work and to reassess our current framework to make sure that it allows the profession to evolve to meet the diverse needs of clients. Good regulation must be forward-looking and be able to adapt to change. It must enable such evolution, not be a barrier.

2. **Managing and using the data that we collect**

   Data is a key enabler to our success, supporting our aim to be an agile, forward-looking regulator that operates efficiently. Our data strategy, implemented as part of our 2017-2020 Strategic Plan, focused on how we collect and manage data internally to measure and report on our regulatory work and performance. We completed this work successfully, however, technology and data analytics techniques have significantly evolved over the last four years. We now need to focus on how we can strengthen our analytics capabilities to help our decision-making and better identification and tackling of risks, to share data more effectively, and to streamline work across the organization to make us more efficient.

3. **Managing increased expectations of information, openness in decision-making and demonstrating our value as the regulator**

   The public and practitioners that are subject to the decisions of regulatory authorities expect increased access to information to better understand the role of the regulator and the procedures that affect them. Without doubt, accessibility of information and transparency in decision-making are becoming more prominent as the public rightly demand to know more about our procedures to be able to better navigate our complex regulatory system. Similarly, midwives are asking for more information, analysis and insight to help them understand our requirements and procedures. These expectations require that we invest time and resources to transform the way we communicate and to make our information more open and accessible.

All these issues and changes present significant challenges but also create valuable opportunities for us to increase the impact of our work. We will work to understand and respond to these challenges so that we can continue to keep the public safe and to support the midwifery profession as it evolves and adapts to new realities.

OUR STRATEGIC PRIORITIES

To achieve our ambition of further developing and maintaining a model of regulation that is agile, responsive and proactive, over the next 5 years we will focus on three strategic priorities:

1. Regulation that enables the midwifery profession to evolve
2. Effective use of data to identify and act on existing and emerging risks
3. Building engagement and fostering trust with the public and the profession

The activities and objective in the following pages describe in detail the key initiatives through which we will achieve our strategic priorities and will measure our success. Some activities we have already started; others require discussions with our partners before we can decide how and at what pace they should be taken forward.

STRATEGIC PRIORITY 1: REGULATION THAT ENABLES THE MIDWIFERY PROFESSION TO EVOLVE

Develop a responsive regulatory framework, without relying on legislative change, that promotes high standards of care and enables midwives to deliver good practice regardless of midwifery practice model, individual practice environment, or practice setting.

How we will achieve it

1. We will continue to develop and implement our plans for introducing an assessment program for midwives who are not able to demonstrate ongoing clinical currency and for non-practising midwives returning to practise. This will ensure that midwives have an alternative route to demonstrate clinical competence, if they are not able to meet the requirements set out in College regulations.

2. We will develop a mentorship program for new registrants to support them in consolidating clinical skills, developing autonomous decision-making and building confidence in their first year of independent practice. We will introduce orientation workshops to help midwives who are new to practice, or new to the province, to understand professional issues that will affect them on a day-to-day basis and what it means to be a regulated professional in Ontario.

3. We will develop and administer a remedial program for midwives who have clinical gaps and deficiencies in their knowledge, skills and judgment, identified through an assessment or an investigation. By intervening early, we aim to reduce the risk of more serious issues and regulatory action later on.

We will know we have been successful when

1. Irrespective of legislative change, our regulatory framework is designed to meet the realities of the evolving midwifery profession and supports the use of early and proportionate regulatory interventions targeted to areas of greatest risk.

2. We have greater assurance that all practising midwives are fit to practise.

3. We have increased confidence in the ability of mentoring environments to support midwives' learning needs, from continuing professional development to remedial needs.

4. We are recognized as regulating in a way that is responsive to the realities of midwifery practice.

STRATEGIC PRIORITY 2: EFFECTIVE USE OF DATA TO IDENTIFY AND ACT ON EXISTING AND EMERGING RISKS

Make better use of data about midwifery practice to identify, analyze and understand trends and areas of risk to the public to be able to maintain an effective system of regulation.

How we will achieve it

1. We will gain a better understanding of clients' needs and expectations across the range of settings in which midwifery care is provided and through analysis of our complaints and discipline data. This will enable us to engage constructively with the profession to address clients' expectations and find solutions to the issues which lead to complaints by setting new standards or providing regulatory guidance.

2. We will enhance our data capabilities so that we better understand our registrant population, their practice environments, challenges they face, and the emerging risks to and opportunities for safe and ethical practice. This will help target our regulatory activities where they add most value in supporting good practice and act upon critical issues that present a risk of harm to clients.

3. We will build on our engagement with midwifery and other regulators and partner organizations to share data and information effectively and to identify shared concerns. We will explore ways to formalize such information and data-sharing with our key partners which will commit us to collaborating to support each other's goals.

4. We will publish insights drawn from our data on a range of identified themes affecting midwifery practice and client safety. This will assist the profession to take action to ensure regulatory compliance and to avoid conduct that may warrant investigations into their practice.

5. We will enhance our analytical capabilities by investing internally and by seeking external expertise where needed to help us with our growing information needs.

We will know we have been successful when

1. We effectively use data to underpin decision-making and determine regulatory risks and mitigating strategies.

2. We have a better understanding of clients' needs and their expectations of midwifery practice and of factors that affect midwives' ability to deliver the best care to clients, and as a result our work addresses these identified areas.

3. Shared data and insight contribute to a fuller understanding of, and response to, risks and trends within the profession and the healthcare sector.

4. We have a secure information infrastructure in place to ensure that records are systematized and readily accessible.

5. We have enhanced analytical capabilities and there is internal understanding of the value of data, how to contribute effectively to its collection and use, and how it benefits our work.

STRATEGIC PRIORITY 3: BUILDING ENGAGEMENT AND FOSTERING TRUST WITH THE PUBLIC AND THE PROFESSION

Deliver services and demonstrate our role and value as the regulator through greater engagement, openness and accessibility so that the public and the profession have confidence that we fulfill our public protection mandate effectively, efficiently and fairly.

How we will achieve it

1. We will use modern information systems and digital technologies to present information in a format that is accessible and allows the public to understand the College's role, what it means to regulate in the public interest, how our complaints process works, and how we make decisions that affect them.

2. We will continue to engage with midwives to improve the transparency of our regulatory processes and decision-making. We will continue to make information about our ongoing requirements, standards and guidelines available to midwives in an engaging and accessible format.

3. We will work with our midwifery education partners to incorporate regular workshops on professional regulation into their curriculum with the purpose of educating midwifery students about their professional obligations within the Ontario system of regulation and preparing them for entry to practice.

4. We will introduce a survey to track perceptions of the College of Midwives of Ontario so we can better understand the impact of our work and how we can

support, provide guidance, and communicate more effectively with the public and midwives.

5. We will publicly report on our regulatory performance.

We will know we have been successful when

1. There is a digital transformation strategy in place that allows the public access to information to understand the College's public protection mandate and how to navigate our system, including the complaints and discipline processes.

2. Midwives understand College and other regulatory requirements and have access to information about our processes and likely outcomes when they are subject to a College proceeding.

3. Midwifery students recognize the role of professional regulation in supporting good midwifery practice and the duties and expectations of regulated professionals.

4. Our feedback surveys record improvements in perceptions of the work of the College.

5. We show improved regulatory performance.

RISK ASSESSMENT MATRIX

#	Risk	Description	Risk Level	Identified issues/gaps	Action/mitigating strategy
	External Risks				
1	Changing midwifery environment	Risks arising from changes in the midwifery environment that may affect midwifery practice		Midwifery is evolving and midwifery careers are becoming more diverse. Midwives are now able to work in a wider range of environments than when the profession was first regulated in 1993. These changes mean that more and more midwives are not/will not be able to meet College requirements (e.g. clinical currency requirements) that were set 25 years ago and were based on the premise that all midwives work a course of care model (i.e. provide all aspects of midwifery care).	Identified as a strategic priority in our in our Strategic Plan 2021-2026.
2	Lack of adequate training opportunities	Risks arising from a lack of adequate training, including bridging and remedial opportunities for midwives with identified gaps and deficiencies in professional knowledge.		There are very few training/requalification opportunities available for midwives who have identified clinical gaps or deficiencies in their knowledge, skills and judgment. While under the legislation and regulations governing the profession, it falls on committee panels to determine the content of such programs that are	Develop and administer a remedial program for midwives who have clinical gaps and deficiencies in their knowledge, skills and judgment, identified through an assessment (quality assurance or registration) or an investigation.

				individualized (e.g. requalification programs in the context of class changes or specified continuing education or remediation program in the context of a complaint/report), there is a need to create a more robust program that can be relied on by all departments/committee panels.	
3	Political, Economic, Social, Technological, Legal and Environmental (PESTLE)	Risks arising from the impact of political, economic, social, technological, legal and environmental factors.		No gaps identified.	No action required. Monitor
4	Public emergencies	Risks that external public emergencies affect midwives' ability to delivery safe care.		The pandemic affected many College processes (registration and discipline)	Relevant changes were made to address the impact of the pandemic. We're monitoring the developments and further changes will be made as needed.
5	Poor perception of the College	Risk that the perception of the College and its ability to regulate in the public interest is adversely affected.		No gaps identified.	No action required. Monitor

6	Unauthorized practise	Risk that an unregulated individual holds themselves out as a midwife or misuses the title.		No gaps identified.	No action required. Monitor
#	**Risk**	**Description**	**Risk Level**	**Identified issues/gaps**	**Action**
	Member practice risks				
7	Professional knowledge and practice	Risk that a midwife does not maintain the knowledge and clinical skills necessary to provide safe and effective care to clients.		Clinical currency is one way of ensuring that Ontario midwives are competent to provide safe and effective care. In accordance with the College's registration regulation, midwives are required to demonstrate active practice to keep their registration or to switch from the inactive class to the general class. Currently, active practice requirements are met if certain number of births can be reported. While not an objective measure, birth numbers is a hard measure that the College currently uses to address active practice shortfalls and to determine requalification programs/additional training requirements. With more and more midwives working outside the course of care model	Develop a competency-based assessment program for midwives who are unable to demonstrate active practice/clinical currency. This applies to midwives who are unable to demonstrate currency at renewal; and non-practising midwives and former midwives to want to return to practice. This will ensure that midwives have an alternative route to demonstrate clinical competence, if they are not able to meet the requirements set out in College regulations.

				including not providing intrapartum care (see above under risk #1 Changing midwifery environment), the College will soon be in a situation where we will have no objective way of assessing midwives' overall clinical knowledge, skills and judgment.	
8	Failure to act with integrity	Risk that a midwife's conduct lacks integrity and undermines the reputation and values of the midwifery profession		No gaps identified.	No action required. Monitor
9	Barriers to filing a complaint	Risk that a midwife creates barriers to clients' right to file a complaint with the College.		No gaps identified.	No action required. Monitor
10	Sexual abuse	Risk that a midwife sexually abuses their client.		No gaps identified.	No action required. Monitor

11	Fitness to practise	Risk that a midwife's physical or mental health condition affects their ability to provide safe and effective care		No gaps identified.	No action required. Monitor
12	Failure to meet legislative or regulatory requirements	Risk that a midwife fails to meet legislative or regulatory requirements		See above under risk #1 changing midwifery environment	
#	**Risk**	**Description**	**Risk Level**	**Identified issues/gaps**	**Action**
	Organizational risks				
13	Eligibility to practise	Risk that the College grants eligibility to enter practice to an individual who does not have the knowledge & skills to practice safely, ethically and competently		The College relies on the International Midwifery Pre-registration Program (IMPP) at the Chang School of Continuing Education at Ryerson University for assessment of internationally educated midwives based on the demonstration of competencies. This bridging program is the only route available to enter the profession for midwives who did not complete the Ontario Midwifery Education Program.	Continue to work with the IMPP to ensure there are stable systems in place and the program is sustainable (e.g. availability of funding). This in turn will ensure that the College continues to provide fair access to the profession.

14	Disproportionate regulation	Risk that the College regulates in a way that is disproportionate to the risk of harm		No gaps identified.	No action required. Monitor
15	Failure to register in a fair and consistent manner	Risk that the College fails to register in a fair and consistent manner		See above under risk # 7 Professional knowledge and practice	
16	Mismanagement of complaints and reports	Risk that the College mismanages complaints and reports from the clients, the public and midwives.		No gaps identified.	No action required. Monitor
17	Ineffective quality assurance program	Risk arising from ineffective quality assurance program		The College's Quality Assurance Regulation has been submitted to the Ministry and we are waiting for government approval.	No action required at this stage. Monitor.
18	Denial of request to access information	Risk that the College inappropriately denies a request to access information		No gaps identified.	No action required. Monitor
19	Inappropriate release of information	Risk that the College inappropriately releases information		No gaps identified.	No action required. Monitor
20	Breach of privacy	Risk of breach of privacy		No gaps identified.	No action required. Monitor

21	Poor governance	Risk arising from ineffective decision-making by Council and its Committees		No gaps identified that could be addressed by the College	The College continues to work with HPRO and the Ministry to request governance changes (e.g. competency-based appointments).
22	Poor regulatory performance	Risk that the College does not comply with its governing legislation and regulations as well as voluntary standards that it committed to achieving that can adversely affect its reputation.		The College implemented its regulatory performance measurement framework in the spring 2020 and internal recommendations were made.	Implement recommendations and prepare for the 2021 internal review. The results of the 2020/2021 internal review will be available on the website.
23	Lack of transparency	Risk that the College lacks openness and transparency regarding its members and its regulatory decision-making.		No gaps identified.	No action required. Monitor

24	Data and records mismanagement	Risk arising from a lack of data and records mismanagement		There are number of identified gaps in this area, including outdated records retention and disposition policy that needs updating and paper records (e.g. member and applicant files) that need to be destroyed or digitized in accordance with established guidelines. In addition, we need to strengthen our analytics capabilities to help our decision-making and better identification and tackling of risks, to share data more effectively, and to streamline work across the organization to supporting our aim to be an agile, forward-looking regulator that operates efficiently.	Identified as a strategic priority in our Strategic Plan 2021-2026.
25	Safety and security of College staff and assets	Risk that inadequate systems or infrastructure are in place to protect the College's staff and assets.		No gaps identified.	No action required. Monitor
26	IT security	Risk that the College has not adequately protected the College's information.		No gaps identified.	No action required. Monitor
27	Lack of effective human resource system	Risk that the College does not have an effective human		No gaps identified.	No action required. Monitor

		resource system that allows it to hire and retain staff.			
28	Wrongful dismissal	Risk arising from a wrongful dismissal of College staff.		No gaps identified.	No action required. Monitor
29	Employee fraud	Risk that staff use their position at the College to get involved in fraudulent activities intended to result in financial or personal gain.		No gaps identified.	No action required. Monitor

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Stage II of the Standards Review

Summary

Stage II of the standards review process has been completed this year and involved changes to a number of documents, including the Professional Standards for Midwives and the proposed implementation of a new guiding document on the midwifery scope of practice.

Background

In 2016, the College adopted a risk-based approach to regulation which required a review of all of its existing standards. Once the review was complete, staff made recommendations about each standard; some were proposed for rescinding and some for revising or replacing relatively quickly (Stage I of the standards review). For example, standards such as Ambulance Transport and Induction and Augmentation of Labour were recommended for rescinding because they did not meet the definition of a standard and did not set a minimum standard of expected behaviour. Other standards were not immediately addressed but were proposed for rescinding, revising or replacing later in the review process. For example, standards such as Delegation, Orders and Directives and the Consultation and Transfer of Care Standard (CTCS) were to be addressed at a later time (Stage II of the standards review).

At the June 2017 Council meeting, Council was presented with recommendations for all of the College's existing standards at that time. These recommendations included numerous standards slated for rescinding with the implementation of a new document called the Professional Standards for Midwives (Professional Standards). When the Professional Standards was implemented on June 1, 2018, twenty-five College standards were rescinded. This was the end of Stage I of the standards review.

Stage II of the review began after June 1, 2018 and involved work to implement the remaining Council recommendations from the June 2017 Council meeting.

The following main recommendation were proposed by the Quality Assurance Committee (QAC) to Council in March 2020. Council reviewed and approved them for a public consultation at its March 2020 meeting:

1. Rescind the CTCS, implement a guiding document on the midwifery scope of practice, and add a standard to the Professional Standards for Midwives that sets minimum expectations for midwives after a transfer of care.
2. Rescind the standard Delegation, Orders and Directives and propose changes to the Professional Standards for Midwives.

3. Rescind When a Client Chooses Care Outside Midwifery Standards of Practice and make changes to the Guideline on Ending the Midwife-Client Relationship.

** Council members who were not involved in this project from the beginning or who would like to refresh their memories can find the background information in the consultation paper that summarizes the proposed changes and provides the rationale for these changes: https://www.cmo.on.ca/wp-content/uploads/2020/08/Consultation-Paper-Phase-2-Final-.pdf.*

Key Considerations

The consultation was initially scheduled for the spring 2020 but, due to the pandemic, was postponed until August. The consultation was launched on August 13th, 2020 and closed on October 17th, 2020.

As mentioned above, this consultation included feedback about the proposed guiding document on the midwifery scope of practice ("Midwifery Scope of Practice"), proposed changes to the Professional Standards for Midwives, and rescinding the following standards:

1. Consultation and Transfer of Care Standard (CTCS)
2. Delegation, Orders and Directives
3. When a Client Chooses Care Outside Midwifery Standards of the Profession

The responses were as follows:

- 23 responses from midwives (20 on the website and 3 in an email)
- 3 responses from practices (2 on the website and 1 in email)
- 1 response from a midwifery student on the website
- A letter from Association of Ontario Midwives (AOM)

The majority of the responses were about the Midwifery Scope of Practice with some comments about rescinding the CTCS. There were very few comments about rescinding the standard Delegation, Orders and Directives and a few comments on the proposed changes to the Professional Standards for Midwives. There were no comments about the proposed rescinding of When a Client Chooses Care Outside Midwifery Standards of the Profession

Responses were mostly supportive of the overall approach to rescinding the CTCS and implementing a new guide on the midwifery scope of practice. Some respondents felt that rescinding the CTCS and implementing the new Midwifery Scope of Practice will increase the autonomy of midwives, support interprofessional collaboration and put client safety first. Some respondents felt the opposite expressing concern that rescinding the CTCS will erode the scope of practice and create more tension with interprofessional colleagues.

All of the responses were taken into consideration and led to a number of important changes that were reviewed by the QAC in November 2020. Changes from two reviews by the AOM were also incorporated. The following are the main themes that came out of the consultation. Each theme is described and revisions, if any, are noted under each section.

Theme 1: Frustration with scope restrictions

Respondents wanted the College to support midwives to practise full scope midwifery and wanted the Midwifery Scope of Practice to reflect that. Respondents also wanted interprofessional colleagues and hospitals to have a better understanding of the midwifery scope and to be prevented from limiting the scope of practice for midwives.

Response: Midwifery scope of practice is defined in the *Midwifery Act, 1991*, and midwives are permitted to work to full scope under this legislation. Where hospitals limit the scope of practice then midwives and their association must advocate for change. However, the following changes were made to the document to address the above concerns:

1. A paragraph was added Midwifery Scope of Practice under "Introduction" to address the intended audience of interprofessional colleagues and clients
2. Information was added to show that optimizing the scope of practice is in the client's best interest as way of addressing scope limitations by hospitals.

Theme 2: The lack of consistency between midwifery practices will increase

Some respondents stated that some midwives practising in the same hospital provide different "scopes" which is confusing for interprofessional colleagues but may be even more so without a list of conditions that dictate when to consult and transfer care. Some respondents were also concerned that without a list of clinical indications midwives will practise differently between and even within practices.

Response: The document states that midwives should work in the best interest of clients and according to the principle of person-centred care. This includes working to their fullest scope possible to practise according to research showing it is in the best interest of the public.

Theme 3: Not enough detail and difficult to interpret for midwives

Some respondents felt that the Midwifery Scope of Practice did not have enough details for midwives new to the profession. In addition, it was felt (by one respondent) that Midwifery Education Program (MEP) training does not currently match the level of judgment, expertise and responsibility required to practise according to scope rather than according to the list in the CTCS.

Response: Midwives must only provide care they are competent to provide. Where newer midwives do not have the confidence or experience to anticipate and manage every clinical encounter they should be consulting with their peers. Even with the CTCS, data show that midwives new to practice consult and transfer care more frequently. The College will hold a webinar(s) to discuss the transition to the new framework before the proposals are implemented. In addition, the College will work with the MEP to support necessary changes to the curriculum prior to rescinding the CTCS.

Theme 4: CTCS is necessary because midwives and their colleagues are familiar with it

Some respondents felt that the College must keep the CTCS because it is familiar to midwives and their interprofessional colleagues.

Response: Keeping documents because they are familiar to the profession is not in the best interest of clients. The health care system is continually changing and for midwives this means that even definitions of normal have changed since midwifery became a regulated profession. The College must ensure its guidance is current and responsive to this evolving health care system to ensure clients get high quality, evidence-based midwifery care. A necessary part of this is rescinding prescriptive rules that are not able to easily adapt to the ways in which midwifery is practised to meet the needs of their clients.

Theme 5: Midwifery is a marginalized profession and the CTCS is a necessary advocacy tool

Some respondents were opposed to the rescinding of the CTCS. They argued midwifery is a marginalized profession and midwives require advocacy tools in the way of College existing standards, including the CTCS.

Response: Similar to our 2017/18 consultation about the Professional Standards, we heard that midwifery is a new profession and is marginalized. We reiterate our response from 2017/2018. Marginalization of health professions is not unique to midwifery and there is no evidence to show that prescriptive standards of practice reduce marginalization. Instead, the evidence shows that midwives are not fully integrated into the Ontario health care system as a result of policy legacies that impose restrictions on midwifery practice, such as a funding model that prevents midwives from working interprofessionally.[1] The College does not have the mandate to address these policy legacies.

Theme 6: Specific feedback regarding the Midwifery Scope of Practice document

Significant changes to the document were made to incorporate the AOM's feedback and recommendations from member responses. Many changes were made to provide further clarity to the controlled acts table and the scope of practice decision-making tool in the Appendix.

NOTE: The Scope of Practice document is in final draft in terms of content but has not been formatted. Once recommendations from Council are made the document will be formatted including text boxes highlighting key points and for use on smart phones. It will undergo another round of copy editing to ensure it is ready for implementation.

Theme 7: Specific feedback regarding the Professional Standards for Midwives

No changes were made to the Professional Standards about supportive care (Standard # 26) based on member feedback. The proposed standard: *Collaborate with the MRP, after a transfer of*

[1] Mattison CA, Lavis JN, Hutton EK, Dion ML, Wilson MG. Understanding the conditions that influence the roles of midwives in Ontario, Canada's health system: an embedded single-case study. BMC health services research. 2020 Dec;20(1):1-5.

care, to provide care that is in the best interest of the client will remain. This standard is at the bottom of page 10 in purple font.

Theme 8: Specific feedback regarding the Delegation, Orders and Directives Standard

Very few comments were made regarding the proposed rescinding of the Delegation, Orders and Directives Standard. The QAC reviewed the consultation feedback which led to questioning the barriers to care that might result from the standard *delegating controlled acts only when you have an existing relationship with the client for whom the controlled act will be delegated* from the Professional Standards for Midwives. The discussion at the November QAC, as well as follow up by staff, led to removing this proposed new standard from Professional Standards for Midwives. Thus, the following standards are proposed for the Professional Standards for Midwives (and can be found in the document on page 11 in purple font):

1. Be accountable for your decisions to delegate and accept delegations of controlled acts by:
   ~~a) delegating controlled acts only when you have an existing relationship with the client for whom the controlled act will be delegated~~
   b) delegating acts only to individuals whom you know to be competent to carry out the delegated act, and who are authorized to accept the delegation
   c) delegating only those acts you are authorized and competent to perform
   d) never delegating a controlled act delegated to you by another health care provider (sub-delegation) and never accepting delegation from an individual who has been delegated to perform a controlled act themselves
   e) accepting only delegated acts that you are competent to perform.
   f) ensuring the client has provided informed consent to the performance of the delegated act
   g) documenting in the client record who you received the delegation from or to whom you delegated and the controlled acts that have been delegated.

No changes were made to the additional definitions in the glossary related to delegation (page 17 in purple font)

Theme 8: Specific feedback regarding When a Client Chooses Care Outside Midwifery Standards of Practice

No feedback was provided regarding the proposed rescinding of When a Client Chooses Care Outside Midwifery Standards of Practice. As directed by Council, the Client Relations Committee reviewed and approved the necessary changes to the Guideline on Ending the Midwife-Client Relationship (attached). The relevant changes begin on page 5 of the guideline under the heading "The Client Requests Services Below a Standard of Practice of the Profession". The revised guideline was also reviewed by the QAC at its November meeting.

Recommendations

The following final recommendations are submitted to Council:

1. Rescind the Consultation and Transfer of Care Standard (CTCS) with the implementation of the Midwifery Scope of Practice document
2. Approve proposed standard #26 in the Professional Standards for Midwives
3. Rescind the Delegation, Orders and Directives Standard with the approval of the proposed changes to the Professional Standards for Midwives' standard #31 and revisions to the glossary related to delegation
4. Rescind When a Client Chooses Care Outside Midwifery Standards of the Profession with the proposed changes to the Guideline on Ending the Midwife-Client Relationship

Implementation Date

June 2021

Legislative and Other References

1. *Midwifery Act, 1991*
2. Professional Standards for Midwives
3. Consultation and Transfer of Care Standard
4. Delegations, Orders and Directives Standard
5. When a Client Chooses Care Outside the Midwifery Standards of the Profession
6. Guideline on Ending the Midwife Client Relationship

Attachments

1. Midwifery Scope of Practice
2. Professional Standards for Midwives
3. Guideline on Ending the Midwife Client Relationship

Submitted by: Quality Assurance Committee

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Midwifery Scope of Practice

2020

Table of Contents

1. Introduction

The role of the College of Midwives of Ontario (College) is to ensure that midwifery services provided to the public are delivered in a safe and ethical manner by midwives. Part of this involves ensuring that midwives understand their scope of practice and practise within it.

The purpose of this document is to describe the midwifery scope of practice set out in the *Midwifery Act*[1], its regulations and other legislation that govern the midwifery profession in Ontario. It is intended for use by midwives and their interprofessional colleagues including physicians, nurses, respiratory therapists and pharmacists as well as by health care organizations that oversee institutions where midwives practise. The document is also intended to help clients understand the spectrum of care midwives are permitted to provide.

In addition to providing information about scope, this document also provides regulatory guidance to midwives about working within the midwifery scope of practice and what to do when a client's clinical condition or the care they required is no longer in the midwifery scope of practice.

This document is designed to assist members to ensure their practice complies with legislation. It does not replace professional and clinical judgement, and midwives remain accountable for their practice. The interpretations in the document reflect the context at the time of the documents implementation and interpretations may change as midwifery practice develops. To reflect possible changes the College will update the document from time to time. Please note that the document does not replace the authority of the *Midwifery Act, 1991* and other legislation governing midwifery. If, after reviewing this document, you have questions involving scope of practice and need clarification you should contact the College for professional practice advice or seek the advice of a lawyer.

Throughout the document, the terms "should" and "must" are used. **Must** is used when midwives are obligated to follow or adhere to the College's expectations regarding practice. The term **should** means that midwives can use reasonable discretion or judgment requiring the expectations for practice.

2. Legislative Context in Ontario: Scope of Practice Scheme

A health care professional's scope of practice is the range of activities, including decisions and procedures, that they are authorized to perform by the laws that govern their profession. In Ontario, the scope of practice scheme is set out in the *Regulated Health*

[1] S.O. 1991, c 18

Professions Act (RHPA)[2] and consists of two main elements: a **scope of practice statement** and the **controlled acts** authorized to each profession.

2.1. Scope of Practice Statement

The **scope of practice statement** is found in each profession-specific Act and it defines, in broad terms, the outer parameters of what that particular profession can do. For example, the midwifery scope of practice is set out in *the Midwifery Act, 1991* which is the profession-specific Act for midwives. Profession-specific Acts of other health care professionals include *the Medicine Act, 1991* for physicians, *the Nursing Act, 1991* for nurses and *the Pharmacy Act,1991* for pharmacists.

2.2. Controlled Acts

Controlled acts are set out in the RHPA and are procedures, tests, and treatments that are considered to pose a risk of harm when performed by someone who is not qualified to perform them. Because there is implicit risk of harm in the performance of controlled acts, they can be performed only by the regulated health professionals who are authorized by their profession-specific Acts (e.g., the Midwifery Act) to perform them. There are 14 controlled acts in listed in the RHPA.[3] Some professions do not have any controlled acts. Other professions, like midwifery, are authorized to perform many controlled acts. No profession is authorized to perform all controlled acts.

Controlled acts can be authorized to professions either in their entirety or only partially depending on what is considered appropriate for that profession's scope of practice. For example, the controlled act of *managing labour or conducting the delivery of a baby*[4] is authorized to physicians in its entirety but is authorized to midwives only partially. This means that physicians can perform all of the controlled act of *managing labour or conducting the delivery of a baby* without limitations; whereas for midwives this controlled act is limited, and they can only *manage labour and conduct spontaneous normal vaginal deliveries*.[5]

2.2.1 Delegation of Controlled Acts

Delegation is a formal process by which a regulated health professional, who is authorized to perform a controlled act, delegates the performance of that controlled act to another person who is otherwise not authorized to perform it. This other person may be a member of another profession regulated under the RHPA, a member of an unregulated profession or a member of the public.

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[2] S.O. 1991, c. 31
[3] *Regulated Health Professions Act, S.O., 1991 c.18, s.27*
[4] *Medicine Act,* S.O. 1991, c. 30
[5] *Midwifery Act, S.O.* 1991 c. 31, s.4.

For example, a midwife may be delegated the controlled act of *placing an instrument, hand or finger into an artificial opening into the body*[6] by a physician allowing the midwife to assist during a caesarean birth. Similarly, a midwife might delegate the act of *managing labour and conducting spontaneous normal vaginal deliveries*[7] to a registered nurse.

The delegation must be in accordance with any regulations or standards of practice. For example, it is a College standard that midwives are prohibited from delegating the controlled act of prescribing.[8] It is also a standard of practice that midwives must only accept delegated acts that they are competent to perform.[9]

2.2.2. Exceptions to Controlled Acts under the RHPA

Section 29 of the RHPA permits the performance of controlled acts by people who do not have the authority to perform a controlled act. This person may be a member of another profession regulated under the RHPA, a member of an unregulated profession or a member of the public. These exceptions differ from delegation because no handover of responsibility is required; however, the person must possess the knowledge, skills and judgment required to perform the controlled act. One of the exceptions is rendering first aid or temporary assistance in an emergency.[10]

Midwives, and other health care providers, are permitted to perform controlled acts that they are not otherwise authorized to perform in emergency situations. This exception permits midwives to perform acts, such as suturing a fourth degree tear, during an emergency providing they have the skills to do so. Whether or not a situation constitutes an "emergency" will depend on a number of factors, including the immediate harm to the client and the availability of other resources. What may be an emergency in a remote location may not be an emergency in an urban setting where other care providers, more experienced in managing such an emergency, may be readily available.

Another exception is granted to students or trainees who are authorized to perform controlled acts within the scope of their future profession if those acts are done under the direction and supervision of a member of the profession.[11] This exception would permit midwifery students to insert a urinary catheter into a pregnant client under the supervision of a midwife registered with the College.[12]

2.3 Laboratory and Specimen Collection Centre Licensing Act

The Laboratory and Specimen Collection Centre Licensing Act regulates Ontario's hospitals and private medical laboratories, including these laboratories' specimen-

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[6] *Regulated Health Professions Act, S.O., 1991 c.18, s.27*
[7] *Midwifery Act, S.O.* 1991 c. 31, s.4.
[8] College of Midwives of Ontario, *Standard on Prescribing and Administrating Drugs* (January 2014)
[9] College of Midwives of Ontario, *Professional Standards for Midwives* (June 2018)
[10] *Regulated Health Professions Act*, S.O. 1991 c. 18, s. 29.1(a)
[11] *Regulated Health Professions Act*, S.O. 1991 c. 18, s. 29.1(b)
[12] A complete list of exceptions to controlled acts is in the *Regulated Health Professions Act, S.O. 1991, c. 18,* s 29.1

collection centres. Laboratories Regulation 682 of the Laboratory and Specimen Collection Centre Licensing Act authorizes midwives to collect specimens and order laboratory tests and in accordance with a specific list outlined in Appendix B. This means that while midwives are authorized to order laboratory tests and collect specimens, this authority extends only to those tests and specimens that are listed in Appendix B.

2.4. The Public Domain

While the RHPA limits the performance of controlled acts to health professionals who are authorized by their profession-specific Act to perform them, many components of health care are not controlled acts because they do not pose risk of harm. This means that these components of care are not prohibited by the controlled acts in the RHPA and can be done by anyone, not only by regulated health professionals. This care is sometimes referred to as being in the **public domain**. For example, taking a blood pressure is in the public domain (i.e., is not a controlled act) which means that unregulated professionals and members of the public can do it. But diagnosing someone with a disease or disorder based on the reading of that blood pressure (e.g., diagnosing a pregnant client with gestational hypertension based on their blood pressure) is a controlled act. This is because there is not a great risk of harm in taking the blood pressure but there may be a risk of harm when making a diagnosis based on that blood pressure.

3. Legislative Scope of Midwifery Practice

The legislative scope of midwifery practice consists of the scope of practice statement, the controlled acts authorized to midwives, the Laboratory and Specimen Collection Centre Licensing Act, and all other activities that are in the public domain. This is commonly referred to as the **midwifery scope of practice.** In essence, the **midwifery scope of practice** is the activities, decisions and tasks that a midwife is permitted to do by law. The midwifery scope is a legal boundary; it is not flexible and cannot be expanded by practitioners, regulators, or institutions. Scope changes can only be achieved through a legislative change.

3.1. Scope of Practice Statement – Key Concepts and Definitions

The midwifery scope of practice statement is set out in the *Midwifery Act*:

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.[13]

The scope of practice statement uses several terms including **postpartum**, **newborn, spontaneous** and **normal** that have no universal definition. In order to understand the

[13] *Midwifery Act, S.O.* 1991 c. 31, s.3.

scope, these terms need to be defined. The following are definitions of these terms for the purpose of interpreting the Scope of Practice statement in the Midwifery Act.

Newborn means a baby from the moment of birth up to 8 weeks after birth.
Note: Midwives are authorized to perform the controlled act of communicating a diagnosis only up to 6 weeks after birth. More on the controlled act of communicating a diagnosis is described in Table 1)

Normal means a clinical picture that is considered healthy or uncomplicated. Normal applies to the overall health status of the individual and does not necessarily rule out the presence of a specific condition or indicate the complete absence of abnormal. Normal can include infections, conditions, or clinical presentations requiring monitoring or treatment when the overall health status of the client or newborn is considered healthy or uncomplicated. Determining if a clinical situation is normal requires clinical judgment and may also require diagnostic tests or consultations with other care providers.

Postpartum means the period of time beginning with the birth of a baby and ending 8 weeks after the birth when the effects of pregnancy on many systems have largely returned to the unpregnant state.
Note: Midwives are authorized to perform the controlled act of communicating a diagnosis only up to 6 weeks after birth. More on the controlled act of communicating a diagnosis is described in Table 1)

Spontaneous means a birth that occurs with maternal effort only and is not assisted by any means. A birth requiring forceps or vacuum is not spontaneous. Spontaneous refers only to the birth of the newborn and does not refer to the onset of labour and can therefore include induction and augmentation.

Woman means an individual who is pregnant, labouring, giving birth or postpartum. In this document, the terms "client" and "individual" will be used in place of woman unless woman exists in the language of the legislation.

Using the definitions provided above, the midwifery scope of practice involves providing care to individuals during normal pregnancy, labour, spontaneous vaginal birth and for up to 8 weeks postpartum for both clients and newborns. Any individual who falls outside of this time frame is not considered in the scope of practice and midwives cannot provide care to them on their own authority. This means midwives are not permitted to provide midwifery care to individuals who are not pregnant or postpartum or who are not in labour or having a spontaneous vaginal birth. Midwives also cannot provide midwifery care to babies over 8 weeks of age.

3.2. Controlled Acts Authorized to Midwives

Midwives are authorized to perform a number of controlled acts. Controlled acts are only authorized to midwives while engaging in the practice of midwifery. All of the controlled acts authorized to midwives are authorized only partially which means midwives do not have the authority to perform any of the controlled acts in their entirety. The details of the controlled acts are described below in Table 1. Column 1 sets out the controlled acts

authorized to midwives as set out in the Midwifery Act and the Controlled Acts Regulation. Column 2 describes what the authorized act permits midwives to do and column 3 describes what midwives are not permitted to do related to the authorized act.

Table 1: Controlled acts and their interpretation

#	Controlled Act authorized to midwives under the *Midwifery Act, 1991*	Interpretation	
		Permitted	Not Permitted
1	Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks postpartum.	May communicate a diagnosis to a client identifying diseases and disorders, based on tests or investigations, for clients and newborns up to 6 weeks postpartum.	Must not communicate a diagnosis identifying diseases and disorders for individuals after 6 weeks postpartum or for newborns who are older than 6 weeks.
Note: This controlled act is one of the most challenging to define because not every interaction with a client, in relation to their health or condition, constitutes communicating a diagnosis. It is generally accepted that **communicating a diagnosis** includes the following three components: 1. It must identify the existence of a disease or disorder based on tests and investigations 2. It must include direct communication with a client or their representative regarding the identified disease or disorder based on tests or investigations 3. It must be reasonably foreseeable that a client or their representative will rely on this diagnosis to make choices about treatment[14] This means that communicating a diagnosis to another healthcare provider, communicating the results of an assessment to a client or forming a hypothesis of what could be causing the symptoms do not fall within the controlled act of communicating a diagnosis and so can be performed for individuals up to 8 weeks postpartum or for newborns who are up to 8 weeks old.			
2	Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area.	May perform episiotomies and amniotomies. May repair lacerations and episiotomies that involve the skin and muscle of the perineum and labia.	Must not perform any other procedures below the dermis as they fall under the broader controlled act not authorized to midwives. This includes repairing tissues of the anus, anal sphincter, rectum, urethral or periurethral area and performing procedures such as acupuncture or newborn frenectomies.

[14] Steinecke, Richard. *A Complete Guide to the Regulated Health Professions Act*. Aurora, Ont: Canada Law Book, 1995. Continually updated resource.

3	Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking.	May take blood samples from newborns by skin pricking only. May take blood samples from a client's veins by venipuncture or by skin pricking. May take blood samples from a non-client if the test is related to the delivery of midwifery care to the client.	Must not perform venipuncture on newborns. Must not take blood samples from a non-client if the test is unrelated to the delivery of care to the client.
4	Administering, by injection or inhalation, a substance designated in the regulations.	May administer, by injection or inhalation, any substance that is included in the Designated Drugs regulation,[15] such as nitrous oxide for inhalation, Hepatitis B vaccine by injection, or fluids through intravenous catheters.	Must not administer by injection or inhalation a substance that is not designated in the Designated Drugs regulation.
5	Administering a substance by injection or inhalation if the procedure is ordered by a member of the College of Physicians and Surgeons of Ontario.	May administer by injection or inhalation any substance that has been ordered by a physician.	Must not administer by injection or inhalation a substance that is not designated in the Designated Drugs regulation and is not ordered by a physician
6	Putting an instrument, hand, or finger ii. beyond the point in the nasal passages where they normally narrow,	Midwives may perform this controlled act in an emergency situation only such as during the performance of neonatal resuscitation	Midwives are not authorized to put an instrument hand or finger beyond the point in the nasal passages where they normally narrow while practising in a non-emergency situation because this controlled act is not authorized to them under the Midwifery Act.

[15] *Designated Drugs* O. Reg. 884/93

7	Intubation beyond the larynx of a newborn[16]	May insert an instrument beyond the larynx of a newborn for the purpose of intubation only.	Must not insert an instrument beyond the larynx of a newborn for anything other than intubation. Must not insert anything beyond the larynx of an adult
8	Inserting urinary catheters into women	May go beyond the opening of the urethra only for inserting catheters into clients.	Must not insert urinary catheters into individuals who are not clients. Must not insert urinary catheters into newborns
9	Putting an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the postpartum period.	May perform procedures that involve hands, fingers or instruments placed beyond the labia majora or anal verge. This means midwives may perform numerous procedures on clients including inserting a speculum into the vagina, inserting fingers or catheters into the vagina and cervix, inserting a finger into the rectum, and inserting a fetal scalp electrode.	Must not perform any procedures on a newborn that goes beyond the labia majora or the anal verge.
	Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour and the post-partum period.	May go beyond the anal verge for the purpose of administering medications that are included in the Designated Drugs regulation	Must not administer any medications beyond the anal verge that are not included in the Designated Drugs regulation. Must not administer suppository drugs to newborns.

[16] Under the Midwifery Act, a midwife is only authorized to perform this procedure when performed in accordance with the *Intubation of a Newborn* requirements set out in the *General Regulation* O. Reg. 335/12, 1991 c. 31. S. 15.1.

10	Prescribing drugs designated in the regulations.	May prescribe drugs included in the Designated Drugs regulation and drugs that can be lawfully purchased or acquired without a prescription.	Must not dispense, sell, or compound a drug. Must not prescribe a drug that is not included in the regulation.
11	Managing labour and conducting spontaneous normal vaginal deliveries.	May manage labours and only conduct deliveries that are spontaneous, normal and vaginal.	Must not conduct deliveries that are not spontaneous, normal and vaginal
	Controlled Act authorized to midwives under the *Controlled Acts Regulation*	**Interpretation**	
		Permitted	**Not Permitted**
12	Applying and ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound.[17]	May order and perform pregnancy diagnostic ultrasounds and pelvic ultrasounds during the postpartum period. Examples include routine fetal assessment, confirmation of placental location and retained products of conception.	Must not order or perform diagnostic ultrasounds for conditions that are not related to pregnancy, birth or postpartum, or on parts of the body that do not include the fetus or pelvic organs Must not order or perform ultrasounds on newborns

3.3. Practising to the full legislative scope

Practising to the full legislative scope, also known as full scope midwifery, means providing all aspects of midwifery care scope including labour, birth, postpartum and newborn care, including all of the authorized acts.

The ability to work to the full midwifery scope is influenced by intrinsic and extrinsic factors. Intrinsic factors are personal factors, such as being a new midwife who has not been exposed to all of the procedures required to work to full scope or a midwife who has an injury that limits their ability to provide all aspects of midwifery care. Midwives cannot, however, limit their scope of practice in contravention of provincial or national laws. For example, a midwife cannot use discretion over their own scope of practice to exclude individuals from care based on one of the protected grounds in the Ontario Human Rights Code.

[17] This controlled act is authorized to midwives by way of an exemption under the *Controlled Acts* O. Reg. 566/17, s. 2. The exemption means midwives are permitted to apply and perform pregnancy and pelvic diagnostic ultrasounds but the authorization to do so is not found in the Midwifery Act with the other authorized acts. This is the only exemption set out in the Controlled Acts regulation that applies to midwives.

Extrinsic factors are those such as practice setting or client needs. For example, a midwife may be practising in a hospital that does not provide epidural analgaesia so would not have access to this part of the scope. While extrinsic factors should be based on resources and the best interest of clients, there are situations where this is not the case. This occurs when midwifery practices choose not to work to the full scope even when their privileging hospital supports it. This also occurs when institutions, such as hospitals, limit midwives from providing full scope midwifery care despite evidence showing that optimizing the midwifery scope of practice is in the best interest of the public. *The scope of practice of every health professional should enable them to contribute optimally to providing high quality patient-centred care without compromising patient safety and that ... the health care system should enable them to practice to the fullest extent of this scope*[18]. When client care is not central to the decision-making about scope limitations then midwives, midwifery practices and advocacy organizations should work with these institutions to develop policies and protocols that reflect the legislative scope of midwifery practice.

Practising to the full legislative scope requires that midwives have the necessary competencies to do so. As primary care providers and regulated healthcare providers, midwives are responsible for determining the limits of their own competence. A midwife's competence can change throughout their career. Midwives can gain new competencies by engaging in professional development activities, such as participating in trainings, taking courses, and providing elements of care they had not previously provided. At the same time, a midwife may lose competencies if they have not provided certain elements of care for an extended period of time. In all situations midwives must be competent in all aspects of care they are providing or they must consult with, or transfer the care of the client to, another care provider.

4.0. When a Client's Condition is Outside the Legislative Scope of Practice

When a client's condition falls outside the legislative scope of practice the midwife has two options: either they transfer responsibility and accountability (i.e., transfer care) for the client to another health care provider or provide care under delegation in accordance with College standards.

4.1. Transfer care to another care provider

A transfer of care is the transfer of primary clinical responsibility to another care provider and is required when a client's condition is outside the legislative scope of practice. For example, a pregnant client with a breech presentation choosing a caesarean section must be transferred to a physician for the birth because only births that are spontaneous and vaginal are in the midwifery scope of practice and a caesarean birth is not spontaneous and vaginal. If this same client were to choose a vaginal birth, then a transfer of care

[18] Canadian Medical Association. (2015). Best practices and federal barriers:Practice and training healthcare professionals. Submission to the House of Commons Standing Committee on Health. (pg. 3)

would not be required if the midwife is competent to provide this care because a spontaneous vaginal birth is not outside the legislative scope of practice.

Transfers can be temporary, such as in this case of a planned caesarean section for a breech presentation, because only the intrapartum period is outside of the scope of practice. Transfers can also be permanent, for example when a client gives birth at 24 weeks gestation and the newborn requires months of hospitalization and treatments. When a transfer of care is required, clients should understand the need to transfer and that they will be under the care of a physician so their plan of care may change. After a transfer of care has taken place, a midwife should continue providing care in collaboration with the most responsible provider (MRP) and in the best interest of the client and their newborn. In this situation, all controlled acts must be performed under delegation.

4.2. Working under delegation

Delegation allows midwives to work outside the scope of practice as long as a regulated health professional, with the authority to perform the controlled act, grants this authority to the midwife. This provides midwives with the legal authority to perform a controlled act that is otherwise not authorized to the profession. For example, in the case of the 24 week preterm infant transferred to physician care, a midwife can participate in the care of this newborn as long as any controlled acts, such as inserting an intravenous catheter, are provided under delegation. Midwives must also work under delegation when performing controlled acts on individuals who are not pregnant, in labour, postpartum or newborn.

5.0. When Elements of Care are Outside the Legislative Scope of Practice

When a client's clinical condition is in the midwifery scope but they require tests, treatments or procedures that are not authorized to midwives, the midwife must consult with another health care provider, such as a physician, to provide the required care. For example, midwives are able to determine when a perineal tear is outside their scope of practice (i.e., a tear that involves the anus, anal sphincter, rectum, urethra and periurethral area) and will need to consult with a physician to repair this tear. While a complete transfer of accountability is not required for the management of the client's course of care, a consultation is required to perform the controlled act that is not in the midwifery scope. Another example demonstrating the need to consult relates to ordering ultrasounds. It is in the scope of practice to order pregnancy and postpartum diagnostic ultrasounds but it is not in scope to order ultrasounds on newborns. This means that when a healthy newborn requires an ultrasound to follow up on findings from an ultrasound done in pregnancy, a midwife must consult with a physician to order it.

5. Conclusion

No document can define every activity, such as a test or treatment, that a midwife is or is not authorized to perform because it is not possible to foresee and address all clinical situations that will arise throughout a midwife's professional career. Therefore, midwives must use their judgment to determine when they can perform an activity on their own authority because it falls within the legislative scope of practice or when they need to

transfer care because their client's condition no longer falls within their scope of practice. Determining if care or a client's clinical condition falls within or outside the scope of practice is not always straightforward. It depends on a range of inter-related factors and may require a consultation with another care provider. The College has developed decision-making tools[19] to assist midwives in making decisions in relation to their scope of practice and accepting a delegation.

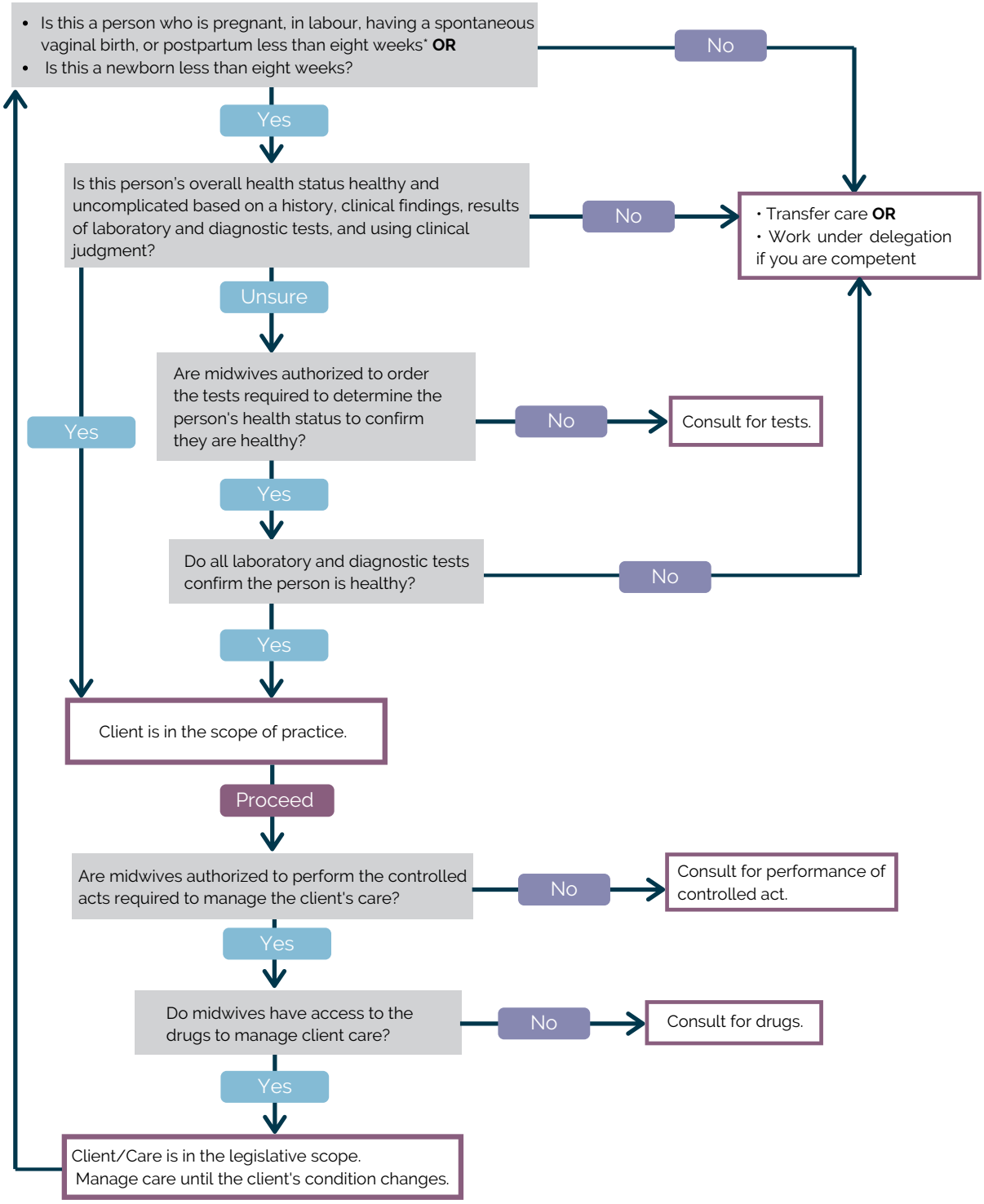
[19] See appendices A and B

Appendix 1: Scope of Practice Decision Making Tool for Midwives

The midwifery scope is defined by the legislation but midwives must only practice within the scope where they have the knowledge, skills and judgment to do so. This tool takes you through the legislative scope of practice based on the Midwifery Act beginning with whether the client or newborn is in the scope of practice and then whether midwives have the controlled acts and access to the tests and treatments to provide care to each client or newborn.

Providing care on the midwife's own authority requires that all clients and all procedures, tests and treatments be in the legislative scope of practice. Providing care on the midwife's own authority also requires that they have the knowledge, skills and judgment to perform each task competently.

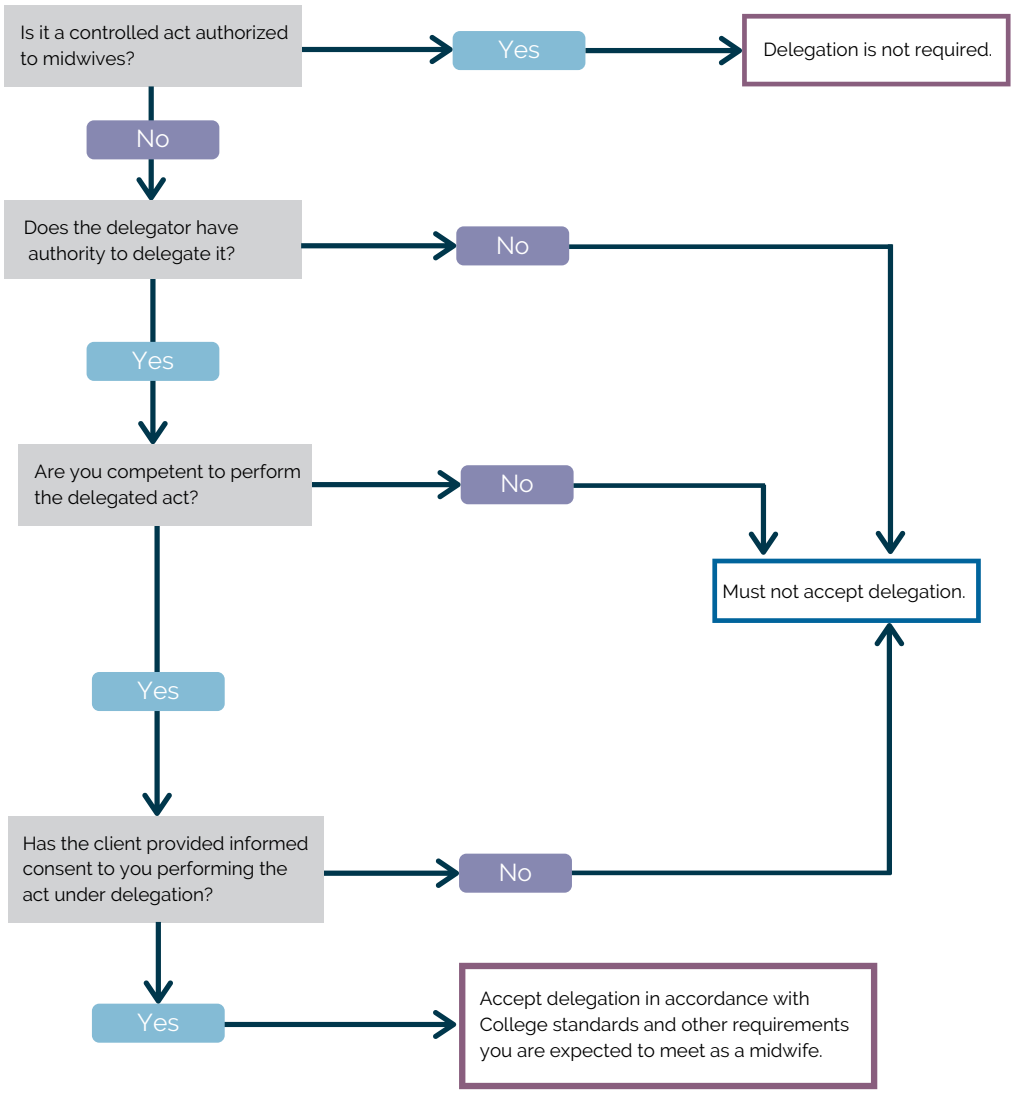
[Once Council approves the document, we will add a small number of clinical situations that will be determined in scope or not in scope based on the decision-tree. The examples include a client at 36 weeks with a blood pressure of 92/142; a client in labour at 35 weeks with an abnormal fetal heart rate; a client at an initial visit who has a history of depression and Hepatitis C; and a term newborn at 48 hours of age with jaundice].



*The scope ends at six weeks if it involves communicating a diagnosis that the individual will rely on.
All other care extends to eight weeks.

Appendix 2

Decision-making tool for a midwife accepting a delegation



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PROFESSIONAL STANDARDS FOR MIDWIVES

PROFESSIONAL KNOWLEDGE & PRACTICE

PERSON-CENTRED CARE

LEADERSHIP & COLLABORATION

INTEGRITY

COMMITMENT TO SELF-REGULATION

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

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OVERVIEW

The Professional Standards for Midwives ("Professional Standards") describes what is expected of all midwives registered with the College of Midwives of Ontario ("College"). The Professional Standards sets out the College's minimum requirements regarding your practice and conduct, and helps you achieve the best outcomes for your clients and the public.

All midwives involved in client care hold the role of a trusted professional. There are duties arising from this role and obligations owed to others, including your clients, the public, your peers, other health care providers, and your regulator.

It is your responsibility to be familiar with and comply with the Professional Standards. You must use your judgment in applying the principles to the various situations you will face as a midwife. While no standard can foresee or address every issue or ethical dilemma which may arise throughout your professional career, your decisions, and actions must be justifiable.

You must always act in accordance with the law. The Professional Standards is not a substitute for legislation and regulations that govern the midwifery profession in Ontario. If there is any conflict between the Professional Standards and the law, the law prevails.

Midwives provide care in a variety of settings including homes, clinics, hospitals, and birth centres, so you must also be aware of, and work in accordance with, the rules set by each of the locations where you practise, including institutional policies and procedures, and community standards. When those institutional policies and procedures in your community standards are less stringent than, or contradict the Professional Standards, you must comply with the Professional Standards. While many standards are compiled, written down, and formally approved by the College, other

standards are not documented and are unwritten expectations that describe the generally accepted practice of midwives who work in similar contexts in Ontario. In addition to the Professional Standards, the College has approved other written standards, which are available on the College's website.

The Principles

Five (5) mandatory principles form the Professional Standards. These principles define the fundamental ethical and professional standards that the College expects all practices and individual midwives to meet when providing midwifery services. The standards are not negotiable or discretionary. You must be able to demonstrate at all times that you work in accordance with the principles and standards set out in the Professional Standards. A failure to maintain a standard of practice of the profession may amount to professional misconduct.

You must practise according to the standards expected of you by:

- Demonstrating professional knowledge and practice
- Providing person-centred care
- Demonstrating leadership and collaboration
- Acting with integrity
- Being committed to self-regulation

Structure of the Professional Standards

The Professional Standards is divided into five (5) principles. Each principle includes a definition of the principle and a set of standards. The standards describe what midwives must achieve for compliance with the relevant principle. For midwives who are practice owners, there are additional standards at the end of each section that apply to you.

Interpretation

Words highlighted in grey are defined in the Glossary.

PROFESSIONAL KNOWLEDGE & PRACTICE

Professional Knowledge and Practice focuses on developing and maintaining the knowledge and clinical skills necessary to provide high quality care to clients. All midwives practising in Ontario must possess the knowledge, skills, and judgment relevant to their professional practice. They must exercise good clinical and professional judgment to provide safe and effective care. Midwives must be committed to an ongoing process of learning, self-assessment, evaluation, and identifying ways to best meet client needs.

To demonstrate Professional Knowledge and Practice, you must meet the following standards:

1. Work within the boundaries of the Midwifery Act related to scope of practice and the controlled acts authorized to midwives.
2. Be competent in all areas of your practice.
3. Know, understand, and adhere to the standards of the profession and other relevant standards that affect your practice.
4. When you are also a member of another regulated profession and acting in this capacity:

4.1. inform clients if any part of a proposed service or treatment is outside the scope of midwifery practice or will be administered outside your role as a midwife

4.2. maintain midwifery records separate from the records for the practice of the other profession

4.3. inform clients that they are not obligated to receive care from you in your capacity as another regulated professional.

5. Maintain contemporaneous, accurate, objective, and legible records of the care that was provided during client care.
6. Offer treatments based on the current and accepted evidence, and the resources available.

7. Order tests or prescribe medications only when you have adequate knowledge of clients' health and are satisfied that tests and medications are clinically indicated.
8. Maintain and carry supplies and equipment necessary for safe care in home or out-of-hospital settings.
9. Continuously monitor and make efforts to improve the quality of your practice using reflection, and client and peer feedback.

Midwives who are practice owners must also:

10. Maintain a practice environment that supports compliance with relevant legislation, regulations, policies, and standards governing the practice of midwifery.
11. Ensure essential operational and clinical supplies are available to midwives in your practice.
12. Develop and maintain quality improvement systems to support the professional performance of midwives and to enhance the quality of client care.

PERSON-CENTRED CARE

Person-centred care is focused on the client and their life context. Person-centred care recognizes the central role the client has in their own health care, and responds to their unique needs, values, and preferences. Working with individuals in partnership, person-centred care offers high-quality care provided with compassion, respect, and trust.

To achieve Person-Centred care, you must meet the following standards:

13. Ensure that every birth you attend as the most responsible provider is also attended by a second midwife or second birth attendant.
14. Listen to clients and provide information in ways they can understand.
15. Support clients to be active participants in managing their own health and the health of their newborns.
16. Recognize clients as the primary decision-makers and provide informed choice in all aspects of care by:

16.1. providing information so that clients are informed when making decisions about their care

16.2. advising clients about the nature of any proposed treatment, including the expected benefits, material risks and side effects, alternative courses of action, and likely consequences of not having the treatment

16.3. making efforts to understand and appreciate what is motivating clients' choices

16.4. allowing clients adequate time for decision-making

16.5. ensuring treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law

16.6. supporting clients' rights to accept or refuse treatment

16.7. respecting the degree to which clients want to be involved in decisions about their care.

17. Ensure clients have 24-hour access to midwifery care throughout pregnancy, birth, and postpartum or, where midwifery care is not available, to suitable alternate care known to each client.
18. Provide clients with a choice between home and hospital births.
19. Provide care during labour and birth in the setting chosen by the client.
20. Take reasonable steps to provide care in the early postpartum in the setting chosen by clients.
21. Ensure that your personal biases do not affect client care.

Midwives who are practice owners must also:

22. Develop a reasonable and transparent client intake process.

LEADERSHIP & COLLABORATION

Leadership and Collaboration requires that you work both independently and together with midwives, and other regulated and unregulated health care providers in relationships of reciprocal trust. Leadership and Collaboration demands that midwives work with clearly defined roles and responsibilities in all health care settings and when in health care teams. Communication, cooperation, and coordination are integral to the principle of Leadership and Collaboration.

To demonstrate Leadership and Collaboration, you must meet the following standards:

23. Be accountable and responsible for clients in your care and for your professional decisions and actions.
24. Provide continuity of care by developing an ongoing relationship of trust with your clients.
25. Establish and work within systems that are clear to clients whether you are a sole practitioner, part of a primary care team of midwives, or a member of an interprofessional care team by:
    - 25.1. developing and following a consistent plan of care
    - 25.2. practising with clearly defined roles and responsibilities based on scopes of practice
    - 25.3. assuming responsibility for all the care you provide
    - 25.4. ensuring that the results from all tests, treatments, consultations, and referrals are followed-up and acted upon in a timely manner
    - 25.5. providing complete and accurate client information to other midwives or care providers at the time care is transferred over to them
    - 25.6. taking reasonable steps to ensure that a midwife or another care provider known to the client is available to attend the birth.
26. ~~Take reasonable steps to continue in a supportive role with clients when their care is transferred to another care provider.~~ Collaborate with the MRP, after a transfer of care, to provide care that is in the best interest of the client.

27. Coordinate client care with other providers when an alternative to midwifery care is requested.
28. Consult with or transfer care to another care provider when the care a client requires is beyond the midwifery scope of practice or exceeds your competence, unless not providing care could result in imminent harm.
29. Provide complete and accurate client information to the consultant at the time of consultation or transfer of care.
30. Ensure that clients and health care providers know who the most responsible provider throughout the client's care is, including when there are delegations, consultations, and transfers of care.
31. Be accountable for your decisions to delegate and accept delegations of controlled acts by:
    - 31.1.1. delegating acts only to individuals whom you know to be competent to carry out the delegated act, and who are authorized to accept the delegation
    - 31.1.2. delegating only those acts you are authorized and competent to perform
    - 31.1.3. never delegating a controlled act delegated to you by another health care provider (sub-delegation) and never accepting delegation from an individual who has been delegated to perform a controlled act themselves
    - 31.1.4. accepting only delegated acts that you are competent to perform.
    - 31.1.5. ensuring the client has provided informed consent to the performance of the delegated act
    - 31.1.6. documenting in the client record who you received the delegation from or to whom you delegated and the controlled acts that have been delegated.

INTEGRITY

Integrity is a fundamental quality of any member of the midwifery profession. Every midwife has a duty to practise truthfully and honestly, with the best interest of their clients as paramount. Integrity demands that midwives consistently model appropriate behaviour, recognize the power imbalance inherent in the midwife-client relationship, and maintain the reputation and values of the profession.

To demonstrate Integrity, you must meet the following standards:

32. Conduct yourself in a way that promotes clients' trust in you and the public's trust in the midwifery profession.
33. Never abandon a client in labour.
34. Be honest in all professional dealings with clients, midwives, other health care providers, and the College.
35. If a client experienced any harm or injury during your care that is related to your care, disclose the following information promptly and accurately:
    - 35.1. the facts of the incident
    - 35.2. anticipated short-term and long-term effects
    - 35.3. recommended actions to address the consequences.
36. Avoid caring for clients while in a conflict of interest, unless all the following circumstances apply:
    - 36.1. you have explained the conflict to clients and have advised clients of their right to seek care from another provider
    - 36.2. you have a reasonable belief that clients understand the conflict and their right to seek care elsewhere
    - 36.3. you and the clients are satisfied that it is in the clients' best interest for you to provide care
    - 36.4. you have documented the clients' choice to you providing care despite the conflict.

37. Take every reasonable precaution to protect the confidentiality and privacy of your clients' personal health information, unless release of information is required or permitted by law.
38. Recommend the use of products or services based on evidence and clinical judgment, and not commercial gain.
39. Make referrals to other health care providers only based on the client's best interest and not financial gain.
40. Appropriately use the healthcare resources available to you for client care.
41. Establish and maintain clear and appropriate professional boundaries always.
42. Never pursue or engage in a sexual relationship with a client.
43. Ensure that any physical or mental health condition does not affect your ability to provide safe and effective care.
44. Recognize the limits imposed by fatigue, stress, or illness, and adjust your practice to the extent that is necessary to provide safe and effective care.

Midwives who are practice owners must also:

45. Manage practice in a way that supports the physical and mental well-being of all individuals involved in client care.
46. Ensure that information you publicize about your practice or any other practice is accurate and verifiable.

COMMITMENT TO SELF-REGULATION

Self-regulation is the authority, delegated from the government to the members of the profession, to govern their profession. Commitment to self-regulation demands that midwives demonstrate personal responsibility by diligently fulfilling their duties owed to others, including their clients and the public, other midwives, midwifery students, and the College. As self-regulated professionals, midwives must uphold the standards and reputation of the profession, protect and promote the best interests of clients and the public, and collectively act in a manner that reflects well on the profession.

To demonstrate Commitment to Self-Regulation, you must meet the following standards:

47. Appropriately supervise students and peers whom you have a duty to supervise by:
    - 47.1. role modelling integrity and leadership
    - 47.2. facilitating their learning and providing opportunities for consolidating knowledge
    - 47.3. providing honest and objective assessments of their competence.
48. Co-operate fully with all College procedures. This duty applies to:
    - 48.1. investigations of your practice and the practice of others
    - 48.2. peer and practice assessments and audits
    - 48.3. referrals to a committee panel
    - 48.4. any other proceedings before the College.
49. Know, understand, and comply with mandatory reporting obligations and notification requirements.
50. Respond promptly to College correspondence that requires a response.
51. Do not discourage or prevent anyone from filing a complaint or raising a concern against you.

52. Provide appropriate information to your clients about how the midwifery profession is regulated in Ontario, including how the College's complaints process works.

Midwives who are practice owners must also:

53. Establish a system to deal with clients' expressed concerns promptly, fairly, and openly.

GLOSSARY

The Glossary comprises a set of defined terms which are used in the Professional Standards. Defined terms are highlighted in grey within the individual standards under each principle. The Glossary may also contain commentary and interpretation.

Boundaries

means a clear separation between professional conduct aimed at meeting the needs of a client and the midwife's personal views, feelings, and relationships which are not relevant to a client-midwife relationship.

College

means the College of Midwives of Ontario established under the *Midwifery Act, 1991.*

Conflict of interest

means a situation that arises when a midwife, entrusted with acting in the best interests of a client, also has professional, personal, financial or other interests, or relationships with third parties which may undermine the midwife's professional judgment and affect their care of the client.

Confidentiality and Privacy

means complying with the legal and professional duty to maintain the confidentiality of clients' personal health information and protecting that information from inappropriate access. The *Personal Health Information Protection Act, 2004* (PHIPA) governs midwives' use of personal health information, including its collection, use, permitted disclosure, and access. For more guidance, refer to the *Personal Health Information Protection Act, 2004* (PHIPA) and the College's Guide on Compliance with the *Personal Health Information Protection Act.*

Consent

means consent to treatment as defined in the *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A. According to section 11(1) of *the Health Care Consent Act, 1996*, the following are the required elements for consent to treatment:

- The consent must relate to the treatment.
- The consent must be informed.
- The consent must be given voluntarily.

The consent must not be obtained through misrepresentation or fraud

Consultation

means a discussion with another professional (e.g., a midwife or physician) who has a particular area of expertise for the purpose of seeking clinical advice or treatment.

Controlled acts authorized to midwives

means the list of controlled acts provided to midwives pursuant to section 4 of the *Midwifery Act, 1991.*

Delegation

means a process where a regulated health professional (the delegator) who is authorized to perform a controlled act, as defined under the *Regulated Health Professions Act, 1991,* designates that authority to someone else (delegatee) who is not authorized to perform that controlled act. When an act is delegated, both the delegator and the delegate are accountable. Delegation is carried out by either a direct order or a medical directive.

A direct order provides the delegatee with authority to carry out a medical procedure on one specific client and occurs after the client has been assessed by the delegator. A direct order can be written or verbal and provides the details required for the delegatee to carry out the procedure.

A medical directive provides authority to carry out a medical procedure or series of procedures for any client as long as clinical conditions set out in the directive exist and are met. Medical directives are written in advance.

Early postpartum

means the time period from birth to 7 days after birth.

Mandatory reporting obligations

means a statutory responsibility to report relevant matters to the College or other authorities. The *Regulated Health Professions Act, 1991* (RHPA) governs midwives' use of personal health information, including its collection, use, permitted disclosure, and access. For more guidance, refer to the *Regulated Health Professions Act, 1991* Health Professions Procedural Code Section 85.1, and the College's Guide on Mandatory and Permissive Reporting.

Midwifery Act

means the legislation that sets out the midwifery scope of practice and controlled acts that are authorized to midwives, as well as provisions on title protection and Council composition.

Most responsible provider (MRP)

means a midwife or another health care provider who holds overall responsibility for leading and coordinating the delivery and organization of a client's care at a specific moment in time.

Notification requirements

means a requirement to provide information to the College in accordance with the Registration Regulation, made under the *Midwifery Act, 1991* and Article 14 of the General by-law.

Practice Owner

means a midwife who owns a midwifery practice as a sole proprietor, partner in a partnership as defined in the *Partnerships Act, 1990* (Ontario), or shareholder of a corporation.

Quality improvement systems

means developing and maintaining an approach for evaluating and improving client outcomes. Quality improvement is a team process and includes monitoring and data collection, including client feedback, implementation of quality improvement measures, and evaluation.

Scope of Practice

has the same meaning as in section 3 of the *Midwifery Act, 1991.*

Second birth attendant

has the same meaning as in the Second Birth Attendant Standard.

Transfer

means the transfer of responsibility from a midwife to another midwife or a physician for some, or all, of the duration of the client's care.

ABOUT THE COLLEGE

The College of Midwives of Ontario was established with the proclamation of the *Regulated Health Professions Act, 1991* (RHPA) and the *Midwifery Act, 1991* on December 31, 1993 to govern midwifery. The mandate of the College is to regulate the profession of midwifery in accordance with the RHPA. The College's primary obligation to the public is to ensure that members of the profession are qualified, skilled, and competent in the area in which they practise.

Professional Standards for Midwives
Approved by the College of Midwives of Ontario Council
Approval Date: March 21, 2018
Implementation Date: June 1, 2018

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Guideline on Ending the Midwife-Client Relationship

February 2019

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Introduction

An effective midwife-client relationship is based upon mutual trust and respect. This enables the provision of safe and effective care.

Circumstances may arise in which either the client or midwife decides to end the midwife-client relationship.

Midwives must be aware that ending the midwife-client relationship can have significant consequences for the client. For example, their access to midwifery care may be limited and their level of trust in the midwifery profession may be undermined.

Midwives should make the effort to resolve a situation affecting their ability to provide care and only consider ending the midwife-client relationship when those efforts have been unsuccessful or it may not be possible or safe to attempt to resolve the conflict with the client.

The purpose of this Guideline is to describe situations in which it is appropriate for a midwife-client relationship to end and the corresponding obligations of a midwife in such situations.

Circumstances in Which the Midwife-Client Relationship Cannot End

It is not appropriate to end the midwife-client relationship when it is prohibited by law.

The *Ontario Human Rights Code*[1] prohibits a midwife from ending the midwife-client relationship based on one of the protected grounds in the Code. Protected grounds include age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status, gender identity, gender expression, receipt of public assistance in housing, record of offences in employment, sex and sexual orientation.[2]

In addition, the *Commitment to the Future of Medicare Act*[3] prohibits midwives from ending the midwife-client relationship if the client chooses not to pay a block fee.[4]

A block fee is a flat fee charged for a predetermined set of uninsured services. Uninsured services are typically administrative services in relation to the client's care that take a midwife's time and resources such as sick notes for work, copying and transferring midwifery records and prescription refills over the phone.

Therefore, a midwife cannot end the midwife-client relationship if a client chooses not to pay a block fee for such services.

[1] R.S.O. 1990, c. H. 19
[2] *Ibid*, s. 1.
[3] S.O. 2004, c. 5.
[4] *Ibid*, s. 18(2).

Circumstances in Which the Midwife-Client Relationship Can End

Circumstances where the midwife-client relationship may end include:

- Upon a client's request[5]
- A breach of trust exists[6]
- The midwife has ceased to practise, is on a leave of absence or has relocated
- The midwife is under suspension, revocation or has voluntarily committed to suspend their practise
- The client requests services inconsistent with the standards of practice of the profession and the midwife has adhered to the standard of practice for discontinuing care in such circumstances[7]
- The full course of care has been provided

These circumstances shall be described in turn.

Upon a Client's Request

A client is the primary decision maker with respect to their health care and can request that the midwife-client relationship end for various reasons. For example, a client may decide that midwifery care is not appropriate for their circumstances or may relocate outside of the midwife's catchment area while pregnant.

Whatever the reason, the College's *Professional Standards* require midwives to recognize clients as the primary decision-makers and support their right to accept or refuse treatment.[8] As a result, a midwife should accept a client's request to end the midwife-client relationship.

A Breach of Trust Exists

The midwife-client relationship is built upon mutual trust and respect. When these qualities are absent or have been undermined, the quality of care being provided can be compromised.

Once a breach of trust is found to exist in a midwife-client relationship, a midwife may not be able to continue to provide safe care, in which case they may choose to terminate care, though they must allow the client a reasonable opportunity to arrange for alternative services.[9]

The following are examples of situations that may lead to a breach of trust.

Reporting to Children's Aid Society

Midwives are obligated to report suspected child abuse and/or neglect to the *Children's Aid Society* (CAS). This can be an overwhelming and upsetting experience for a client and can automatically undermine trust in their midwife.

Where possible, midwives should consider:

- Contacting the client prior to making a report to CAS and advising the client of their legal obligation to make the report
- Offering to call CAS together with the client
- Notifying any other midwives involved in the client's care about the report being made
- If it is necessary to terminate the midwife-client relationship, informing the client that their care is being terminated and

[5] O.Reg. 388/09, 8 i.
[6] *Ibid*, 8. iii.
[7] *Supra* note 5, 8.
[8] (June 2018), 16.6.
[9] *Supra* note 5, 8 iii.

arranging for an appropriate transfer of care in a timely manner

Distrusting the Midwife's Competency

Clients may question a midwife's competency and suggest that they would feel more comfortable receiving care from another midwife or health care provider. A midwife should listen to their client's concerns and attempt to address them. For example, a failure to communicate the rationale for a midwife's opinion on managing a certain aspect of the client's care may be the reason why the client does not trust the midwife. This can be easily clarified, and the midwife-client relationship may resume without any distrust remaining. However, if a client suggests that their trust in the midwife's knowledge, skill and judgment has been undermined and the midwife has been unable to remediate the client's concerns, the midwife should offer to transfer the client's care to another midwife or health care provider, depending on the client's wishes.

Inappropriate Behaviour

In some cases, the behaviour of a client and/or their support persons can result in a breach of trust. For example, if a client or a client's spouse repeatedly swears at a midwife or makes demeaning comments, a midwife may feel unsafe and/or unconfident in continuing to provide care and may end the midwife-client relationship.

Inappropriate behaviour also includes crossing professional boundaries, such as a client making sexual advances or comments to a midwife.

Midwives must always assess whether such behaviour would undermine their ability to provide care to a client that is safe and in the client's best interests. If this is the case, then the midwife should end the midwife-client relationship.

Risk of Harm

In some cases, a client and/or their support person(s) may pose a risk of harm to the midwife, their colleagues and/or other clients such as by being physically violent. In such cases, the midwife should immediately end the midwife-client relationship.

Midwives are also reminded that if they have reasonable grounds to believe that another person is likely to cause severe bodily harm, they have a duty to warn appropriate people (e.g. subject of the threat and the police) of the risk.[10] If the person who will likely cause harm is the client, the duty to warn transcends any confidentiality and privacy obligations that are otherwise owed to that client.[11]

Ceasing to Practice, Leave of Absence and Relocation

When a midwife ceases to practise permanently or for a period of time or relocates, client care will be affected.

Pursuant to the *Professional Misconduct Regulation*, midwives cannot discontinue professional services to a community or group of clients without reasonable cause, unless adequate notice has been given or adequate alternative arrangements for services have been made.[12]

[10] See the College's *Guide on Mandatory Reporting Obligations* (May 2018), available online: http://www.cmo.on.ca/wp-content/uploads/2015/11/Guide-on-Mandatory-Reporting-Obligations-May-20181.pdf

[11] *Smith v Jones* [1999] 1 SCR 455.

[12] *Supra* note 5, 9.

Therefore, a midwife should give ample notice of closure to each client for whom the midwife has primary responsibility, within a reasonable amount of time. Examples include placing signs in the office place/practice and individual communication with clients. This is necessary to allow clients time to seek alternate care.

In addition, former clients need to know where their midwifery record is, so it can be accessed for future care or other reasons. The information within a client record is confidential and proper transfer or storage in a manner known by clients is essential.[13]

In the event a midwife is leaving a practice that will continue to operate with other midwives available to provide client care, the midwife should arrange to have another midwife assume care of the clients and should inform the clients about who their new primary midwife is.

The midwife should also take steps to ensure that their clients can access the results of any tests ordered and that all abnormal test results be reviewed and followed-up on by another midwife or health care provider to whom care has been transferred.

Suspension, Revocation, or Voluntary Commitment to Suspend Practice

A midwife who is suspended, revoked or voluntarily commits to suspend practise should ensure that the following persons or entities are notified of their restrictions:

- Clients
- Partners
- Colleagues
- Hospitals where privileges are held

The midwife should:

- Ensure another midwife is available to assume the care of their clients and communicate to the client who this midwife is
- In the event another midwife is not available, provide the client with a referral to another appropriate health care provider, such as a family physician
- Ensure that the client knows how to access their health care records
- Ensure the client's records are transferred with the client's consent, to another health care provider, if the client's care is being transferred to that health care provider
- Notify the health care provider that is assuming care of the client of any outstanding tests

Pursuant to *the Professional Misconduct Regulation*, it is considered professional misconduct for a midwife to contravene a term, condition or limitation on their certificate of registration.[14]

A midwife's conduct in complying with their terms, conditions and limitations and acting in the best interests of their former clients can be factors in the Registration Committee's determination of whether it would be appropriate to reinstate a midwife whose certificate of registration has been revoked.

The Client Requests Services Below a Standard of Practice of the Profession

Clients may choose care that is below a midwifery standard of practice. A midwife may discontinue care in such circumstances provided they adhere to the standard of practice for doing so.

[13] *Supra* note 8, *Professional Standards*, 37.

[14] *Supra* note 5, 1.

In particular, if a client requests care below a standard of practice prior to labour, a midwife may terminate care depending on the nature of the care requested and if there is time to find another health care provider for the client.

For example, if a client declines all prenatal screening and tests and wants a home birth, then a midwife can terminate their care and attempt to arrange for alternative services acceptable to the client (such as by transferring the client's records over to their local hospital in the event they need assistance during labour).

However, the College's Professional Standards[15] require that a midwife not abandon a client while in labour. As a result, if a client requests care below a standard of practice while they are in labour, a midwife should consider the following:

- If the care requested requires knowledge or skills that a midwife does not have, the midwife should inform the client of this and call for assistance (e.g. EMS at a home birth)
- If the care requested is not in accordance with best practice (e.g. a client chooses to remain home for labour despite having a baby in breech position), then a midwife should conduct an informed choice discussion so the client is aware of the risks of their decision and proceed to provide care in accordance with the client's requests.

It is important to note that it is not appropriate to end a midwife-client relationship just because a midwife doesn't agree with the client's choice or because the client refuses a midwife's recommendation.

The Full Course of Midwifery Care Has Been Provided

It is natural for the midwife-client relationship to end once the full course of midwifery care has been provided. No further care is provided to the client after discharge and the midwife-client relationship comes to its natural conclusion.

General Obligations When Ending the Midwife-Client Relationship

Irrespective of the reason for ending the midwife-client relationship, midwives have general obligations they must adhere to, including the following:

- Document all discussions and decisions[16]
- If discontinuing professional services to a group of clients, providing adequate notice to those clients of the termination[17]
- Making arrangements for health care services to be provided to the client by another health care provider[18]
- Ensuring the client is aware of how to access their midwifery records[19]
- Ensuring that the client's midwifery records are stored and transferred in compliance with the

[15] *Supra* note 8, Professional Standards #33.
[16] *Recordkeeping Standard* (Jan 2013) Available Online: https://www.cmo.on.ca/wp-content/uploads/2020/02/Updated-Record-Keeping-Standard-2019.pdf
[17] *Supra* note 5, 9.
[18] *Ibid*, 8 ii.
[19] *Supra* note 8, Professional Standards #37.

Personal Health Information & Protection Act (PHIPA)[20]
- If initiating a transfer of care, providing complete and accurate client information to the health care provider that is assuming care[21]
- Ensuring that clients can access the results of any tests that have been ordered[22]
- Ensuring that any abnormal test results are followed up on by an appropriate health care provider in a timely manner [23]

In addition, it is recommended that a midwife speak with a client directly either in person or through phone to advise the client of ending the midwife-client relationship and the reasons for doing so.

It is also recommended that a registered letter be sent to the client confirming termination of care and that a copy of the letter be maintained in the client's record.

Conclusion

The midwife-client relationship may come to an end for various reasons. Midwives must ensure that ending the relationship or the manner of ending it will not contravene the law or College standards.

For any questions relating to ending the midwife-client relationship, please contact the Professional Practice Advisor at practiceadvice@cmo.on.ca or call (416)640-2252 x. 230.

[20] S.O. 2004, c.3. See the College's Guide on PHIPA (October 2017) Available Online: http://www.cmo.on.ca/wp-content/uploads/2017/09/Guide-on-Compliance-with-PHIPA-Revised-September-17.pdf

[21] *Supra* note 8, Professional Standards 29.

[22] *Supra* note 19.

[23] *Supra* note 8, Professional Standards 25.4.

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FOR DISCUSSION

BRIEFING NOTE FOR COUNCIL

Subject: Registration Regulation – Clinical Currency Recommendations

Background

The Registration Regulation made under the *Midwifery Act, 1991,* is complex and covers many areas, including:

1. Prescribing non-exemptible and exemptible requirements for the purposes of entry and re-entry to practice, such as clinical experience requirements; good character requirements; qualifying examination; and continuing competencies (i.e., neonatal resuscitation, emergency skills and cardiopulmonary resuscitation).
2. Prescribing classes of registration, including requirements for the issue of and ongoing conditions for certificates of registration, including clinical currency/active practice requirements and continuing competencies, class change requirements and new registrant conditions.
3. Defining suspension, revocation and reinstatement of certificates of registration

Work to review and revise the Registration Regulation has been underway for some time. The Registration Committee has already done a significant amount work around clinical currency, new registrant conditions and classes of registration (including issuance and ongoing conditions of registration), which included literature review and jurisdictional analysis, numerous consultations with partner organizations and direct engagement with midwives. The Committee will continue its work in 2021 with the aim of bringing the first draft of the regulation to Council for review in March 2021.

Key Considerations

At this time, the committee is bringing its initial recommendations on clinical currency to Council for initial review - please refer to the attached regulatory impact assessment (RIA) statement.

The RIA statement is a tool designed to critically assess the positive and negative effects of proposed and existing regulations and non-regulatory alternatives and is a crucial element of the College's risk-based and evidence-based approach to regulatory policy making to enable rigour and better policy outcomes. It was approved by Council in June 2017.

Recommendations

N/A

Implementation Date

N/A

Legislative and Other References

Registration Regulation under the *Midwifery Act, 1991*

Attachments

Regulatory Impact Assessment Statement – Clinical Currency

Submitted by: Registration Committee

Regulatory Impact Assessment Statement

Title of the Initiative: Clinical Currency

Context and Problem Definition

1. **Clearly identify and define the problem you are trying to solve. Demonstrate why it is a problem.**

Background

The College's overarching objective is the protection of the public, which involves a duty to protect, promote and maintain the well-being and safety of the public and to promote and maintain public confidence in the midwifery profession in Ontario. While the quality of midwifery services relies, by and large, on the integrity and professionalism of the practitioner, in terms of both competence and conduct, it is the job of the regulator to set minimum requirements (such as minimum standards of behaviour or registration requirements) that ensure that midwives practising in Ontario possess and are able to demonstrate the knowledge, skills, and judgment relevant to their professional practice.

Many health regulatory bodies and many registration regulations for health professions in Ontario, require their members to fulfill certain clinical currency requirements in order to maintain a practising certificate of registration. In Ontario, active practice has been implemented as the clinical currency requirement for midwives. The Registration Regulation, made under the *Midwifery Act, 1991* defines *active practice* as *the provision of midwifery care to a woman throughout pregnancy, labour, birth and the postpartum period* in the following manner:

1. For the first two years of being registered in the general class, midwives must attend at least 40 births and of those births, at least 20 births must have been attended in the role of primary, including 10 hospital births and 10 births in a residence, remote clinic or remote birth centre (out-of-hospital births).
2. Once the midwife has met these requirements over an initial two-year period, then they may meet the active practice requirements in any subsequent five-year period by providing midwifery care to at least 100 women, with at least 25 births being attended as primary midwife in hospital and at least 25 being attended as primary midwife in a residence, remote clinic, or remote birth centre.

Midwives are required to report their birth numbers annually, for the period of July 1-June 30, at registration renewal time. Each midwife has an active practice requirement due date and if the midwife is due to meet a requirement then their birth numbers are reviewed to determine if the midwife met the requirements or has a shortfall.

A midwife who fails to satisfy the active practice requirements is referred to a panel of the Registration Committee that will do one of the following:

1. Grant an exception under extenuating circumstances; or
2. Propose a shortfall plan to enable the member to meet the active practice requirements, which may include a requirement that the midwife give an undertaking to the Registration Committee that they will comply with any term, condition or limitation imposed on their certificate of registration.

Challenges with the current approach to clinical currency

Currently, the active practice requirements only regulate two aspects of midwifery care: primary birth attendance and location of births. Requiring members to attend a certain number of births in various locations as primary midwife, does not address the fact that midwifery practice also involves the provision of care to women throughout pregnancy, labour, birth and the postpartum period, as well as newborn care.

Definitions of terms used below:

A primary midwife is a midwife that is responsible for the prenatal, intrapartum and postpartum care of the client and the newborn such as performing assessments, organizing consultations, and writing orders. The primary midwife is generally present for the labour, at birth to deliver the baby, and the immediate postpartum.

A second midwife normally attends near the end of the first stage of labour or early in the second stage of labour. The second midwife is present for the birth and provides care together with the primary midwife. The second midwife is normally responsible for the assessment and initial care of the newborn at birth and remains after the birth until the client and baby are stable.

Concerns with the current approach include the following:

1. The required birth numbers are arbitrary and prescriptive.
2. Birth numbers are not an objective measurement of clinical currency. Although the literature supports high volume thresholds for complex surgical and some rare medical conditions, there is no evidence to support the extrapolation of these volume concepts to normal pregnancy and newborn care. Rather, findings demonstrate good outcomes in low-volume settings when access to specialist consultation and timely transfer is available and used appropriately
3. Attendance at births, does not equal clinical currency and the number of births that a member attends in various locations depends on an external factor that is outside the midwife's control, i.e. their client's choice.
4. When members have a shortfall in births, it is usually related to not having enough out of hospital births – low home birth rates are a legitimate reason why some members in some communities will consistently not be able to

meet the out of hospital birth requirements – shared care models may also contribute to this
5. A birth may start at home but end up transferring to hospital for various reasons and is then considered a hospital birth
6. While attending births as primary does help with the maintenance of knowledge and skills related to labour and intrapartum care, it does not assist in the maintenance of skills related to all other aspects of midwifery care. Therefore, it does not point to overall clinical currency
7. Midwives also attend births in the role of second, yet the active practice requirements specified in the Registration Regulation do not explicitly recognize this important aspect of care
8. In more recent years, ways in which the profession practises have evolved and we now have members who are practising midwives but they do not attend births or only attend births in a certain setting

In summary, while active practice as defined in the current regulation provides some assurance that the midwife is practising and attending births in various settings as a primary midwife, it is problematic for regulating clinical currency as one of the measures of competence.

2. Is the problem about risk of harm?

As a risk-based regulator, the College must ensure that any regulatory action is based on evidence of risk and is proportionate to the risk of harm being managed.

It is our view the lack of clarity about what constitutes actively practising the profession and how the College should address active practice shortfalls pose a risk of harm to our public protection mandate. In particular, the College must be able to assure the public that:

- midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care
- midwives demonstrate accountability by complying with legislative and regulatory requirements
- the College of Midwives of Ontario regulates in the public interest

3. If yes, explain the risks.

Determining clinical currency requirements and how the College plans to deal with active practice/currency shortfalls will help mitigate the following risks that may adversely impact midwifery clients and the public interest.

1. Risks arising from the changing midwifery environment that may affect midwifery practice (e.g. diverse midwifery careers, more midwives practising outside of the midwifery practice group model)
2. Risk that public perception of the College and its ability to regulate in the public interest is adversely affected

3. Risk that a midwife does not maintain knowledge and clinical skills necessary to provide high quality care to clients
4. Risk that a midwife fails to comply with legislative or regulatory requirements

Options

4. Are the risks you have identified currently managed?

We believe that the risks the College has identified are not appropriately managed. As demonstrated above, the College's focus historically has been on preserving the midwifery model of care (e.g., ensuring midwives attend births in home settings) instead of looking at the issue of clinical currency more broadly. This has emphasized compliance using rigid, prescriptive rules (i.e., number of births in a particular setting). In keeping with current evidence, the College needs to adopt an approach that ensures clinical currency without restricting practitioner flexibility and allows the profession to evolve.

5. Are there any alternatives to regulation that will mitigate identified risks?

There are no alternatives to regulation that will mitigate the identified risks. The College is the only organization with a legislative mandate to regulate the practice of the midwifery profession to ensure that members of the profession are qualified, skilled and competent in the areas in which they practise. Under the *Regulated Health Professions Act, 1991* (RHPA) the College is required to develop, establish and maintain programs to assure the quality of the practice of the profession and to develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members. The College can make regulations (under its profession-specific statute, i.e., *the Midwifery Act, 1991)* prescribing classes of registration and imposing any terms and conditions on the certificates of registration, including imposing clinical currency requirements.

Evidence Base, Initial Assessment of Impacts and Planning of Further Work

6. What regulatory option are you recommending?

The changes are proposed to the Registration Regulation made under the Midwifery Act, 1991. The following framework is brought forward for Council's review. Recommendations made with regard to clinical currency for practising midwives will be used to propose recommendations for non-practising midwives moving back into practice and former members returning to practice.

When considering these recommendations, it is important to remember that clinical currency requirements alone cannot ensure competence. Nor are they the only measure used by the College to assess its members' knowledge, skills and judgment. It is the College's core functions – registration, quality assurance, standards/policy development and complaints/reports and discipline - that create a complex regulatory

system that exists to protect the public and the public interest. These regulatory functions together ensure that clients in midwifery care can be confident that their midwives possess and maintain the knowledge, skills and judgement required to provide safe and effective care.

Clinical currency requirements for practising midwives		
#	Provisions in the regulation	Details to be included in policy/other tools (these will be finalized and approved after the regulation had been submitted to the Ministry)
1	Midwives holding a certificate of registration in the general class will be required to demonstrate clinical currency every two years.	Policy to define what "demonstrate clinical currency every 2 years" means. It is recommended that - midwives be required to practise for a MINIMUM number of hours over every 2-year period. Please refer to pp. 9-11 to see how we will determine the minimum number of hours. - the hours that midwives will be allowed to count towards clinical currency requirements will be those in which they either provided clinical care to clients (including care that does not include direct client care, such as lab work, consults, etc.), or acted as a supervisor, mentor or a preceptor. - practice hours will reflect the midwifery scope of practice set out in the Midwifery Act, 1991 but midwives will not be required to practise to full scope.
2	Midwives will be required, as a condition of their general certificate of registration, to only practise in the areas of midwifery in which they are competent.	Policy to define what it means to "only practise in the areas of midwifery in which they are competent". - Areas of practice will be tied to the legislative scope as set out in the *Midwifery Act* - this requirement will be imposed as a condition on midwives' certificates of registration *Note: under the Professional Misconduct regulation it is an act of professional misconduct for a midwife to contravene a term, condition or limitation on their certificate of registration.* - A self-assessment tool will be developed to support midwives to reflect on core competencies for each area of midwifery practice to identify strengths and learning needs (if any).
3	Midwives who do not meet clinical currency requirements in the 2-year period will be	This requires development and implementation of a competency-based assessment program. This has

	required to complete an assessment program approved by the Registration Committee.	been identified as a strategic priority in the College's 2021-2026 Strategic Plan. Policy to set out procedures as follows: - any shortfall will trigger an assessment referral to a panel of the Registration Committee. - depending on how the assessment is structured, successful completion of the assessment may result in no action.
4	Midwives whose knowledge, skill and judgment have been assessed and have been found to be unsatisfactory, will be required to complete a requalification/retraining program.	Policy to set out procedures.

7. What are the benefits and costs of the options you are considering?

Benefits:

- Allow the College to determine suitability to practise based on the provision of care to women throughout pregnancy, labour, birth and the postpartum period, as well as newborn care as opposed to just focusing on an arbitrary number of primary births as a measure of competence.
- Allow the College to fulfill its regulatory objectives more effectively and focus on substantive compliance rather than "box-ticking" compliance.
    - Detailed rules (e.g., certain number of births that must be attended within a certain period of time), it is often claimed, provide a clear standard of behaviour and are easier to apply consistently. However, they can lead to inconsistencies, rigidity and are prone to "creative compliance" (e.g., a midwife scheduling to attend an out of hospital birth not based on the needs of their client but because of College requirements).
- Allow the College to develop an effective registration program that clearly sets out what constitutes clinical currency, how the College determines suitability to practise and what action will be taken if a midwife cannot demonstrate suitability to practise.
- Allow the profession to evolve and give midwives more flexibility to organize their practice in a way that better meets the needs of their clients given the unique conditions under which midwives work.

<u>Costs</u>

- Midwives who will be required to complete an assessment program will incur all costs associated with the assessment and any training program they may be

required to complete. This is in line with the current Fees and Remuneration Bylaw under which the College *may charge a member a fee in connection with decisions or activities that the College or a College committee are required or authorized to make or do in respect to a member* (s. 8.1). This includes any monitoring, assessment and requalification program ordered by the Registration Committee.

- The College will require external expertise to develop an assessment program (to be able to objectively assess midwives unable to meet the College's clinical currency requirements). The College will be able to submit its proposed regulation to the Ministry of Health before these programs are developed and implemented.

8. Will the burden imposed by regulation be greater than the benefits of regulation?

The burden imposed by regulation will not be greater than the benefits of regulation. As noted above, the College is the only organization with a legislative mandate to regulate the midwifery profession to ensure that midwives are qualified, skilled and competent in the areas in which they practise. The College must be able to assure the public that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care.

9. What information and data are already available?

The Committee held numerous meetings throughout 2020 and considered/was provided with the following:

1. <u>How should active practice/clinical currency be defined?</u>

The midwifery scope of practice statement is set out in s. 3 of the *Midwifery Act*:

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

Under the *Midwifery Act, 1991*, midwives are not required to practise to full scope (i.e., perform all aspects of legislative scope of midwifery practice) but may choose to perform some, but not all, aspects of the midwifery scope of practice (e.g., only provide postpartum and newborn care) in which case their individual scope will be smaller than the legislative scope. A midwife's individual scope of practice can change throughout their career. Midwives can choose to expand their individual scope by engaging in professional development activities, such as participating in trainings and taking courses.

2. Why the College should stop regulating hospital and out-of-hospital births as a measure of clinical currency?

It is a standard of practice of the profession that midwives must offer choice of birthplace and must provide care during labour and birth in the setting chosen by the client (Professional Standards for Midwives). It is not clear that regulating birth attendance in various locations as a measure of competence is in the public interest. In fact, it may not be fair that a midwife's ability to meet clinical currency requirements is dependent on a choice made by their clients or dictated by necessary changes to birth location in support of client safety.

3. Why the College should develop an assessment program to be able to assess midwives who do not meet the College's clinical currency requirements

When midwives do not meet their active practice requirements and are referred to a panel of the Registration Committee, there are very few options available to the panel. More recently, where a midwife has been working outside of the midwifery practice group model and attended very few births in the previous five years, the panel has decided in the interest of public protection and based on the midwife continuing to practise in this limited way, to impose a term, condition or limitation (TCL) on that midwife's general certificate of registration. The reason for the TCL is to formally and publicly limit the midwife's practice to just the aspects of care that are part of their current role. While this regulatory option is available under the Registration Regulation, it is likely not a sustainable solution going forward if more and more midwives start providing episodic care and are referred to a panel of the Registration Committee. In addition, without an objective assessment program, members may have TCLs imposed when in fact there are no concerns with their competencies.

4. Skills fade research

While there is a lack of research in terms of what midwives must to do to remain clinically current and generally no research to support a certain number of births, there is research that looks at when and how time out of practice impacts on skills, competence and performance from the literature about health care practitioners.

- There is substantial evidence that time out of practice does impact on skills retention.
- Skills have been shown to decline over periods ranging from 6 to 24 months, according to a curve, with a steeper decline at the outset and a more gradual decline as time passes.
- Skills fade depends on the following factors:
    - Organizational: Skills fade may be mitigated by staying in touch with peers and staying aware of recent developments
    - Job or task
        - Particular skills fade at different rates
        - Skills fade faster than knowledge
        - Fine motor skills fade more than other tasks

        - Fade is quicker in first 6 months then tapers off
    - Training or assessment: Skills fade more if there is no opportunity to practise them between trainings (e.g., CPR, NRP)
    - Individual factors
        - Older age can lead to lower performance
        - Increasing time out of practice can lead to lower performance
        - Novices lose skills faster than more experienced practitioners
        - The higher the level of proficient pre-hiatus the higher the level of retention
- While the available evidence substantiates that practitioners, who do not actively practise are vulnerable to skill decay, there is no available literature objectively measuring skill decay or describing strategies to support practitioners as they transition back to clinical duties. However, there is evidence that self -assessment of competence is poor and is not sufficient to determine how skills fade should be addressed
- All clinicians need updating

5. Jurisdictional scan to help the committee understand how other Canadian and international regulators currently approach clinical currency

While the vast majority of primary care regulators require that their registrants' complete certain number of practice hours over a certain number of years, there is no research about how many hours or weeks practitioners must practise to remain clinically current.

6. The two-year threshold

It is acknowledged that there is a lack of empirical evidence to back-up or justify timeframes. However, two years seems to be the outside edge of research. A literature review of Canadian and international scholarly articles and research papers with respect to skills fade showed that practitioners', including midwives' skills begin to fade in as little as 6 months out of practice or a particular clinical aspect.

7. How should the number of practice hours be set?

As noted above, the Committee recommends that midwives demonstrate clinical currency by practising for a set minimum number of hours over a 2-year period. The next question is, how should this number be determined?

Despite the fact that all types of data are being collected through different organizations, there is very little actual practice data available in the province.

We know that the majority of midwives are compensated through midwifery practice groups (MPGs) based on a funding formula that requires midwives to provide prenatal, intrapartum, postpartum, and newborn care. This is known as a "course of care model".

In accordance with the funding agreement (negotiated by the Association of Ontario Midwives on behalf of the profession) "course of care" involves, on average, 48 hours of midwifery services per client. In addition, the agreement says that a midwife practising full time who works in a course of care model provides 40 courses of care annually. Based on staff's discussions with College stakeholders, 48 hours of midwifery services and 40 courses of care are not necessarily accurate and should not be used to for the purposes of clinical currency.

Staff have analyzed College internal data and were able to obtain some information from the Better Outcomes Registry & Network (BORN), Ontario's prescribed maternal, newborn and child registry funded by the Ministry of Health.

What we know:

1. BORN data show that each midwifery client receives, on average, 23 prenatal and postpartum visits during their care with an average of 45 minutes per visit. So that amounts to approximately 17 hours of visits but not including labor/birth and immediate postpartum.

2. Labour/delivery and immediate postpartum vary significantly between each client. We will use a low number of 10 hours for our calculation.

3. A full-time practising midwife provides, on average, 30 courses of care. We can assume, based on the funding model, that each primary birth equals one course of care (*one course of care does not necessarily equal one client). This assumption is supported by College internal data. For example, based on our active practice data, in the 2018/2019 reporting year approximately 52% of midwives registered in the general or supervised practice class provided 30 or more primary births. In the 2017/2018 reporting year, 55% of midwives registered in the general or supervised practice class provided 30 or more primary births.

Based on the above 3 bullet points, the following calculation can be made: (17 hours of prenatal/postpartum visits + 10 hours of labour/delivery/immediate postpartum) x 30 courses of care = 810 practice hours for a full-time practising midwife.

4. We do not have any information regarding other clinical activities that do not necessarily include direct client contact, such as lab work, consults as well as births in the role of a second midwife. Once determined these hours will be counted towards clinical currency requirements.

5. We do not know how midwives who work outside the course of care model practise. While we know that some midwives who practise exclusively within other models provide episodic midwifery care (e.g. they do not provide intrapartum care), we do not know approximately how many hours of clinical care they provide.

Important: *clinical practice hours set to demonstrate clinical currency will be much lower than hours practised by a full-time midwife. The committee has not made this decision yet.*

How are we planning to validate the above analysis/calculation?

We will survey midwives to collect baseline data in 2021. The survey will be carefully designed with questions that accurately reflect midwifery practice to be able to validate the accuracy of our data. We will conduct the same survey annually to track how responses change against a set of baseline questions that were asked in the previous annual surveys. The same question wording will be used to maintain a similar context to be able to compare results from the current survey and previous surveys in which the questions were asked.

10. **What further information needs to be gathered? How will this be done, and by when?**

Mostly, information related to midwives who work outside the course of care model. The Committee plans to review any additional information at its January 2021 meeting to be able to finalize its recommendations.

11. **How do you plan to engage with those who will be affected by this policy proposal?**

Please see above under *How are we planning to validate the above analysis/calculation.* We anticipate further consultations with midwives when final recommendations are made.

12. **Are there any areas of uncertainty that could impact the final decision?**

None at this stage.

Implementation

13. **How are you planning to implement and evaluate the proposed policy option?**

This section will be completed when the recommendations are finalized.

Attachments: None

Submitted by: Registration Committee

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Claudette Leduc

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Claudette Leduc — Sep 23 20

Name (please print) — Signature — Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Don Strickland

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Don Strickland	Don Strickland	09/22/2020
Name (please print)	Signature	Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Claire Ramlogan-Salanga

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Claire Ramlogan-Salanga	CRS	Sept 25/20
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Edan Thomas _____

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

[X] DO NOT have an actual or perceived conflict of interest.

[ ] DO have a conflict of interest (please explain)

_____

_____

_____

_____

_____

Edan Thomas  September 23 2020

_____

Name (please print) Signature Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Isabelle Milot

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

I. Milot — Name (please print)

Signature

Sept 23-20 — Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

KAREN McKENZIE

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

[X] **DO NOT** have an actual or perceived conflict of interest.

[ ] **DO** have a conflict of interest (please explain)

KAREN McKENZIE	K McKenzie	2020-09-29
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Lilly Martin

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☒ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Lilly Martin | [signature] | 29 Sept 20

Name (please print) | Signature | Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Marianna Kaminska

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Marianna Kaminska	Marianna K.	Oct 2, 2020
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Maureen Silverman

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

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Maureen Silverman		29-Sept-2020
Name (please print)	Signature	Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Pete Aarssen

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Pete Aarssen		September 23, 2020
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Sarah Baker

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Sarah Baker		2020/10
Name (please print)	Signature	Date

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Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Judith Murray

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Judith Murray — J Murray — 26-11-20

Name (please print) | Signature | Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Declaration of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Jan Teeuwsen

a Member of Council or a Committee of the Council of the College of Midwives of Ontario currently

☒ **DO NOT** have an actual or perceived conflict of interest

☐ **DO** have a conflict of interest (please explain)

Jan Teeuwsen | Jan Teeuwsen | November 26, 2020

Name (please print) | Signature | Date

Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.