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

Council Meeting

June 23, 2021

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, June 23, 2021 from 9:30 AM to 2:30 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.

AVIS DE RÉUNION DU CONSEIL

L'Ordre des sages-femmes de l'Ontario tiendra une réunion par vidéoconférence, de 9 h 30 à 14 h 30, le 23 juin.

Cette réunion est ouverte au public. Toute personne intéressée peut obtenir les détails pour accéder à la réunion en écrivant à l'Ordre, à cmo@cmo.on.ca , ou en composant le 416-640-2252, poste 227.

Kelly Dobbin
Registrar & CEO/ Registrateure et PDG

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.

Strategic Framework
2021–2026

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

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 paves the way forward for the organization, builds a stronger sense of common purpose and direction and a shared understanding of why we exist, what guides our work, and what we want to achieve as an organization.

Our Vision

A leader in regulatory excellence, inspiring trust and confidence

Our Mission

Regulating midwifery 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.

Key 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 Guiding Principles

These interrelated principles define how we strive to work as an organization, shape our culture and our relationships with the public, midwives, and partner organizations.

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 tangible benefits for the organization.

COUNCIL AGENDA

Wednesday, June 23, 2021 | 9:30 am to 2:30 pm
College of Midwives of Ontario
Microsoft Teamshare

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
1.	Call to Order: Welcome & Land Acknowledgment	C. Ramlogan-Salanga	9:30	INFORMATION	-	-
2.	Conflict of Interest	C. Ramlogan-Salanga	9:40		*All Council COIs appended to end of meeting book	-
3.	Review and Approval of Proposed Agenda	C. Ramlogan-Salanga	9:42	MOTION	3.0 Agenda	5
4.	Consent Agenda - Draft Minutes of March 24, 2021 Council Meeting Annual reports of: - Executive Committee - Registration Committee - Quality Assurance Committee - Inquiries, Complaints and Reports Committee Report - Discipline Committee - Fitness to Practise Committee - Client Relations Committee	C. Ramlogan-Salanga	9:45	MOTION	4.0 Draft Minutes 4.1 Executive Committee 4.2 Registration Committee 4.3 Quality Assurance Committee 4.4 Inquiries, Complaints and Reports Committee 4.5 Discipline Committee 4.6 Fitness to Practise Committee 4.7 Client Relations Committee	7
5.	Chair Report	C. Ramlogan-Salanga	9:50	MOTION	5.5 Chair Report	44
6.	Executive Committee Report	C. Ramlogan-Salanga	10:05	MOTION	6.0 Executive Committee Report 6.1 Revised Costed Strategic Plan 6.2 Q4 SOP	46

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
	I. Audited Financial Statements	Hilborn, LLP		MOTION	6.3 Draft Audited Financial Statements	58
			Break 10:45			
7.	Registrar Report	K. Dobbin	11:00	MOTION	7.0 Registrar's Report 7.1 Grey Matters 7.2 Letter to Colleges Regulatory re: Governance Reform	77
8.	IN CAMERA: Registrar Review	C. Ramlogan-Salanga	11;45	MOTION	*Documents not Public. Council members see IN-CAMERA folder for access.	86
			LUNCH 12:15			
9.	QAC: Quality Assurance Program	L. Martin	1:00	MOTION		87
10.	Measuring Regulatory Performance	M. Solakhyan	1:30	INFORMATION	10;0 Briefing Note 10.1 Regulatory Performance Report	114
11.	Housekeeping		2:15	INFORMATION	-	-
12.	Adjournment	C. Ramlogan-Salanga	2:30	MOTION	-	-
	Next Meetings: October 5-6, 2021 December 7-8, 2021			INFORMATION		

MINUTES OF COUNCIL MEETING

Held on March 24, 2021 | 9:30 am to 3:20 pm
Microsoft Teams Videoconference

Chair:	Claire Ramlogan-Salanga
Present:	Jan Teevan, RM; Lilly Martin, RM; Edan Thomas, RM; Maureen Silverman, RM; Claudette Leduc, RM; Isabelle Milot; Marianna Kaminska; Judith Murray; Don Strickland; Pete Aarssen; Sarah Baker; Karen McKenzie, RM
Regrets:	None.
Staff:	Kelly Dobbin; Carolyn Doornekamp; Victoria Marshall; Marina Solakhyan; Johanna Geraci; Nadja Gale;
Observers:	Sarah Kibaalya (MOH); Julie Toole (AOM)
Recorder	Zahra Grant

1. Call to Order, Safety, Welcome and Land Acknowledgement

   Claire Ramlogan-Salanga Chair, called the meeting to order at 9:31 am and welcomed all present. Council member Jan Teevan shared a land acknowledgement to open the meeting.

2. Declaration of Conflict of Interests

   No conflicts of interest were declared.

3. Proposed Agenda

   The proposed agenda was approved as presented

   Moved: Marianna Kaminska
   Seconded: Maureen Silverman
   CARRIED

4. Consent Agenda

   MOTION: THAT THE CONSENT AGENDA CONSISTING OF:

   - Draft Minutes of December 11, 2020 Council Meeting

   Quarter 3 Reports of:

   - 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: Don Strickland
Seconded: Jan Teevan
CARRIED

5. Chair Report

The Chair, Claire Ramlogan-Salanga presented her report providing highlights and a summary of her meetings with various stakeholders since the last meeting.

MOTION: That the President's Report to Council be approved as presented

Moved: Marianna Kaminska
Seconded: Maureen Silverman
CARRIED

6. Executive Committee Report

The Chair introduced the Executive report providing highlights. The committee at their last meeting approved the Q3 statement of Operations on behalf of Council included in materials for Council reference. The College remains in good cash flow position.

The committee has engaged with Hilborn LLP, the College's independent financial auditor, regarding the scope and process of this years' financial audit.

The committee reviewed the College's Governance Manual and Governance Education Modules to approve language and legislative related updates.

Sam Goodwin of Goodwin Consulting joined the meeting to review the proposed criteria for the Registrar's performance review for future years, as well to review the performance review process for the current review period ending March 31, 2021. Mr. Goodwin then provided a timeline of what to expect of the upcoming review and what communications Council members could expect to receive during the process.

MOTION: That the Executive report be approved as presented

Moved: Judith Murray
Seconded: Lilly Martin
CARRIED

7. Registrar's Report

Kelly Dobbin, Registrar announced that there will be two vacancies in this year's Council election. Jan Teevan is serving her third and final term and is therefore not eligible for re-election. Maureen Silverman is serving the end of her first term and is eligible for re-election. The call for nominations will go out April 1, with the deadline to receive nominations May 1, 2021.

There is an ongoing effort to increase the diversity of representation of members of Council to represent Indigenous, Black and racialized midwives, as well as midwives working in rural or remote locations, internationally educated midwives, and midwives who work in Expanded Midwifery Care Models. The Registrar shared the various strategies staff will use to expand and target outreach and encouraged current professional members to reach out to colleagues to share and encourage individuals to participate in the election. Chair, Claire Ramlogan-Salanga, also added that an opportunity to have an open conversation with her as Chair to speak to experiences on Council may be helpful and is something that will be considered for this election cycle.

Regarding the College's submission for Ministry's College Performance Measurement Framework, the report is in the final stages will be finalized and posted to website by March 31st. Once posted it will be shared with members of Council.

The 2020-2021 Annual Operational plan was also presented. Most of the planned activities to be achieved over the year were completed. There were a few initiatives that were not achievable due to the ongoing Covid-19 pandemic.

The Registrar presented the 2021-2026 Strategic Plan for final approval, Council was also provided with a Costed plan outlining the proposed schedule of planned initiatives and their associated (estimate) costs.

MOTION: That the Registrar's Report be approved as presented approve the 2021-2026 Strategic Plan and that & the Costed Plan be approved as presented.

Moved: Lilly Martin
Seconded: Donald Strickland
CARRIED

8. Budget 2020-2021

Carolyn Doornekamp, Director of Operations introduced the proposed budget for fiscal year 2021-2022. The Executive Committee, acting as the College's finance Committee reviewed in detail the one-year budget during their meeting in February and had discussed all potential implications on the College's long-term financial position.

With the 2021-22 budget the College continues to project a deficit. That deficit will be offset by the Colleges existing unrestricted net assets. The College projects several more years of deficit budgets ahead, but can also project through the use of its unrestricted net assets, its financial sustainability.

MOTION: That the proposed Budget for the 2021-22 fiscal year be approved as presented

Moved: Don Strickland
Seconded: Jan Teevan
CARRIED

9. Registration Regulation

Isabelle Milot provided Council with a brief update on the significant work the committee has been doing on the revisions and proposals to the Registration Regulation. Nadja Gale, Manager of Registration was introduced to present the proposals of the committee and their accompanying regulatory impact assessments (RIA). The RIA a tool used by College committees to critically assess the risks to the public and public interest, to understand potential positive and negative impacts of proposed and existing policies, as well as structure ideas and test assumptions.

Council reviewed and discussed the recommendations regarding classes of registration, including requirements for issuance and ongoing registration requirements as well as the recommendations on new registrant conditions.

Regarding new registrant conditions, a mentorship program will be developed before the proposed regulation comes into effect. The program will be specifically designed to promote the transition of newly registered midwives to independent practice by providing a formal framework of clinical practice support, mentoring, and reflection. The framework will be designed by an expert advisory committee and will be approved by the Registration Committee.

With respect to clinical requirements, the current regulation is very specific in terms of number of births in specific settings (out of hospital and hospital) as well as continuity of care requirements that applicants are expected to have at entry to practice. The specific numbers required are arbitrary and not supported by evidence, the committee is looking to continue to have a clinical requirement and is in the process of consulting with various stakeholders, including the Midwifery Education Program and the International Midwife Pre-Registration Program to establish reasonable requirements to propose in the submission.

A specific recommendation brought to Council's attention was with regard to members who are registered in the Supervised class to be able to move to the Non-Practising class. Under the current regulation, members holding Supervised Practice registration cannot move to the Inactive class. The committee is making the recommendation that this would not change in the new proposal, but Council was asked for specific input on the matter. The Council discussed in depth the various restrictions, as well as various contexts where these conditions may be limiting. One suggestion of the Council that had not been considered by the committee was the idea of a 'retired' class' to maintain title but different from 'non-practising' where there is the perception of eventual return to practise, retired would be clear that the midwife is no longer practising. The committee will review and discuss this consideration.

The committee had previously considered an 'educators' class, however, they concluded in the context of a smaller profession, and recognizing the small numbers of individuals who would actually fall within it, would be administratively burdensome with no public interest rationale.

There was no motion attached to this agenda item and the proposals of the Registration committee were brought for discussion only.

10. IN-CAMERA

College staff and observers left the meeting and Council went in Camera to review and discuss the annual organizational effectiveness survey.

MOTION: Be it resolved that Council move in-camera at 2:50 pm.

Moved: Claudette Leduc
Seconded: Don Strickland

MOTION: Be it resolved that Council move out of in-camera at 3:20 pm.

Moved: Marianna Kaminska
Seconded: Claudette Leduc

11. Birth Centre Presentation

Kelly Dobbin, Registrar presented to Council a summary of the Birth Centre Assessment Program The presentation included of a review of the regulatory framework that gives the College regulatory oversight powers under the *Independent Health Facilities Act* and the role the College plays in setting Facility Standards and Clinical Practice Guidelines. The College administers facility assessments of the two Ontario Midwife-Led Birth Centres on behalf of the Ministry of Health every five years or when requested by the IHF Director. A review of the program, tools, reports, evaluation of program and plan for ongoing maintenance was also shared with Council.

This item was brought for information only with no proposed motion.

12. Adjournment

MOTION: THAT THE MEETING BE ADJOURNED AT 3:41 pm.

Moved: Jan Teevan
Seconded: Judith Murray
CARRIED

EXECUTIVE COMMITTEE

ANNUAL REPORT TO COUNCIL
APRIL 2020-MARCH 2021

Committee Members

April 2020-October 2020	October 2020-March 2021
Chair: Claire Ramlogan-Salanga, RM	Chair: Claire Ramlogan-Salanga, RM
Professional: Edan Thomas, RM; Maureen Silverman, RM	Professional: Edan Thomas, RM; Claudette Leduc, RM
Public: Marianna Kaminska; Susan "Sally" Lewis (Term end July 10, 2020)	Public: Donald Strickland; Marianna Kaminska

Committee Meetings
May 13, 2020 | 9:30 a.m. – 1:30 p.m., Videoconference
June 17, 2020 | 9:30 a.m. – 1:00 p.m., Videoconference
September 11, 2020 | 9:30 a.m. – 12:00 p.m., Videoconference
November 10, 2020 | 9:00 a.m. – 11:30 a.m., Videoconference
February 17, 2021 | 12:00 p.m. – 4:00 p.m., Videoconference

Panel Meetings/Hearings

N/A

Trainings

N/A

Items

- Financial Oversight

  Over the course of the fiscal year, the committee oversaw monitoring of College budget and finances, reviewing and approving quarterly financial statements. Audited financial statements were also reviewed and approved prior to presentation to Council.

  A comprehensive assessment of the External Auditor was completed by the committee and presented to Council at the December Meeting. This was the first year that the Comprehensive Assessment was completed, the committee had no issues and recommended reappointment of the auditor. The committee will complete the annual assessment for the 2021 year.

- Governance Related

Applications from the public and professional members were reviewed for appointment consideration as non-Council committee members. Three public non-council committee members as well as seven professional non-council members were recommended for appointment to committees and approved by Council at the December Council meeting.

The Committee reviewed the annual Council evaluations and self-assessment competency matrices completed by Council members which were presented to Council at the December meeting.

The Committee engaged with Sam Goodwin, of Goodwin consulting who will support the Committee and Council with administration of the annual assessment of the Registrar.

The committee reviewed and approved revisions made to the College's Governance Manual and Governance Education Modules (GEM).

Council and Executive Committee meetings dates for 2022 were approved.

- Policy Related

  The committee reviewed all College Governance Policies and proposed revisions that were approved by Council at the June 2020 meeting.

  The committee approved amendments to the *Criminal Record Screening Policy* on behalf of Council to address limited or no access to police services during the ongoing COVID-19 pandemic. Reported to Council at the June 2020 meeting.

  The committee reviewed and proposed updates to the College's *Privacy Code* which were approved by Council at the September 2020 meeting.

  The committee recommended the *Internally Restricted and Unrestricted Net Asset Policy* for Council approval, which was approved at the December 2020 meeting.

Attachments:

None.

Respectfully Submitted,

Claire Ramlogan-Salanga, Chair

REGISTRATION COMMITTEE

ANNUAL REPORT TO COUNCIL

April 2020 – March 2021

General

Committee Members

Chair	Isabelle Milot, RM
Professional	Claudette Leduc, RM (*term ended December 9, 2020*); Karen McKenzie, RM; Jan Teevan, RM
Public	Peter Aarssen; Sarah Baker *(appointed December 9, 2020)*
Non-Council	Alexandra Nikitakis, RM; Christi Johnston, RM (*term ended December 9, 2020*); Maryam Rahimi-Chatri, RM *(appointed December 9, 2020)*; Jillian Evans; Samantha Heiydt

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held*	5	3	3	4	15
Number of Committee Meetings Held*	2	1	1	2	6
Number of Trainings*	0	0	1	1	2

** Of the 23 meetings held to date, 23 occurred by videoconference using Microsoft Teams.*

In Q4, the Registration Committee addressed the following items:

CONTINUING COMPETENCY REQUIREMENTS 2021 RECOMMENDATIONS

Due to the ongoing circumstances surrounding the COVID-19 pandemic, the Registration Committee approved two options for midwives and applicants to provide satisfactory evidence of continuing competency in Neonatal Resuscitation (NRP), Cardiopulmonary Resuscitation (CPR) and Emergency Skills (ES) for 2021.

Option 1 is to complete a College approved continuing competency course including the in-person component.

Option 2 is to complete the online components of a College approved continuing competency course and skills review/practice. Option 2 is a temporary measure

intended to address the fact that in-person components of courses may not be available, while recognizing the importance of ongoing skills training for public protection, the safety of applicants and midwives and compliance with the Registration Regulation.

It is expected that all practising midwives will have completed full training, including in-person components by the October 1, 2022, renewal deadline, unless otherwise stated by the College.

ORIENTATION AND TRAINING

The Registration Committee members were given an in-depth orientation and training on the role and responsibilities of the Registration Committee by the College staff as well as legal counsel, Erica Richler from Steinecke Maciura Leblanc (SML). The training covered topics including:

- Key concepts & context, including legal framework
- Registration committee powers and an overview of the registration process and requirements
- Confidentiality and avoiding conflicts of interest
- Decision-making process, including an overview of types of panels and decision tools
- Writing reasons
- Appeals, reviews and oversight
- Fair registration practices

REGISTRATION REGULATION PROJECT – ONGOING WORK

The Registration Committee continued its work to review and revise the Registration Regulation. During the quarter, the Committee reviewed recommendations around new registrant conditions based on further work done by staff and analysis of surveys related to midwifery practice environments and transitioning to independent practice as a new midwife.

In addition, the Committee reviewed for a second time, the Regulatory Impact Assessment (RIA) related to classes of registration and considered entry to practice requirements and conditions for each class. The Committee reviewed an initial framework of conditions to be included in the revised registration regulation.

Staff continued to work with legal counsel to develop a draft of the revised registration regulation. In March, Council reviewed the RIAs for classes, new registrant conditions and clinical currency as well as a presentation of the initial framework of the revised regulation.

The Committee will continue its work in 2021 (including conducting a comprehensive survey with midwives and stakeholders) with the aim of bringing the final draft of the regulation to Council for review and approval in late 2021.

INACTIVE TO GENERAL CLASS CHANGE POLICY

To enable the streamlining of the inactive to general class change panel referral process where requalification programs are required under s.15(4)(b) of the Registration Regulation, the Registration Committee approved a Requalification Program Approval and Registrar Authorization Policy ("the Policy"). The Policy along with Schedule A outlines the minimum low risk criteria established by the Committee and the components of a standard requalification program. Where applicants meet the low risk criteria as outlined in the Policy, staff are authorized to have the applicant complete the standard requalification program without having to refer the applicant to a panel of the Registration Committee. Any applicants who do not meet the criteria will continue to be referred to the Committee. The Policy was implemented as of April 1, 2021 and the Committee rescinded the Temporary Class Change Policy and Registrar Authorization which had been in effect from the onset of the COVID-19 pandemic.

In Q3, the Registration Committee addressed the following items:

REGISTRATION REGULATION PROJECT – ONGOING WORK

The Committee updated that the College staff is continuing to work on the feedback received from the Committee to finalize the recommendations around new registrant conditions. The College conducted two surveys related to midwifery practice environments and transitioning to independent practice as a new midwife. The results of these surveys will be analyzed and the feedback will be brought forward to the Committee. Through the Midwifery Education Program Accreditation process, the staff has obtained information which supports the approaches for new registrants that the Committee had considered in a previous meeting. The staff is also working with legal counsel and have created a plan for drafting the Registration Regulation, which will help to identify any outstanding questions.

REGISTRATION REGULATION PROJECT – CLINICAL CURRENCY PRELIMINARY RECOMMENDATIONS

The Committee reviewed the updated regulatory impact assessment and preliminary recommendations on clinical currency. The preliminary recommendations made by the Registration Committee were brought forward to Council in December, with a clear picture of the outstanding items that still remain. This was to help the Council understand how the Registration Committee plans on approaching clinical currency going forward, as it impacts a number of

aspects of the Registration Regulation such as re-entry to practice, as well as how members practice once becoming a member of the College. The staff will continue to work on this topic, including surveying midwives in 2021 to collect baseline data which will be conducted to accurately reflect midwifery practice in order to validate the accuracy of the data used to calculate the proposed number of hours presented, as well as contacting stakeholders to further clarify suggestions and questions raised by the Committee.

INACTIVE TO GENERAL CLASS CHANGE – DEVELOPMENT OF CRITERIA AND REQUALIFICATION PROGRAMS

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.

Following the Committee's agreement to develop a Registrar Authorization Policy to enable the streamlining of the inactive to general class change panel process under the Registration Regulation, College staff presented the Committee with a draft approach to a risk assessment tool. The Committee reviewed and discussed the proposed approach to establish criteria to support a Registrar Authorization Policy. The Committee also established what would constitute a standard requalification program.

Based on the Committee's decisions and guidance around criteria and standard requalification programs, staff will revise the risk assessment tool to support the development of a draft policy for approval by the Registration Committee.

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.

In Q1, the Registration Committee addressed the following items:

APPROVING THE QUALIFYING EXAMINATION FOR THE 2020 GRADUATING COHORT

Due to the COVID-19 pandemic, the Canadian Midwifery Regulators Council (CMRC) postponed the May 7, 2020 sitting of the Canadian Midwifery Registration Exam (CMRE) until October 29, 2020. With the postponement of the CMRE, an alternative solution was proposed by the College and approved by the Registration Committee to allow the incoming 2020 cohort to become registered with the College.

As of April 2, 2020, the Midwifery Education Program Final Clerkship Exam was approved as the qualifying examination for the purpose of s. 8(1)3 of the Registration Regulation made under the Midwifery Act, 1991. This is a temporary decision to address a public health emergency. It will be in effect during the period that Ontario is responding to the consequences of the COVID-19 pandemic and will be reversed by the Registration Committee as needed. The Registration Committee further agreed to having applicants undertake to complete the CMRE

at the next available date and to finalize the details of the undertaking with legal counsel.

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 updated regulatory impact assessments and preliminary recommendations on clinical currency and new registrant conditions. The Committee identified some remaining 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. The Committee also reviewed jurisdictional research and initial information regarding classes of registration. 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, potentially in December 2020.

CONTINUING COMPETENCIES – RENEWAL 2020

As part of the Registration Regulation s. 12.(1)2 and 3, to demonstrate compliance with the continuing competency requirements, members must provide evidence satisfactory to the College of continuing competency in neonatal resuscitation (NRP) every year and satisfactory evidence of continuing competency in emergency skills (ES) and cardiopulmonary resuscitation (CPR) every two years.

All members provided evidence satisfactory to the College of continuing competency in NRP, ES and CPR in 2019 through their registration renewal. In accordance with the Registration Regulation, members do not need to provide evidence in ES and CPR until 2021, however they must provide evidence for neonatal resuscitation this year. Therefore, to address the current lack of available approved continuing competency courses, due to the COVID-19 pandemic, the Registration Committee approved the following approach for renewal 2020. Members do not have to report on ES or CPR and will only be asked to report on the following:

- Show satisfactory evidence of NRP by meeting one of the following as of October 1, 2020:

a) Have a valid NRP card uploaded to the member portal. Valid implies that the NRP card will not have expired as of October 1, 2020.

b) Have an NRP certificate that expired a year or less than one year ago uploaded to the member portal.

c) Have an NRP certificate that expired more than a year ago and have completed the following:

   I. have reviewed relevant materials, textbooks and guidelines related to neonatal emergency skills;
   II. have discussed and practised responses to hypothetical neonatal emergency case scenarios and practised hypothetical emergencies with one or more members of the College, all of whom must have provided to the College for 2019-20 registration renewal evidence satisfactory to the College of continuing competency in neonatal resuscitation.

d) All members will be asked to declare that they understand that they must have the necessary knowledge, skill and judgment related to NRP.

This approach enables the College to comply with the Registration Regulation and consistently apply the "one year or less than one year" criterion aleady approved by the Registration Committee.

CONTINUING COMPETENCIES – COURSE SUBMISSION UPDATES

The College staff updated the Registration Committee on the two current continuing competency course approval submissions. After further review and collection of more information, College staff will either approve them or bring them to the Registration Committee for their review in accordance with the approved process.

Committee, panel, membership changes and statistics follow:

Members by Class of Registration	#				%
	Q1 (1043)	Q2 (1042)	Q3 (1028)	Q4 (1028)	Total
General	716	737	727	728	71
General with new registrant conditions	99	90	78	63	6

Supervised practice	14	10	6	4	0
Inactive	214	205	217	233	23
Transitional	0	0	0	0	0

New Members by Class of Registration	#					%
	Q1 (40)	Q2 (18)	Q3 (3)	Q4 (3)	Total (64)	Total
General	1	0	1	0	2	3
General with new registrant conditions	30	16	2	2	50	78
Supervised practice	9	2	0	0	11	17
Inactive	0	0	0	1	1	2
Transitional	0	0	0	0	0	0

New Members by Route of Entry	#					%
	Q1 (40)	Q2 (18)	Q3 (3)	Q4 (3)	Total (64)	Total
Laurentian University graduates	13	7	1	1	22	34
McMaster University graduates	16	4	0	0	20	31
Ryerson University graduates	8	4	1	1	14	22
International Midwifery Pre-registration Program (IMPP) graduates	2	2	0	0	4	6
Out of province certificate holders (midwife applicants) from other Canadian regulated midwifery jurisdictions	1	1	1	0	3	5
Former members	0	0	0	1	1	2

Panel Referrals	Q1	Q2	Q3	Q4	Total
Total Number of referrals to a panel of the Registration Committee	9	5	3	15	32

Panels Held by Category	Q1 (9)	Q2 (5)	Q3 (3)	Q4 (15)	Total (32)
Application for registration[1]	1*	0	0	1	2
Class change – Inactive to General[2]	8	5	3	1	17
Active practice requirements shortfall[3]	0	0	0	12	12
Re-issuance of a Supervised Practice certificate of registration[4]	0	0	0	1	1
Reinstatement within one year following revocation[5]	0	0	0	0	0
Variation of terms, conditions and limitations[6]	0	0	0	0	0

**One application referral required three panel meetings.*

Panel Outcomes by Category					
Panel Outcomes By Application for Registration[1]	Q1 (0)	Q2 (0)	Q3 (1)	Q4 (1)	Total (2)
Application approved – Registrar directed to issue certificate of registration	0	0	1	1	2
Application approved – Registrar directed to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel	0	0	0	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	0	0	0
Application approved – Registrar directed to impose terms, conditions and limitations on certificate	0	0	0	0	0
Application not approved – Registrar directed to refuse to issue certificate	0	0	0	0	0
Panel Outcomes By Class change – Inactive to General[2]	Q1 (8)	Q2 (5)	Q3 (3)	Q4 (1)	Total (17)
Requalification program approved – General certificate to be re-issued	8	5	3	1	17

Requalification program approved with supervision required – Supervised Practice certificate to be issued	0	0	0	0	0
Panel Outcomes By Active Practice Requirements Shortfall[3]	Q1 (0)	Q2 (0)	Q3 (0)	Q4 (9)	Total (9)
Exception granted – extenuating circumstances demonstrated	0	0	0	9*	9
Shortfall plan required	0	0	0	0	0
Shortfall plan and undertaking imposing terms, conditions and limitations	0	0	0	0	0
**Three active practice files remained open at year end. Therefore outcomes not reported.*					
Panel Outcomes By Re-issuance of a Supervised Practice certificate of registration[4]	Q1 (0)	Q2 (0)	Q3 (0)	Q4 (1)	Total (1)
Re-issuance approved – supervised practice extended	0	0	0	1	1
Re-issuance not approved	0	0	0	0	0
Panel Outcomes By Reinstatement within one year following revocation[5]	Q1 (0)	Q2 (0)	Q3 (0)	Q4 (0)	Total (0)
Requalification program approved – no supervised practice required	0	0	0	0	0
Requalification program approved – supervised practice required	0	0	0	0	0
Panel Outcomes By Variation of terms, conditions and limitations[6]	Q1 (0)	Q2 (0)	Q3 (0)	Q4 (0)	Total (0)
Application refused	0	0	0	0	0
Registrar directed to remove any term, condition or limitation imposed on the certificate of registration	0	0	0	0	0
Registrar directed to modify terms, conditions or limitations on the certificate of registration	0	0	0	0	0

Timelines: from referral to a panel to a written decision	Q1 (8)	Q2 (5)	Q3 (4)	Q4 (12)	Total (29)
Files closed within 30 days	7	3	1	2	13
Files closed within 60 days	1	2	1	9	13

Files closed beyond 60 days	0	0	2	1	3
Shortest: (reported in number of days)	11	23	23	18	11
Longest: (reported in number of days)	40	35	180	80	180
Average: (reported in number of days)	25	29	102	49	96

Registration Decisions appealed to the Health Professions Appeal and Review Board (HPARB)	Q1 (1)	Q2 (1)	Q3 (0)	Q4 (0)
Open HPARB appeals as of quarter end	1	1	0	0
New HPARB appeals	0	0	0	0
Completed HPARB appeals	0	1*	0	0
Open HPARB appeals at quarter end	1	0	0	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:	Q1 (0)	Q2 (0)	Q3 (0)	Q4 (0)
Confirmed the decision	N/A	N/A	N/A	N/A
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	N/A	N/A	N/A
Required the Committee to issue a certificate of registration to the applicant, with any terms, conditions and limitations the HPARB considers appropriate	N/A	N/A	N/A	N/A
Were referred back for further consideration	N/A	N/A	N/A	N/A

Attrition[7]	#	%
Q1	2	0.2

Q2	19	1.8
Q3	22	2.1
Q4	3	0.3

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.*

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QUALITY ASSURANCE COMMITTEE

ANNUAL REPORT TO COUNCIL
APRIL 2020-MARCH 2021

Committee Members

April 2020-December 2020	December 2020-March 2021
Chair: Lilly Martin, RM	Chair: Lilly Martin, RM
Professional: Jan Teevan, RM; Isabelle Milot, RM	Professional: Jan Teevan, RM; Isabelle Milot, RM
Public: Deirdre Brett (term end June 27, 2020); Marianna Kaminska, Donald Strickland (appointed June 24, 2020)	Public: Donald Strickland
Non-Council:	Non-Council: Sabrina Blaise, RM; Kristen Wilkenson, RM; Sally Lewis

Activities of the Committee

	Q1	Q2	Q3	Q4	2020-2021 Total
Number of Panel Meetings Held	0	0	2	0	2
Number of Committee Meetings Held	0	1	1	0	2
Number of Trainings	0	0	0	0	0

QAP Reporting		Percentage
Total # of midwives subject to requirements	814	78% of total midwives
Total # of midwives who met the requirements	789	97% of midwives who were required
Total # of midwives who did not meet requirements (non-compliant)	14	2% of required
Total # of midwives who were granted exemption from requirements	11	< 1% of required

QAP Exemption Requests	
Total # of requests	11
Total # granted	11
Total # of exemptions not granted	0

Non-Compliance	
Total # records of non-compliance	14
Outcome	
Explanation accepted/no further action required	14
Advice/recommendation	0
Required to participate in a Peer & Practice Assessment	0
Referral to ICRC	0
Average # of calendar days from Notice of Non-Compliance matters from QAC to written decision date	24

Peer & Practice Assessments 2021 Cycle	
Total # of members selected	81
Total # of assessments completed	76
Total # deferred*	5
Assessment Outcomes	
# of members who completed process after distance assessment	76
# of members who were required to complete an in-person assessment	0
# of members referred to QAC	0

*Deferral of an assessment occurs if member goes inactive after date of selection and remains in the inactive class for duration of assessment program cycle.

Items

Exemption Panel Process Approval
At their August 2020 meeting, the committee approved a process allowing staff to approval of exemption requests that meet certain criteria without requiring convention of a panel. This process will apply to members practising in Expanded Midwifery Care Models (EMCM) who have applied for exemptions because the circumstances of their practice model make meeting a QAP requirement impossible.

Professional Standards Review
At their November 2020 meeting, the committee approved making the recommendation to Council to rescind the Consultation and Transfer of Care Standard, the Delegation, Orders and Directives standard and When a Client Chooses Care Outside the Midwifery Scope of Practice standard. Council approved at the December 2020 meeting.

The committee approved making the recommendation to Council to revise the Professional Standards for Midwives. Council approved at the December 2020 meeting.

The committee approved making the recommendation to Council to approve the Midwifery Scope of Practice document. Council approved at the December 2020 meeting.

Quality Assurance Regulation
The Quality Assurance regulation submitted by the College in 2017, was approved by the Ministry and came into force November 27, 2020.

Attachments:

None.

Respectfully Submitted,

Lilly Martin, Chair

INQUIRIES, COMPLAINTS & REPORTS COMMITTEE

ANNUAL REPORT TO COUNCIL
APRIL 2020 - MARCH 2021

General

Committee Members

April 2020-December 2020 Chair: Edan Thomas, RM (until July 2020) and Susan Lewis (from July 2020)	**December 2020-March 2021** Chair: Susan Lewis
Professional: Maureen Silverman RM; Lilly Martin, RM; Claudette Leduc, RM, Edan Thomas, RM, Jan Teevan, RM	Professional: : Maureen Silverman RM; Lilly Martin, RM; Claudette Leduc, RM, Edan Thomas, RM, Jan Teevan, RM (until January 2021)
Public: Judith Murray, Susan Lewis	Public: Judith Murray, Sarah Baker
Non-Council: Christi Johnston, RM, Samantha Heiydt, Jillian Evans,	Non-Council: Christi Johnston, RM, Samantha Heiydt, Jillian Evans, Susan Lewis, Jessica Raison, RM, Sarah Kirkland RM

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held	15	10	10	10	45
Number of Committee Meetings Held	0	0	1	0	1
Number of Trainings	0	0	1	0	1

Notes:
Q4: All 10 panel meetings were held by videoconference
2020/2021 Total: Of the 45 panel meetings held, 16 occurred by teleconference, 17 occurred by videoconference, 10 occurred electronically, and 2 oral cautions were administered by videoconference due to COVID-19.

The Committee held one meeting by videoconference this fiscal year which was devoted to training. This included recurrent training that included an overview of the ICRC but also focused on content to assist the committee in effectively managing the current caseload. These topics included their role as a screening committee, effective deliberations techniques using the risk assessment tool, decision making and reasons writing.

Caseload Work of the ICRC

	Complaints					Reports				
	Q1	Q2	Q3	Q4	2020/2021	Q1	Q2	Q3	Q4	2020/2021
Files Carried Over from previous reporting period	31	37	39	33	N/A	8	13	9	8	N/A
New files	15	12	9	9	45	6	1	0	0	7
Closed files	9	10	15	17	51	1	5	1	3	10
Active files at end of reporting period	37	39	33	25	25	13	9	8	5	5

Notes:
Q4: Nine new complaint files were a result of receiving five complaints. Two complaints involved more than one midwife.
2020/2021 Complaint Stats: The College has received 27 complaints this year to date which resulted in 45 complaint files (ten complaints involved more than one midwife).

Source of New Matters

	Complaints					Reports				
Source of New Matters	Q1 (15)	Q2 (12)	Q3 (9)	Q4 (9)	Total (45)	Q1 (6)	Q2 (1)	Q3 (0)	Q4 (0)	Total (7)
Client	11	9	6	9	35	–	–	–	–	–
Family Member	3	–	2	–	5	–	–	–	–	–
Health Care Provider	1	2	–	–	3	–	–	–	–	–
Information received by Mandatory / Self Report	–	–	–	–	–	4	1	–	–	5
Information received from another source	–	–	–	–	–	2	–	–	–	2
Another Midwife	–	1	1	–	2	–	–	–	–	–

Outcomes/Completed Cases

Number of Resolved Cases and Outcomes	Complaints					Reports				
	Q1 (9)	Q2 (10)	Q3 (15)	Q4 (17)	Total (51)	Q1 (1)	Q2 (5)	Q3 (1)	Q4 (3)	Total (10)
Complaints referred to ADR	–	1	2	2	5	N/A				
Complaints Withdrawn	1	–	–	–	1	N/A				
Frivolous and Vexatious	–	–	–	1	1	N/A				
No Action	7	5	8	9	29	–	2	–	1	3
Advice & Recommendations	1	2	5	5	13	–	–	1	2	3
Specified Continuing Education or Remediation Program (SCERP)	–	2	–	1	3	–	2	–	2	4
Oral Caution	–	–	–	–	–	–	–	–	–	–
SCERP AND Oral Caution	–	–	–	–	–	1	1	–	–	2
Referral to Discipline Committee	–	1	–	–	1	–	–	–	–	–
Referral to Fitness to Practise Committee	–	–	–	–	–	–	–	–	–	–
Acknowledgement & Undertaking	–	–	–	–	–	–	–	–	–	–
Undertaking to Restrict Practise	–	–	–	–	–	–	–	–	–	–
Undertaking to Resign and Never Reapply	–	–	–	–	–	–	–	–	–	–

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.

Timelines

Closed cases	Complaints					Reports				
	Q1 (9)	Q2 (10)	Q3 (15)	Q4 (17)	Total (51)	Q1 (1)	Q2 (5)	Q3 (1)	Q4 (3)	Total (10)
Number of files closed <150 days	7	2	2	3	14	1	2	–	–	2
Number of files closed between 150 days and 210 days	1	0	4	6	11	0	0	1	–	1
Number of files closed >210 days	1	8	9	8	26	0	3	–	3	7
Shortest: (reported in number of days)	90	91	107	82	82	233	99	164	235	99
Longest: (reported in number of days)	672	814	442	446	814	233	683	164	446	683
Average: (reported in number of days)	326	391	233	240	292	233	479	164	352	402

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

Alternative Dispute Resolution

Stats	Q1	Q2	Q3	Q4	Total
Open files with ADR (Files carried over)	0	2	2	2	0
New files referred to ADR	3	0	5	0	N/A
Closed files with in 60 days	0	0	0	0	0
Closed files with in 120 days	1	0	2	2	5
Files returned to ICRC due to timeframe	0	0	0	0	0
Files returned to ICRC due to unsuccessful mediation	0	0	0	0	0
Files returned to ICRC - Registrar did not ratify the agreement	0	0	0	0	0
Open files as at end of reporting period	2	2	2	0	0

Other useful information:	Q1	Q2	Q3	Q4	Total
Total Number of Complaints Received	15	12	9	9	45
Number of complaints that were not ADR eligible	4	10	4	8	26
Number of Complaints that were ADR eligible	11	2	5	1	19
Number of Complaints ELIGIBLE that proceeded to ADR upon consent of all parties	3	0	2	0	5
Number of Members who agreed to participate in ADR	9	2	2*	1	12
Number of Complainants who agreed to participate in ADR	3	0	3	0	6

**Two Members did not respond before the College advised that the Complainiant declined ADR.*

Appeals

Complaint Matters	Q1	Q2	Q3	Q4	Total
Open HPARB appeals (Appeals carried over)	2	2	5	5	N/A
New HPARB appeals	0	3	0	5	8
Completed HPARB appeals	0	0	0	0	0
Open HPARB appeals (Appeals carried over)	2	5	5	10	10

Notes:
Q4:The five new appeals is a result of 3 complaint matters being appealed by the Complainant. One of those complaints involved three midwives)
Open files: The ten appeals are representative of six complaint matters. Five complaints involve more than one midwife. All appeals are by Complainants.

Respectfully Submitted,

Susan Lewis

DISCIPLINE COMMITTEE

ANNUAL REPORT TO COUNCIL
APRIL 2020-MARCH 2021

Committee Members

April 2020-December 2020	December 2020-March 2021
Chair: Judith Murray	Chair: Judith Murray
Professional: Edan Thomas, RM, Maureen Silverman RM, Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM,	Professional: : Edan Thomas, RM, Maureen Silverman RM, Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM, Karen McKenzie, RM
Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Sarah Baker	Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Sarah Baker
Non-Council: None	Non-Council: Susan Lewis

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Prehearing Conferences Held	0	1	0	1	2
Number of Hearing Days	0	1	0	1	2
Number of Meetings	0	0	0	0	0
Number of Trainings	1	0	0	0	1

The Committee met at the June Council Meeting to receive training. Five Committee Members attended Discipline Orientation Workshops offered by the Health Profession Regulators of Ontario during the year.

Caseload Work

	Q1	Q2	Q3	Q4	Total
Open files (Files carried over from previous report)	1	1	1	1	0
Number of new referrals by the ICRC	0	1	0	0	1
Closed files	0	1	0	1	2
Open files (Files carried over to next reporting period)	1	1	1	0	0

Statistics on Closed Cases

Types of Hearings	Q1	Q2	Q3	Q4	Total
Number of Uncontested Hearings	0	1	0	1	2
Number of hearings that resulted in findings of professional conduct	0	1	0	1	2

Findings of Professional Misconduct	Q1	Q2	Q3	Q4	Total
Failed to maintain a standard of practice of the profession	–	0	–	1	1
Practicing the profession while the registrant is in a conflict of interest	–	1	–	0	1
Engaging in conduct that would reasonably be regarded as conduct unbecoming a midwife	–	1	–	0	1
Engaging in conduct relevant to the practice of the profession that would reasonably be regarded by registrants as unprofessional	–	1	–	1	2

Penalties	Q1	Q2	Q3	Q4	Total
Reprimand	–	1	–	1	2
Terms, conditions and limitations of the Registrant's certificate of registration requiring the Member to complete remediation	–	1	–	1	2
Costs Award	–	1	–	1	2

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 (reported in days)	Q1	Q2	Q3	Q4	Total
Actual	–	294	–	248	–
Average	–	294	–	248	271

Summary of Discipline Committee Decision(s)

Natasha Singleton-Bassaragh v. CMO

On March 5, 2020, a panel of the Discipline Committee of the College of Midwives of Ontario found that Natasha Singleton-Bassaragh (the Member) engaged in professional misconduct by failing to meet a standard of the profession; 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.

The Client involved in this case delivered a baby girl who was stillborn. The Client was a client of the Practice and the Member became involved when the Client contacted the Practice to report reduced fetal movement and the Client's primary midwife was off call.

The Panel found that the agreed facts supported the findings of professional misconduct in that the care provided failed to meet the standard, in particular with regard to the management of fetal movement. The Member failed to conduct an in-person assessment of the Client when the Client reported concerns relating to fetal movement and failed to clearly communicate a plan to the Client and document a plan for an in-person assessment following a call related to concerns of reduced fetal movement. The Member failed to appropriately monitor fetal well-being and the fetal heart rate upon the Client's admission to hospital and prior to transferring primary care back to the primary midwife, including failing to conduct a non-stress test upon the Client's admission and failing to auscultate the fetal heart

rate in a timely manner. The Panel was satisfied that the Member's conduct noted above would reasonably be regarded by other members of this profession as unprofessional.

Penalty

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

1. The Member 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 the Member's certificate of registration:

   a. Within three months of the date of the Discipline Committee's Order, the Member is required to prepare and submit a 1,500-word reflective paper, to the satisfaction of the Registrar, regarding the management of decreased fetal movement and the assessment of fetal well-being in labour.

   b. Within six months of the Member's return to practice, the Member must participate in a chart audit with a College appointed auditor, subject to the following terms:

      i. The Member must notify the Registrar in writing one week before the date that she returns to practice;

      ii. The auditor will review a minimum of five and a maximum of eight charts, with care provided by Ms. Singleton-Bassaragh after her return to practice referred to in paragraph (i) above, focusing on the documentation and care surrounding the assessment of fetal heart rate, including any charts with reported decreased fetal movement, if available;

      iii. The auditor will provide a written report to the Registrar regarding the outcome of the chart audit in a form and manner approved by the Registrar;

      iv. The Member is responsible for any costs or expenses associated with the chart audit to a maximum of $1,500.

3. The Member is required to pay to the College costs in the amount of $1,500, to be in paid in 15 monthly instalments of $100.00, beginning one month after the date of the Discipline Committee's Order and continuing every month until paid in full.

- Decision and Reasons of the Discipline Committee dated March 15, 2021.

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:

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;

The Registrar is directed to impose the following terms, conditions and limitations on Ms. Knight's certificate of registration:

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

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

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

ANNUAL REPORT TO COUNCIL
APRIL 2020-MARCH 2021

Committee Members

April 2020-December 2020	December 2020-March 2021
Chair: Judith Murray	Chair: Judith Murray
Professional: Edan Thomas, RM, Maureen Silverman RM, Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM,	Professional: : Edan Thomas, RM, Maureen Silverman RM, Jan Teevan, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM, Karen McKenzie, RM
Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Sarah Baker	Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Sarah Baker
Non-Council: None	Non-Council: Susan Lewis

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Hearings Held	0	0	0	0	0
Number of Committee Meetings Held	0	0	0	0	0
Number of Trainings	0	0	0	0	0

The Committee[1] did not meet this year it received no referrals from the Inquiries, Complaints and Reports Committee (ICRC) in the fiscal year. A training is being planned to occur in the first part of the new fiscal year.

Caseload Work of the Panel

	Q1	Q2	Q3	Q4	Total
Referals from the ICRC	0	0	0	0	0

Respectfully Submitted,

Judith Murray

[1] All Commiitee members are members of the Discipline Committee who met this year to receive Discipline Training.

CLIENT RELATIONS COMMITTEE

ANNUAL REPORT TO COUNCIL
APRIL 2020-MARCH 2021

Committee Members

April 2020-December 2020	December 2020-March 2021
Chair: Deirdre Brett (until June 2020), Marianna Kaminska (as of June 2020)	Chair: Pete Aarssen
Professional: : Lisa Nussey, RM (until October 2020), Karen McKenzie, RM (as of October 2020)	Professional: Karen McKenzie, RM, Maureen Silverman, RM
Public: Marianna Kaminska	Public: Marianna Kaminska
Non-Council: Alexandra Nikitakis, RM	Non-Council: N/A

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held	N/A	N/A	N/A	N/A	N/A
Number of Committee Meetings Held	0	0	1	0	1
Number of Trainings	0	0	0	0	0

Items

The Committee approved the following:

- a revised version of the *Guide on Compliance with Personal Health Information Protection Act* (PHIPA), which reflected amendments made to the Act in March 2020 and included additional information regarding succession planning in response to a request from the Information & Privacy Commissioner to address the potential problem of abandoned health records and associated privacy breaches
- a revised version of the *Guideline on Ending the Midwife-Client Relationship* to include additional information to assist midwives in understanding what factors to take into

account in considering whether to terminate a midwife-client relationship when a client requests care that is below midwifery standards of practice. The revisions were a response to Council rescinding the Standard "When a Client Chooses Care Outside Midwifery Standards of Practice" in March 2020.

Attachments:

None

Respectfully Submitted,

Pete Aarssen, Chair

CHAIR'S REPORT

REPORT TO COUNCIL – June 2, 2021
Prepared by: Claire Ramlogan Salanga RM

1. General Highlights

   As a society we are again facing another harmful and painful reminder of the legacy of the residential school system in Canada. To my Indigenous peers and community members, on behalf of Council, I am so deeply sorry. As a racialized settler on this land, I have been struggling to face this event head on; it may be my own trauma of colonization or my grief and sadness. Either way, I will not avoid it. Council members: I ask you to take stock in your own response to this national crisis and find ways to connect in order to start the education and healing process, whatever that may look for you. I am hopeful that as a collective force, if we all face these truths together, we can create change.

   The College remains virtual due to the pandemic; however, case numbers are slowing which could signal a change for all Ontarians. For the moment, Council training and meetings will remain online as planned.

2. Governance

   Weekly meetings with the Registrar continue to keep me well-informed of ongoing work at the College. I am happy to report that the Registrar and staff continue to be innovative and efficient with their resources.

   For the first time, the College held two online "lunch-and-learns" in April regarding the 2021 Council elections for professional members. The first offering was open to all professional members, while the second was specifically reserved for members who identify as Indigenous, Black, or racialized. The sessions were well attended, and members were appreciative of the opportunity to better understand the role of a Council member. I am pleased to report that there are four candidates nominated for this year's election.

   The fiscal 2020 external audit is in progress and the Executive Committee was able to participate in the online audit process. The annual review of the audit will be completed this month by the executive committee and Hilborn will be presenting the results of the audit at June Council.

   The review of the Registrar-CEO will be coming to a close this month with the final review taking place on June 16th. Overall, the process has been seamless due to the support of an engaged Council, Executive Committee and of course Registrar-CEO. Thank you to Mr. Sam Goodwin of Goodwin Consulting for guiding us through this process.

We will be saying goodbye to Sarah Baker, public member of Council. Sarah has been a valuable member of Council and will be missed. Thank you for your critical engagement at Council and committee meetings. We wish you the best in your future endeavours.

3. Stakeholder Engagement

1. Ontario Midwifer Strategy Council (OMSC) – May 17
2. Council elections webinars: April 20 & 21
3. Ex-Officio:
   Quality Assurance Committee meeting – April 27
   Registration Committee meeting – June 3

EXECUTIVE COMMITTEE

REPORT TO COUNCIL June 2021

Committee Members

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

Committee Meetings

May 12, 2021 | Videoconference
May 21, 2021 | Videoconference
Upcoming: June 16, 2021 | Videoconference

Items

Approved on behalf of Council:

- Costed Strategic Plan

Costed Strategic Plan
The committee approved a minor revision made to the costed plan approved by Council at the March 24, 2021 meeting. The revision was with respect to initiative 3.2, in the version presented to Council, initiatives 3.1 and 3.2 were listed identically and while they are similar there were some differences to note. There was no change to the estimated costs and copy of revised plan is attached.

Q4 Statement of Operations
A draft Q4 statement of operations was reviewed on May 12, 2021. Adjusting entries during the financial audit will make small changes to the previously reviewed statements. The Executive Committee will review and approve the final Q4 statement of operations at its June 16th meeting and will be attached to the Council package at that time.

Audit
Members of the committee met with Hilborn, LLP financial auditors during the College's financial audit and were able to ask questions about the audit process that was underway. The draft audited financial statements will be reviewed by the Committee on June 16th and will be attached to the Council package at that time.

Registrar Review
The committee met on May 21, 2021, with Sam Goodwin of Goodwin Consulting to review the results of the Registrar Review. The committee will meet with the Registrar on June 16th to discuss findings of the report and will present to Council on June 23, 2021.

Attachments:

1. Revised Costed Strategic Plan 2021-2026
2. Q4 Statement of Operations - Approved by committee June 16, 2021.
3. Audited Draft Financial Statements - March 31, 2021

Respectfully Submitted,

Claire Ramlogan-Salanga

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

working with midwives | working for the public

COSTED STRATEGIC PLAN 2021–2026

working with midwives | working for the public

COSTED STRATEGIC PLAN 2021–2026

This document provides a summary of our Costed Strategic Plan 2021-2026. It details the planned initiatives that will contribute to the delivery of each of our three strategic priorities as well as provides the forecasted costs to deliver on our plans.

Start and finish dates are provided for all the initiatives listed. These estimates are based on the information available during the planning period and may be subject to a changing organizational priorities and external environment. This document will be updated annually.

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

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

Strategic Framework

The 2021-2016 Strategic Framework is a high-level statement of the College's vision, mission, outcomes and key prioritiesover the next five years. It paves the way forward for the organization, builds a stronger sense of common purpose and direction and a shared understanding of why we exist, what guides our work, and what we want to achieve as an organization.

Our Vision

A leader in regulatory excellence, inspiring trust and confidence.

Our Mission

Regulating midwifery in the public interest.

Key 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 Guiding Principles

These interrelated principles define how we strive to work as an organization, shape our culture and our relationships with the public, midwives, and partner organizations.

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 tangible benefits for the organization.

STRATEGIC PRIORITY 1

Regulation that enables the midwifery profession to evolve

Develop a responsive regulatory framework, without relying on legislative change, to ensure that all midwives, regardless of midwifery practice model, individual practice environment, or practice setting, are qualified to deliver good practice.

The initiatives and the work programs designed to meet this priority are summarized below.

1.1. 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 the required clinical competence if they are not able to meet the criteria set out in College regulations.

INITIATIVE	START	FINISH
Develop a project plan, including work schedule and identifying the necessary resources	Y1	Y1
Develop a competency-based assessment program	Y2	Y3
Pilot and implement the competency-based assessment program	Y4	Y4

1.2. We will identify remedial and educational programs to address knowledge and skills gaps in midwives who have undergone an assessment or been the subject of an investigation. By intervening early, we aim to reduce the risk of more serious issues and regulatory action later on.

INITIATIVE	START	FINISH
Conduct needs assessment and jurisdictional scan	Y2	Y2
Develop and implement a comprehensive tool identifying programs to address knowledge and skills gaps in midwives	Y3	Y4

The forecast expenditure for this strategic priority is $95,000.

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.

The initiatives and the work programs designed to meet this priority are summarized below.

2.1. 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 internal College 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.

INITIATIVE	START	FINISH
Develop a data strategy frame-work and analytics strategy	Y1	Y1
Develop and conduct surveys with midwifery clients	Y2	Y3
Analyse the results. Using the findings develop a program of action	Y4	Y4
Execute the program of action	Y5	Y5

2.2. 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 insupporting good practice and act upon critical issues that present a risk of harm to clients.

INITIATIVE	START	FINISH
Develop a data strategy frame-work and analytics strategy	Y1	Y1
Develop and conduct surveys with midwifery clients	Y2	Y3
Analyse the results. Using the findings develop a program of action	Y4	Y4
Execute the program of action	Y5	Y5

2.3. 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.

INITIATIVE	START	FINISH
Conduct needs assessment and jurisdictional scan	Y2	Y2
Work with partner organizations to explore ways to share the data we collect	Y3	Y3
Formalize data sharing agreements	Y4	Y5

2.4. We will publish insights drawn from our data on a range of identified themes affecting midwifery practice and client safety with the goal to inform and improve practice.

INITIATIVE	START	FINISH
Publish data and insights drawn from surveys conducted with midwifery clients and midwives	Y4	Y5

2.5. Create data management strategies and systems including digitization of all appropriate records to ensure that data resources are easily accessible and effectively structured and managed, and that the College is retaining and disposing of data assets in a sustainable and appropriate manner.

INITIATIVE	START	FINISH
Revise Records Retention and Disposition Policy	Y1	Y1
Create and implement data management strategy and systems	Y2	Y5

The forecast expenditure for this strategic priority is $260,000.

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 initiatives and the work programs designed to meet this priority are summarized below.

3.1. We will 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 and discipline processes work, and how we make decisions that affect them.

INITIATIVE	START	FINISH
Develop a project plan, including work schedule and identifying the necessary resources	Y1	Y1
Rebuild the content of the website as it relates to educating the public about the role of the College and our complaints and discipline processes	Y1	Y3
Create materials to better educate the public about the standards of the profession and other requirements midwives are held to. Make materials available in French (and other languages)	Y1	Y3
Develop an online portal to provide complainants with access to key information about the complaints process and to the status of their specific case at each step	Y1	Y3

3.2. 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.

INITIATIVE	START	FINISH
Develop a project plan, including work schedule and identifying the necessary resources	Y1	Y1
Develop a repository of practice advisories and decision-making tools and flowcharts to improve the transparency of our decision-making and to manage expectations appropriately	Y2	Y3
Rebuild the content of the website as it relates to consultations and surveys and presenting the information to midwives	Y1	Y2
Develop an online portal to provide midwives who are subject to a College proceeding with access to key information about the process and to the status of their specific case at each step	Y1	Y3

3.3. 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.

INITIATIVE	START	FINISH
Develop content for orientation workshops	Y2	Y2

3.4. We will continue to 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.

INITIATIVE	START	FINISH
Develop student engagement plan (in line with our stakeholder engagement strategy)	Y1	Y1
Develop content for workshops	Y1	Y2
Survey final year students to track attitude or perception changes (a baseline survey was conducted in 2020)	Y4	Y5

3.5. Survey the public and midwives to track their perceptions of the College so we can better understand the impact of our work and how we can communicate more effectively with them.

INITIATIVE	START	FINISH
Develop a data strategy framework and analytics strategy	Y1	Y1
Develop and conduct surveys. Analyse the results and develop a program of action	Y1	Y2
Execute the program of action	Y3	Y4
Survey the public and midwives to track attitude or perception changes	Y5	Y5

3.6. We will publicly report on our regulatory performance on an annual basis.

INITIATIVE	START	FINISH
Conduct internal review on our regulatory performance and develop content on the website (this will be done on an annual basis using the same format)	Y1	Y1

The forecast expenditure for this strategic priority is $70,000.

The College of Midwives of Ontario

Q4 Statement of Operations (Fiscal April 1, 2020 - March 31, 2021)

April 1, 2020 - March 31, 2021

Final - Post Audit

	F21 Projected Revenue	Revenue F21	Revenue F20	Percentage Variance Against Budget
REVENUE				
Membership Fees	$ 2,384,797	$ 2,380,257	$ 2,139,459	99.81%
Administration & Other	$ 107,316	$ 52,104	$ 104,350	48.55%
Project Funding - Birth Centres	$ 67,121	$ 67,121	$ 66,130	100.00%
TOTAL REVENUE	**$ 2,559,233**	**$ 2,499,481**	**$ 2,309,939**	**97.67%**

	F21 Budget	Spending F21	Spending F20	Percentage Variance Against Budget
EXPENSES				
Salaries & Benefits	$ 1,479,847	$ 1,408,563	$ 1,318,732	95.18%
Professional Fees	$ 116,068	$ 78,499	$ 73,174	67.63%
Council and Committee	$ 150,696	$ 114,112	$ 81,808	75.72%
Office & General	$ 155,764	$ 102,589	$ 121,834	65.86%
Information Technology, Security & Data	$ 145,400	$ 94,863	$ 74,561	65.24%
Rent & Utilities	$ 196,764	$ 192,042	$ 184,795	97.60%
Conferences, Meeting Attendance & Membership Fees	$ 82,975	$ 62,676	$ 59,482	75.54%
Panel & Programs	$ 325,919	$ 128,563	$ 165,613	39.45%
Birth Centre Assessment & Support	$ 67,121	$ 67,121	$ 66,130	100.00%
Capital Expenditures	$ 43,043	$ 43,063	$ 36,285	100.05%
TOTAL EXPENDITURES	**$ 2,763,597**	**$ 2,292,090**	**$ 2,182,414**	**82.94%**
PROJECTED LOSS	**$ (204,364)**	**$ 207,392**	**$ 127,526**	

ADDITIONAL NOTES

1 Professional Conduct Accrual

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 Spending to end of Q4	$ 108,813

Included in the Statement is an accrual for outstanding matters at March 31, 2021.

2 Birth Centre Assessments

The College conducts periodic assessments of the Birth Centres. All costs are invoiced to Independent Health Facilities.

Expenses in 2020-21 (not included in statement above)	$ 8,601.05
Payment Received March 1, 2021 from IHF	$ 8,601.05
Assessment Cost to the College	$ -

COLLEGE OF MIDWIVES OF ONTARIO

FINANCIAL STATEMENTS

MARCH 31, 2021

HILBORN LLP

HILBORN LLP

Independent Auditor's Report

To the Council of the College of Midwives of Ontario

Opinion

We have audited the financial statements of the College of Midwives of Ontario (the "College"), which comprise the statement of financial position as at March 31, 2021, and the statements of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at March 31, 2021, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Other Information

Management is responsible for the other information. The other information comprises the information, other than the financial statements and our auditor's report thereon, in the annual report.

Our opinion on the financial statements does not cover the other information and we will not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

The annual report is expected to be made available to us after the date of our auditor's report. If, based on the work we will perform on this other information, we conclude that there is a material misstatement of this other information, we are required to report that fact to those charged with governance.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the ability of the College to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the financial reporting process of the College.

Independent Auditor's Report (continued)

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal control of the College.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ability of the College to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

We also provide those charged with governance with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

Toronto, Ontario
Date to be determined

Chartered Professional Accountants
Licensed Public Accountants

COLLEGE OF MIDWIVES OF ONTARIO

Statement of Financial Position

March 31	2021 $	2020 $
ASSETS		
Current assets		
Cash and cash equivalents (note 3)	**3,189,665**	3,025,221
Accounts receivable	**4,721**	15,069
Prepaid expenses	**38,193**	38,029
	3,232,579	3,078,319
Capital assets (note 4)	**108,620**	108,657
	3,341,199	3,186,976
LIABILITIES		
Current liabilities		
Accounts payable and accrued liabilities (note 5)	**264,730**	345,777
Deferred registration fees	**1,155,406**	1,115,596
	1,420,136	1,461,373
Deferred lease incentives (note 7)	**16,908**	28,839
	1,437,044	1,490,212
NET ASSETS		
Invested in capital assets	**99,875**	93,741
Internally restricted for therapy and counselling (note 8)	**16,000**	16,000
Internally restricted for investigations and hearings (note 9)	**300,000**	-
Unrestricted	**1,488,280**	1,587,023
	1,904,155	1,696,764
	3,341,199	3,186,976

The accompanying notes are an integral part of these financial statements

Approved on behalf of the Council:

President

Vice-President

COLLEGE OF MIDWIVES OF ONTARIO

Statement of Operations

Year ended March 31	2021 $	2020 $
Revenues		
Registration fees	**2,380,257**	2,139,459
Administration and other	**52,104**	104,350
Government grant - project funding (note 6)	**75,722**	78,011
	2,508,083	2,321,820
Expenses		
Salaries and benefits	**1,408,563**	1,318,732
Professional fees	**78,499**	73,174
Council and committees	**120,271**	93,555
Office and general	**109,425**	124,322
Rent and utilities (note 7)	**192,042**	184,795
Quality assurance program	**23,491**	26,711
Investigations and hearings	**98,913**	130,706
Membership dues and fees	**55,840**	53,442
Information and communications technology	**94,863**	74,561
Government projects (note 6)	**75,722**	78,011
Amortization	**43,063**	36,285
	2,300,692	2,194,294
Excess of revenues over expenses for year	**207,391**	127,526

The accompanying notes are an integral part of these financial statements

COLLEGE OF MIDWIVES OF ONTARIO

Statement of Changes in Net Assets

Year ended March 31

	Invested in capital assets $	Internally restricted for therapy and counselling $	Internally restricted for investigations and hearings $	Unrestricted $	2021 Total $
Balance, beginning of year	93,741	16,000	-	1,587,023	**1,696,764**
Excess of revenues over expenses for year	-	-	-	207,391	**207,391**
Amortization of capital assets	(43,063)	-	-	43,063	**-**
Amortization of deferred lease incentives	6,171	-	-	(6,171)	**-**
Purchase of capital assets	46,096	-	-	(46,096)	**-**
Disposal of capital assets, net book value	(3,070)	-	-	3,070	**-**
Internally imposed restriction (note 9)	-	-	300,000	(300,000)	**-**
Balance, end of year	99,875	16,000	300,000	1,488,280	**1,904,155**

The accompanying notes are an integral part of these financial statements

COLLEGE OF MIDWIVES OF ONTARIO

Statement of Changes in Net Assets

Yeah ended March 31

	Invested in capital assets $	Internally restricted for therapy and counselling $	Unrestricted $	2020 Total $
Balance, beginning of year	102,128	16,000	1,451,110	1,569,238
Excess of revenues over expenses for year	-	-	127,526	127,526
Amortization of capital assets	(36,285)	-	36,285	-
Amortization of deferred lease incentives	6,171	-	(6,171)	-
Purchase of capital assets	21,727	-	(21,727)	-
Balance, end of year	93,741	16,000	1,587,023	1,696,764

The accompanying notes are an integral part of these financial statements

COLLEGE OF MIDWIVES OF ONTARIO

Statement of Cash Flows

Year ended March 31	2021 $	2020 $
Cash flows from operating activities		
Excess of revenues over expenses for year	**207,391**	127,526
Adjustments to determine net cash provided by (used in) operating activities		
Government grant - project funding	**(75,722)**	(78,011)
Amortization of capital assets	**43,063**	36,285
Amortization of deferred lease incentives	**(11,931)**	(11,931)
	162,801	73,869
Change in non-cash working capital items		
Decrease in accounts receivable	**10,348**	21,064
Increase in prepaid expenses	**(164)**	(9,521)
Increase (decrease) in accounts payable and accrued liabilities	**(81,047)**	21,645
Increase in deferred registration fees	**39,810**	187,334
	131,748	294,391
Cash flows from investing activities		
Purchase of capital assets	**(46,096)**	(21,727)
Proceeds on disposal of capital assets	**3,070**	-
	(43,026)	(21,727)
Cash flows from financing activities		
Receipt of government grant - operations	**-**	398,381
Receipt of government grant - project funding	**75,722**	66,130
	75,722	464,511
Net change in cash and cash equivalents	**164,444**	737,175
Cash and cash equivalents, beginning of year	**3,025,221**	2,288,046
Cash and cash equivalents, end of year	**3,189,665**	3,025,221

The accompanying notes are an integral part of these financial statements

March 31, 2021

Nature and description of the organization

The College of Midwives of Ontario (the "College") was incorporated as a non-share capital corporation under the Regulated Health Professions Act, 1991 (the "RHPA"). As the regulator and governing body of the midwifery profession in Ontario, the major function of the College is to administer the Midwifery Act, 1991 in the public interest.

The College is a not-for-profit organization, as described in Section 149(1)(l) of the Income Tax Act, and therefore is not subject to income taxes.

1. **Significant accounting policies**

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations and include the following significant accounting policies:

(a) **Revenue recognition**

Contributions

The College follows the deferral method of accounting for contributions.

Restricted contributions, including funding received from the Ontario Ministry of Health and Long-Term Care, are deferred and recognized as revenue in the year in which the related expenses are incurred.

Registration fees

Registration fees are recognized as revenue in the fiscal year to which they relate. The registration year of the College is October 1 to September 30. Registration fees received in advance of the fiscal year to which they relate are recorded as deferred registration fees.

Administration and other

Administration and other fees are recognized as revenue when the service is rendered.

(b) **Cash and cash equivalents**

Cash and cash equivalents consist of cash and guaranteed investment certificates which are readily convertible into cash, are not subject to significant risk of changes in value and have a maturity date of three months or less from the date of acquisition.

March 31, 2021

1. **Significant accounting policies (continued)**

(c) **Capital assets**

The costs of capital assets are capitalized upon meeting the criteria for recognition as a capital asset, with the exception of expenditures on internally generated intangible assets during the development phase, which are expensed as incurred. The cost of a capital asset comprises its purchase price and any directly attributable cost of preparing the asset for its intended use.

Capital assets are measured at cost less accumulated amortization and accumulated impairment losses.

Amortization is provided for, on a declining balance basis upon commencement of the utilization of the assets, using rates designed to amortize the cost of the capital assets over their estimated useful lives. The annual amortization rates are as follows:

Office equipment	20%
Computer equipment	20% - 30%

Amortization of leasehold improvements is provided for on a straight-line basis over the remaining term of the respective lease.

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. If any potential impairment is identified, the amount of the impairment is quantified by comparing the carrying value of the capital asset to its fair value. Any impairment of the capital asset is recognized in income in the year in which the impairment occurs.

An impairment loss is not reversed if the fair value of the capital asset subsequently increases.

(d) **Net assets invested in capital assets**

Net assets invested in capital assets comprises the net book value of capital assets less the unamortized balance of tenant inducements used to purchase capital assets.

(e) **Deferred lease incentives**

Lease incentives consist of free rent benefits and tenant inducements received in cash used to purchase capital assets.

Lease incentives received in connection with original leases are amortized to income on a straight-line basis over the terms of the original leases. Lease incentives received in connection with re-negotiated leases are amortized to income on a straight-line basis over the period from the expiration date of the original lease to the expiration date of the re-negotiated lease.

1. **Significant accounting policies (continued)**

(f) **Financial instruments**

Measurement of financial assets and liabilities

The College initially measures its financial assets and financial liabilities at fair value adjusted by the amount of transaction costs directly attributable to the instrument.

The College subsequently measures all of its financial assets and financial liabilities at amortized cost.

Amortized cost is the amount at which a financial asset or financial liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization of any difference between that initial amount and the maturity amount, and minus any reduction for impairment.

Financial assets measured at amortized cost include cash and cash equivalents and accounts receivable.

Financial liabilities measured at amortized cost include accounts payable and accrued liabilities.

Impairment

At the end of each year, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. Objective evidence of impairment includes observable data that comes to the attention of the College, including but not limited to the following events: significant financial difficulty of the issuer; a breach of contract, such as a default or delinquency in interest or principal payments; and bankruptcy or other financial reorganization proceedings.

When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the year in the expected timing or amount of future cash flows from the financial asset.

When the College identifies a significant adverse change in the expected timing or amount of future cash flows from a financial asset, it reduces the carrying amount of the financial asset to the greater of the following:

- the present value of the cash flows expected to be generated by holding the financial asset discounted using a current market rate of interest appropriate to the financial asset; and

- the amount that could be realized by selling the financial asset at the statement of financial position date.

March 31, 2021

1. **Significant accounting policies (continued)**

(f) **Financial instruments (continued)**

Impairment (continued)

Any impairment of the financial asset is recognized in income in the year in which the impairment occurs.

When the extent of impairment of a previously written-down financial asset decreases and the decrease can be related to an event occurring after the impairment was recognized, the previously recognized impairment loss is reversed to the extent of the improvement, but not in excess of the impairment loss. The amount of the reversal is recognized in income in the year the reversal occurs.

(g) **Management estimates**

The preparation of financial statements in conformity with Canadian accounting standards for not-for-profit organizations requires management to make judgments, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the current year. Actual results may differ from the estimates, the impact of which would be recognized in future years.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

2. Financial instrument risk management

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the College's risk exposure and concentrations.

The financial instruments of the College and the nature of the risks to which those instruments may be subject, are as follows:

	Risks				
			Market risk		
Financial instrument	Credit	Liquidity	Currency	Interest rate	Other price
Cash and cash equivalents	X			X	
Accounts receivable	X				
Accounts payable and accrued liabilities		X			

Credit risk

The College is exposed to credit risk resulting from the possibility that parties may default on their financial obligations, or if there is a concentration of transactions carried out with the same party, or if there is a concentration of financial obligations which have similar economic characteristics that could be similarly affected by changes in economic conditions, such that the College could incur a financial loss.

The maximum exposure of the College to credit risk is as follows:

	2021 $	2020 $
Cash and cash equivalents	3,189,665	3,025,221
Accounts receivable	4,721	15,069
	3,194,386	3,040,290

The College reduces its exposure to the credit risk of cash and cash equivalents by maintaining balances with a Canadian financial institution.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due.

The liquidity of the College is monitored by management to ensure sufficient cash is available to meet liabilities as they become due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and other price risk.

2. **Financial instrument risk management (continued)**

Currency risk

Currency risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in foreign exchange rates.

The College is not exposed to currency risk.

Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instrument will fluctuate due to changes in market interest rates.

Other price risk

Other price risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate because of changes in market prices (other than those arising from currency risk or interest rate risk), whether those changes are caused by factors specific to the individual instrument or its issuer or factors affecting all similar instruments traded in the market.

The College is not exposed to other price risk.

Changes in risk

There have been no significant changes in the risk profile of the financial instruments of the College from that of the prior year.

3. **Cash and cash equivalents**

	2021 $	2020 $
Cash	1,187,627	3,025,221
Guaranteed investment certificate - 0.450%, due 04/08/2021	2,002,038	-
	3,189,665	3,025,221

March 31, 2021

4. **Capital assets**

	Cost $	Accumulated Amortization $	2021 Net $
Office equipment	65,464	51,433	14,031
Computer equipment	78,465	27,017	51,448
Leasehold improvements	201,327	158,186	43,141
	345,256	236,636	108,620

	Cost $	Accumulated Amortization $	2020 Net $
Office equipment	65,464	47,925	17,539
Computer equipment	63,160	43,944	19,216
Leasehold improvements	201,327	129,425	71,902
	329,951	221,294	108,657

During the year, computer equipment with a net book value of $3,070 (cost of $30,791 and accumulated amortization of $27,721) was disposed of for proceeds of $3,070 resulting in no gain or loss.

During the prior year, office and computer equipment with a net book value of nil (cost and accumulated amortization of $10,919) was disposed of for no proceeds resulting in no gain or loss.

5. **Accounts payable and accrued liabilities**

	2021 $	2020 $
Trade payables and accrued liabilities	112,555	102,601
Accrued liabilities - investigations and hearings	146,624	233,050
Government remittances	5,551	10,126
	264,730	345,777

6. Deferred project funding

The College receives special project funding from the Ontario Ministry of Health and Long-Term Care to develop and implement a quality assurance program for Birth Centres.

The College previously received special project funding from the Ontario Ministry of Health and Long-Term Care to promote changes to narcotics regulation in order to ensure its members are able to perform their duties adequately.

	Narcotics Regulation $	Birth Centres $	2021 Total $
Deferred project funding, beginning of year	-	-	-
Project funding received during the year	-	75,722	75,722
Project funding recognized as revenue in the year	-	(75,722)	(75,722)
Deferred project funding, end of year	-	-	-

	Narcotics Regulation $	Birth Centres $	2020 Total $
Deferred project funding, beginning of year	3,352	-	3,352
Project funding received during the year	-	66,130	66,130
Project funding receivable	-	8,529	8,529
Project funding recognized as revenue in the year	(3,352)	(74,659)	(78,011)
Deferred project funding, end of year	-	-	-

March 31, 2021

7. **Deferred lease incentives**

	Cost $	Accumulated Amortization $	2021 Net $
Tenant inducements	43,200	34,455	8,745
Free rent benefits	40,323	32,160	8,163
	83,523	66,615	16,908

	Cost $	Accumulated Amortization $	2020 Net $
Tenant inducements	43,200	28,284	14,916
Free rent benefits	40,323	26,400	13,923
	83,523	54,684	28,839

During the year, amortization of lease incentives in the amount of $11,931 (2020 - $11,931) was credited to rent and utilities expense.

8. **Net assets internally restricted for therapy and counselling**

The Council of the College has internally restricted net assets for the purposes of funding therapy and counselling for midwifery clients as directed under the RHPA.

The internal restriction is subject to the direction of Council upon the recommendation of the Executive Committee.

9. **Net assets internally restricted for investigations and hearings**

The College makes best efforts to anticipate the costs associated with investigation and hearing matters based on past experience and current caseload. However, in the event that the College incurs costs beyond the normal scope of such matters, the Council of the College has internally restricted net assets to fund expenditures related to these matters.

During the current year, the Council approved a transfer of $300,000 from unrestricted net assets to net assets internally restricted for investigation and hearings.

The internal restriction is subject to the direction of the Council upon the recommendation of the Executive Committee.

10. **Commitment**

The College is committed to lease its office premises until August 2022. The future annual lease payments, including an estimate of premises common area expenses, are as follows:

	$
2022	201,841
2023	84,100
	285,941

11. **Impact of COVID-19**

The global pandemic of the virus known as COVID-19 has led the Canadian Federal government, as well as provincial and local governments, to impose measures, such as restricting foreign travel, mandating self-isolations and physical distancing and closing non-essential businesses. Because of the high level of uncertainty related to the outcome of this pandemic, it is difficult to estimate the future financial effect, if any, on the College.

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REGISTRAR-CEO QUARTERLY REPORT

REPORT TO COUNCIL – June 23, 2021.
Submitted by: Kelly Dobbin

The Registrar-CEO Quarterly Report assures Council that the College operates effectively and achieves its strategic goals, and that the Registrar performs in accordance with the expected duties outlined in Council's Governance Policies.

The Registrar-CEO is accountable for the College's performance in six main areas:

1. Strategic Leadership and Direction Setting
2. Development and Achievement of Goals
3. Reputation and Relationship Management
4. Financial Accountability and Management
5. People and Organizational Leadership
6. Council Governance and Engagement

1. Strategic Leadership and Direction Setting

Bill 283 Advancing Oversight and Planning in Ontario's Health System Act, 2021

Bill 283 passed its third reading on June 1, 2021 and received Royal Assent on June 3, 2021.

This Government omnibus bill proposes the formation of an additional health regulatory system in Ontario, separate from the *Regulated Health Professions Act* (RHPA). It calls for the creation of a new act called the *Health and Supportive Care Providers Oversight Authority Act* (HSCPOAA). This Act will establish a new voluntary registration system for Personal Support Workers in Ontario. It will not be a self-regulatory College model that currently exists for health professions under the RHPA, but rather a delegated administrative authority that is less independent of the government. It will have an appointed competency-based Board of Directors, and none will be members of the profession it oversees. Rather, profession-specific input will be obtained using advisory committees. Once established, there is the possibility of "moving" health professions who currently fall under the RHPA over to this system, as the Act is intended to allow for more health and support professions to come under its umbrella. The Ministry has suggested that any decisions to move a profession from the RHPA to the HSCPOAA would be made using a risk-of-harm framework, for example, those health and support professions that inherently pose less risk of harm to patients, could be considered candidates for moving. At this time, we have no reason to believe that the College of Midwives of Ontario would be a candidate for moving over to the HSCPOAA.

In addition, the government bill makes changes under the RHPA to regulate Physician Assistants under the *Medicine Act* (CPSO) and Applied Behavioural Analysts under the *Psychology Act* (which would undergo a name change to the *Psychology and Applied Behaviour Analysts Act*).

Bill 276, Supporting Recovery and Competitiveness Act, 2021

Bill 276 passed its third reading on June 1, 2021 and received Royal Assent on June 3, 2021.

This government omnibus bill includes amendments to the *Regulated Health Professions Act* (RHPA) and the profession-specific acts to eliminate reference to the Health Professions Regulatory Advisory Council (HPRAC). HPRAC was established under the RHPA, with a statutory duty to advise the Minister on health professions regulatory matters in Ontario. This included providing advice to the Minister on:

- Whether unregulated health professions should be regulated;
- Whether regulated health professions should no longer be regulated;
- Amendments to the *Regulated Health Professions Act* (RHPA);
- Amendments to a health profession's Act or a regulation under any of those Acts;
- Matters concerning the quality assurance programs and patient relations programs undertaken by health colleges; and,
- Any matter the Minister refers to HPRAC relating to the regulation of the health professions.

The Minister currently relies on the Ministry to fulfil this function.

In addition, a new section to the *Statutory Powers Procedure Act* empowers hearing tribunals (including discipline committees of health regulatory bodies) to make orders preventing the recording and dissemination of recordings and pictures of hearings, including virtually held hearings.

Laurentian University Midwifery Education Program

On 1 February 2021, Laurentian University (LU), home of one of three Midwifery Education Programs (MEPs) in Ontario, filed for creditor protection. On 12 April 2021, LU announced the closure of 69 programs, including the Midwifery Education Program, and terminated over 100 faculty positions related to those programs. The rapid closure of the program was a surprise to all students and faculty as well as stakeholders. LU's MEP was the only bilingual program in the country and graduated a class of approximately 30 northern, rural, Indigenous, and Francophone students each year. In the days and weeks following the announcement, the College met regularly with stakeholders to understand the potential impacts on students who were set to graduate later that month and become applicants of the College, as well as those who had a year or more left to complete, before becoming applicants.

The remaining MEPs at Ryerson University and McMaster University agreed to increase their class sizes (upon the Ministry of Colleges and Universities approval which was granted on April 30th for up to one year) to absorb those students affected by the closure and to accommodate 30 additional candidates who were expecting entry into the program this September. Students who had northern community placements will maintain those placements under this temporary revised structure and Francophone students are being supported by bilingual faculty members.

The government has announced that it intends to find a new home for a bilingual and northern midwifery education program.

COVID-19

The College continues to actively monitor the pandemic as it relates to the health profession regulatory sector and midwives in particular. We continue to participate in weekly Ministry Emergency Operations Centre (MEOC) teleconferences and meet regularly with midwifery stakeholders to ensure sector related issues are discussed and addressed as needed.

Canadian Midwifery Registration Exam (CMRE)

On April 9, 2021, the Canadian Midwifery Regulators Council announced that the May 6, 2021, sitting of the Canadian Midwifery Registration Exam (CMRE) was being postponed due to the status of the ongoing COVID-19 pandemic. The exam has been postponed to the fall sitting, which is due to take place on October 28, 2021. The fall exam will be delivered in an online format for the first time, and all future sittings will be online as well, preventing any further postponements due to the pandemic. The College is following the same process for registration as last year when we were faced with the same problem. To be eligible for registration in Ontario, applicants must have successfully completed the Final Clerkship Exam and will be asked to sign an Acknowledgement and Undertaking agreeing to write the CMRE at its next sitting.

2. Development and Achievement of Goals

Performance Measurement

We are pleased to report on our annual self-assessment in accordance with the College's approved Performance Measurement Framework (approved by Council in June 2019). As Council knows, this framework provides the College with a mechanism to review, evaluate, and report on our performance using a set of standards based on its legislative mandate and expected outcomes, including ensuring that midwives registered with the College possess the relevant knowledge, skills, and behaviours to provide safe, ethical, and effective care; and taking action when risks are identified. This process is not legislatively mandated but is a voluntary commitment by the College to evaluate our performance and to demonstrate that we indeed regulate in the public interest. The College will publish the report for the first time, as no formal report was made last year since the framework was being tested in its pilot year. The Council will receive a presentation by staff on the review process and the results at the June meeting. The published report will follow shortly thereafter.

3. Reputation and Relationship Management

Scope of Practice Webinars

To build engagement and foster trust with the profession, the College held two webinars in May 2021 to support members' understanding and acceptance of the Phase 2 – Standards of Practice Changes that were approved by Council in December 2020 and implemented on June 1st, 2021. We are pleased to report that over 200 members attended the sessions which involved a brief overview of the changes as well as an in-depth question-and-answer period.

New Registrants

Newly developed visual tools have been uploaded to our website to help new registrants understand their regulatory requirements in their first year of practice. The visual guide welcomes members to the profession, explains the new registrant conditions placed on their General certificate of registration, helps them understand how to stay informed, and how to log into the Member Portal where they will update their personal and professional information and submit annual Registration and Quality Assurance reports. The visual guide can be found here: https://www.cmo.on.ca/members/registration/new-registrants/ for your information.

Quality Assurance Program 2021

Considering the extraordinary circumstances of the COVID-19 pandemic, the Quality Assurance Committee made the decision that midwives will not be required to report on their participation in the Quality Assurance Program for the 2020-21 year.

During the pandemic, midwives have had to continually adapt their practice to keep up with changes such as revised clinical practice guidelines and recommendations on Infection Prevention and Control (IPAC). To alleviate some of the pressures midwives are experiencing and to recognize the ongoing learning they continue to participate in because of the pandemic, the College will exempt all midwives from their Quality Assurance Program (QAP) reporting this year. While the College encourages midwives to continue participating in quality assurance activities, to reduce their administrative responsibilities, midwives will not be required to report.

Registration Renewal 2021

In consideration of the pandemic and the continued pressures that midwives face, the College has made the following changes to the 2021 annual renewal process:

a) Renewal Period
The 2021 renewal period will be extended, enabling midwives to successfully renew their registration up to November 1, 2021. A bylaw change is not necessary for this to take place as the Registrar has discretionary powers to waive or reduce registration-related fees (in this case penalty fees which would typically be applied after October 1st) and can delay sending notices of intent to suspend to members by one month to allow for the extension to take place.

b) Continuing Competencies
The College has outlined two options for meeting the continuing competency requirements in neonatal resuscitation (NRP), cardiopulmonary resuscitation (CPR) and Emergency Skills (ES) for 2021.
Option 1: Complete an approved continuing competency course(s) including the in-person component.
Option 2: Complete the online components of an approved continuing competency course(s) and skills review/practice.

To further assist in easing the administrative burden for midwives during this challenging time, practising midwives will not be required to upload training certificates and will only be required to complete a declaration within the renewal form noting completion of option 1 or option 2. Midwives are expected to maintain records of activities undertaken should the College request the information later.

c) Active Practice Requirements (APR)
This year, midwives will not be required to submit their annual active practice reports. While midwives are expected to continue practising in accordance with the conditions on their certificates of registration, including working towards meeting the active practice requirements, midwives are not required to report their birth numbers this year.

4. Financial Accountability and Management

Statement of Operations & Financial Statements

A draft Q4 Statement of Operations was provided to the Executive Committee at its last meeting; however, the final Q4 SOP cannot be rendered until after any audit related adjustments take place.

The College has undergone its annual financial audit which was executed virtually in May and June. Typically, the auditors perform both offsite and onsite reviews during the audit week, however, due to the pandemic, all reviews were conducted offsite again this year. The Executive Committee met with the auditors by videoconference to ask questions and to provide oversight to the audit process on May 12, 2021. The draft Financial Statements have not yet been received by the College. The Executive Committee is scheduled to meet on June 16 to review both the audited Financial Statements and the adjusted Q4 SOP. Council will be provided with both documents after that date and will be asked to approve the Financial Statements at the June meeting.

5. People and Organizational Leadership

Staff Trainings

Staff have recently had their annual mandatory training regarding workplace harassment and violence policies and procedures. In addition, staff had a refresher training on email phishing to keep staff on high alert for new and improved system breach attempts.

Staff Changes

We are pleased to announce that Victoria Marshall will be taking a parental leave in July, and we are actively recruiting a 13-month contract replacement for her position as Communications and Stakeholder Relations Officer. We thank Victoria for the work she has done to make sure the transition is a smooth one and wish her all the best on her leave.

Staff Performance Reviews

We have made the decision to move the timing of staff annual performance reviews from November/December to January/February (delaying two months in this first year of change) to better accommodate work planning. The annual Organizational Effectiveness Survey of staff will continue to be delivered in December of each year.

6. Council Governance and Engagement

Council Members

We are pleased to announce that on the anniversary of their one-year appointments, public members Pete Aarssen and Don Strickland were reappointed to serve three-year terms with our Council. We are grateful to have them continue as engaged public council members. Sarah Baker, however, will resign from Council as she has moved out of country to reside with family. Once a public appointee is found to replace her, her membership on Council will be revoked. Thank you, Sarah for your service to the College. We will miss your contribution and wish you all the best.

Professional member elections are currently underway. In recognition that there is a lack of diverse representation in the composition of our Council, the College encouraged midwives from Indigenous, Black, and racialized communities, marginalized communities, rural communities, as well as midwives who are internationally educated, or practising in expanded, collaborative and/or community health team models to run for election.

For the first time, the College hosted two webinars for midwives interested or having questions about serving on Council. Council Chair, Claire Ramlogan-Salanga, and Council Coordinator, Zahra Grant, hosted both sessions. One session was reserved for midwives from Indigenous, Black, or racialized communities. While attendance was low, engagement was high, and we are pleased that four candidates are now running for two positions.

On Tuesday, June 1 all eligible electors received an email from the College with a link to cast their secure ballot at any time during the month of June. After one week, 20% of the membership had voted. Typical elections range from 21-31% of membership voting throughout the month and we expect that the percentage will increase once reminders are sent out. Results of the election will be emailed to Council and the membership by July 7, 2021.

Attachments:

1. Grey Areas: Responding to the Pandemic: Reflections by Regulators
2. Letter to Colleges Governance Reform

Grey Areas
A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION
SML Steinecke Maciura LeBlanc Barristers & Solicitors

Responding to the Pandemic: Reflections by Regulators

by Rebecca Durcan
June 2021 - No. 257

While the pandemic is not yet over, reflections on how regulators have responded to, and can learn from, their pandemic experience is already happening. Last month the UK oversight body, the Professional Standards Authority (PSA) released its preliminary report entitled: *LEARNING FROM COVID-19: A case-study review of the initial crisis response of 10 UK health and social care professional regulators in 2020*. The report can be found at: https://www.professionalstandards.org.uk/publications/detail/learning-from-covid-19-a-case-study-review.

Many of the points made in the report will be familiar to Canadian regulators including the following:

- Regulators rapidly changed their registration rules to quickly re-register recently retired practitioners and offer some sort of limited registration to recent graduates who did not meet all of the requirements in order to ensure sufficient health care staffing needs.
- Education programs worked with regulators to facilitate acceptance of remote and alternative ways of training future practitioners.
- Remote investigations and virtual discipline hearings became common.
- Regulators had to issue guidance and standards of practice on short notice without the usual consultation process. Some of those standards provided assurance to practitioners if they were not always able to meet the usual professional expectations and or comply with the usual safeguards for telepractice in the short term.
- Regulators learned to operate remotely and largely without paper documents.

However, there are a number of points made in the report that may be of interest to Canadian regulators as they conduct their own reflections.

Many regulators found that they were not able to involve clients and members of the public in their decision making as they had in the past. Consultation on proposed guidelines and standards of practice was often not feasible. This gap will need to be filled going forward regardless of the "we won't be doing things the same way again" philosophy that has emerged.

There is a sense that on some issues the regulators and other stakeholders (e.g., public health authorities, health care institutions and employers) collaborated more closely than before. This was necessary and in many ways seen as positive. However, there is a risk of the regulators losing focus on their mandate and independence in order to make "the system work".

There was also unique collaboration amongst regulators. For example, one of the case studies in the report discusses how pharmacies and social workers worked together in the "development of community pharmacies as 'safe spaces' for victims of domestic abuse, the prevalence of which rose markedly from the outset of the pandemic."

In the past, the PSA had suggested that the mental health and welfare of practitioners was really the mandate of professional organizations, not regulators. The pandemic caused such strain on the welfare of

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practitioners in ways that jeopardized their ability to practice, that regulators took a much more active role in advocating for the wellness of practitioners. It is unclear at this time whether that will be seen as an ongoing role for regulators.

While there are no statistics, it appears from the discussion in the report and our own anecdotal information that some of the UK regulators permitted a longer backlog of discipline cases to develop than many Canadian regulators.

The report identifies that an entry-to-practise competency for practitioners should include skills for managing emergencies, including making ethical judgments. By way of illustration of the latter, the report mentions that some regulators issued statements that it was unprofessional for practitioners to comply with blanket "do not resuscitate" orders that appear to have been issued in some facilities.

The pandemic has re-emphasized the value in practitioners from multiple health professions receiving joint training in some areas, particularly those related to shared standards (e.g., informed consent) and professionalism. Similarly, it may be time for all health professions to have a single code of conduct.

The pandemic also had a significantly disproportionate effect on racialized individuals and communities. The report noted that some regulators are looking quite seriously at their ability to help address this issue. For example, the medical regulator is examining its role in affecting not only its own handling of complaints about racialized practitioners, but also addressing the causes of increased complaints about them. The regulator is developing initiatives to reduce these systemic causes (e.g., racialized practitioners not being part of the "in group"). The medical regulator has also stated that "the pandemic has highlighted more than ever that a professionals [*sic*] individual health and well-being is central to their ability to deliver good care, and we must focus our attention on supporting the right environments to enable doctors to do so."

The report has noted that the level of trust in health regulators by practitioners seems to have increased during the pandemic. This observation is consistent with the observation in Australia that practitioners reported a significant increase in their view that their regulatory body was doing all it could to protect the public and was trustworthy during the pandemic: (see the presentation of Paul Shinkfield and Alyssa King from Australian Health Practitioner Regulation Agency (AHPRA) on *Measuring strategic performance in regulation - Using data to demonstrate our value* put on by CLEAR at: http://clearweb.drivehq.com/CLEAR_RegAdmin_webinar_Data_Demonstrate_Value_March25_2021.mp4 and http://clearweb.drivehq.com/webinar_handouts/slides_CLEAR_webinar_Data_Demonstrate_Value_March2021.pdf).

For those interested in more information about the report, Douglas Bilton, Assistant Director, Standards and Policy, UK Professional Standards Authority for Health and Social Care will be making a presentation for CLEAR on the topic on June 15, 2021. See: https://www.clearhq.org/ for more details.

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June 8, 2021

158-2021-46

Dear College Presidents and Registrars/ Executive Directors

Over the past several months, we have seen the ongoing diligent and tireless contributions of all our health system partners in response to the COVID-19 pandemic.

As we prepare for a potential burden reduction Bill this Fall, the ministry is exploring opportunities for governance reforms under the *Regulated Health Professions Act, 1991* and your respective 26 health profession Acts that would increase your efficiency and your ability to respond swiftly to emerging needs.

I am aware that many colleges have expressed interest in governance changes since 2017. Since that time, there have been developments, namely, the ongoing pandemic and the introduction of Bill 283, which have added to the discussion on governance reform.

As I have noted in previous conversations, I would like to seek your input on whether previous advice to the ministry on governance reform has changed in light of the progress of time and recent experience with the COVID-19 pandemic, as well as, the government's introduction of legislation establishing a new framework for oversight.

I am requesting your feedback on possible governance reforms by June 30th.

I look forward to our continued partnership as we explore opportunities to improve and strengthen the oversight system for health professions in Ontario.

Sincerely,

Sean Court
Assistant Deputy Minister

Encl.

c. Allison Henry, Director

IN CAMERA

The IN CAMERA session of the of Council meeting excludes the attendance of public observers pursuant to the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, section 7(2)(b).

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Implementation of the Quality Assurance Regulation

Background:

All professions regulated under the Regulated Health Professions Act, 1991 (RHPA) must have a quality assurance program. As stipulated under section 80.1 of the Health Professions Procedural Code (being Schedule 2 of the RHPA), a quality assurance program must include a continuing education and professional development (CE/CPD) component and a peer and practice assessment component. The College's requirements for the CE/CPD component (currently known as the QAP) and the peer and practice assessment component were written in Part 1 of the College's General Regulation (O. Reg. 335/12). In 2017, a new Quality Assurance Regulation was submitted to the Ministry of Health for approval. This new Quality Assurance (QA) Regulation (O. Reg 669/20) came into force on November 27, 2020.

Key Considerations

With the new QA regulation now in force, Council must approve the two program documents that set out the new CE/CPD requirements and the peer and practice assessment program. These documents are:

- the Professional Development Portfolio
- the Peer and Practice Assessment Program

Professional Development Portfolio

- The Professional Development Portfolio could not be implemented under the previous regulation because it did not meet the requirements set out in the regulation. For example, the previous regulation required that all midwives attend 6 peer case reviews, and this requirement is not part of the new program.
- In November 2020, the new QA regulation came into force which allows for the implementation of the Professional Development Portfolio.
- The Professional Development Portfolio replaces the QAP as the CE/CPD component of the former regulation.
- The Professional Development Portfolio was developed based on primary research, gathering information during four focus groups with midwives, about the College's QAP and the existing evidence about quality assurance programs in general.
- The components of the Professional Development Portfolio were approved by QAC during the summer and fall of 2017 and the program was presented to Council in

December 2017 with a plan to approve it once the new regulation came into force. The major changes to the program include:
    - Moving from yearly reporting to reporting every three years
    - Reporting by midwives in the Inactive class
    - Reducing the number of peer reviews from 6 per year to 4 per year
    - Self-reflection activities
- Implementing the Professional Development Portfolio allows for the rescinding of the three guidelines describing the QAP which are no longer relevant:
    - Guideline on Continuing Education and Professional Development
    - Guideline on Peer Case Reviews
    - Guideline on Quality of Care Evaluations
- QAC reviewed the Professional Development Portfolio document (attached) on April 21, 2021 and is bringing it forward to Council for approval with an implementation date of October 1, 2021.

Peer and Practice Assessment Program

Under the previous QA Regulation, revisions to the College's peer and practice assessment program were made. These changes were approved by Council and implemented in December 2019 with the first round of assessments occurring between January and March 2020.

Implementation of the assessment program required hiring and training a pool of assessors, developing, piloting and revising assessment tools, and developing a panel process for reviewing assessment results. In addition, staff survey the midwives who have been assessed and well as meet with the assessors to gather feedback used to revise and refine the program. Over the summer we will be making some small revisions to the assessment tools however, no changes are being proposed to the program at this time.

The document setting out the details of the peer and practice assessment program requires Council approval. QAC reviewed the Peer and Practice Assessment Program document (attached) on April 21, 2021 and is bringing it forward to Council for approval.

Recommendations

The following recommendations are submitted to the Council for approval:

Approve the Professional Development Portfolio Program

Approve the Peer and Practice Assessment Program

Rescind the following guidelines:

- Guideline on Continuing Education and Professional Development
- Guideline on Peer Case Reviews
- Guideline on Quality of Care Evaluations

Implementation Date

October 1, 2021

Legislative and Other References

1. Quality Assurance Regulation (O. Reg 669/20)
2. *Midwifery Act, 1991*
3. Regulated Health Professions Act, 1991

Attachments

1. Peer and Practice Assessment Program
2. Quality Assurance Program

Submitted by QAC

PEER AND PRACTICE ASSESSMENT PROGRAM

QUALITY ASSURANCE PROGRAM

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

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INTRODUCTION

Peer and practice assessments are a component of the College of Midwives of Ontario's (College) Quality Assurance Program (QAP). This program is a requirement of all regulated health professionals under the *Regulated Health Professions Act, 1991* (RHPA). The requirement for midwives to participate in peer and practice assessments is set out in the Quality Assurance Regulation (O. Reg 669/20). Participation in a peer and practice assessment allows midwives of the College to demonstrate their professional knowledge, skills and judgment with a peer assessor. The QAP is intended to ensure the provision and maintenance of safe, appropriate, effective and ethical care that is expected of Ontario midwives as primary care providers during pregnancy, labour and the postpartum.

Peer and practice assessments are grounded in the assumption that midwives are practicing competently while recognizing that the changing dynamics of practice environments and best practices create the need for continued learning and development. Striving to improve professional practice is a career-long expectation and goal.

PEER AND PRACTICE ASSESSORS

Peer and practice assessments are conducted by peer and practice assessors (assessors). Assessors are midwifery professionals who have been appointed by the Quality Assurance Committee and trained by the College to conduct assessments. Information about the recruitment, expectations, roles, and responsibilities of assessors who conduct peer and practice assessments for the Quality Assurance Program (QAP) on behalf of the College are set out in the Quality Assurance Program Assessor Guide.

ASSESSMENT SELECTION

The Quality Assurance Regulation sets out the criteria by which midwives can be assessed. The process for selecting a midwife for assessment is determined by the Quality Assurance Committee and is currently done by random selection. The number of midwives selected for assessment will vary, but every year approximately 10% of eligible midwives will be randomly selected. Eligibility for random assessment is determined by the midwife's current registration class and history of assessments. Midwives in the General or Supervised Practice class are all eligible to be assessed as well as anyone who has not been randomly assessed in the previous five years (i.e., 60 months).

When random sampling is stratified based on a set of criteria, these criteria must be approved by the QAC in advance of the assessment selection process and be posted on the College's website at least three months before the midwives are selected on the basis of those criteria.

PEER AND PRACTICE ASSESSMENT

The purpose of the assessment is to have one's professional practice reviewed and evaluated by one's peer for the purpose of quality improvement and practice development. The College's peer and practice assessment program is based on minimum standards of practice established by regulations, College policies, and essential competencies for midwives in Ontario. Assessments may involve a number of activities as set out in Section 3 of the regulation such as an interview with the midwife, an inspection of the premises where the midwife practices, or an inspection of the midwife's records.

There are two components to the assessment process that are applicable to all practising midwives selected for a random peer and practice assessment, the first is the peer assessment or peer interview, and the second is the practice assessment. Depending on the outcome of the peer assessment, participation in a practice assessment may not be required.

Peer Assessment Component

A peer assessment is conducted virtually between the assessor and the midwife being assessed and takes approximately one hour to complete. The assessor will ask the midwife a series of short scenario-based questions designed to allow the midwife to demonstrate their knowledge of midwifery practice, standards of practice, and the regulations that govern the profession. Questions are not necessarily focussed on clinical care and can include other aspects of midwifery practice such as interprofessional care. These questions ask midwives to think about midwifery as broader than that of their own specific practice locations. The questions are pre-selected from a bank of questions. Sample questions are available on the College's website.

A pre-selected percentage of midwives who receive scores of 75% or above will be streamed out of the process and not required to participate in the practice assessment. Their names are then removed from the assessment selection pool for five years.

Practice Assessment Component

Midwives who were randomly selected to participate in both components of the peer and practice assessment and midwives who were not streamed out of the process based on their scores in the peer assessment continue with the practice assessment. Components of the practice assessment include chart reviews, chart stimulated recall interviews, and a review of the midwife's Quality Assurance Program/Professional Development Portfolio activities. Parts of the assessment include disclosure of client chart information. Assessors are authorized to do so through provisions under the RHPA despite privacy legislation, such as the *Personal Health Information Protection Act, 2004* (PHIPA).

Chart Review

During a chart review, the assessor will ask for a sample of client charts to review. The criteria for the selection of charts will be provided to the midwife during the pre-assessment discussion.

The chart review is an interactive process wherein the assessor will review the charts using the review tool and then conduct an interview with the midwife. Midwives are not required to be present for the chart review process but must be present for the interview portion of the review. The chart review tool is available on the College's website.

Chart Stimulated Recall

During chart stimulated recall, the midwife and assessor discuss the same client charts that were reviewed. This interview will allow the assessor to clarify things and ask for more detailed information that was not evident through the chart review. The questions are open-ended to allow midwives the opportunity to describe their approach to the care provided, including testing and treatment options, informed choice discussions, collaborative care, and management plans.

During the interview, the assessor will provide feedback highlighting areas for improvement and give direction to resources that might be used to support those potential areas of improvement.

Review of a Midwife's Participation in the Quality Assurance Program History Review

This portion of the assessment includes a review of the midwife's Professional Development Portfolio (not including the self-assessment requirement) in accordance with Subsection 5(2) of the regulation. In accordance with the time specified by the Quality Assurance Committee, midwives are required to retain copies of their Professional Development Portfolio for their previous two reporting cycles. Together with the midwife, the assessor will look at potential opportunities for practice improvement through case reviews and continuing professional development activities.

A practice assessment will take approximately three to four hours.

ASSESSMENT EVALUATION

For the assessment evaluation, assessors use the information gathered during the assessment process to summarize the midwife's knowledge of midwifery legislation, standards and best practices in the provision of client care. Evaluations are completed in a fair and consistent manner using assessment tools with performance indicators that are based on what is expected from a competent midwife. The assessor's role is to facilitate the process and gather information to complete the assessment tools. The assessor does not make any judgments during the process of assessment. All information is summarized and compiled into a report that is submitted to the Quality Assurance Committee (QAC) for review and determination of outcomes. Reports must be received by the College within two weeks of the assessment.

ASSESSMENT OUTCOMES

The QAC is the committee responsible for administering the QAP. A panel of the committee is tasked with reviewing assessment reports to determine the outcomes and recommendations, if any, to the midwife. Midwives will be notified of the outcome with four weeks of the peer assessment portion and be provided with a report within four weeks of the practice assessment.

Meets Standards

If the assessment report indicates that the midwife assessed demonstrated the knowledge, skills, and judgment required for the provision of safe, appropriate, and ethical care, then the assessment process is considered complete, and the midwife assessed is removed from the assessment selection pool for five years. The midwife who was assessed will receive a copy of the assessment report along with any advice or recommendations.

Does Not Meet Standards

If, after considering the assessment report, the panel determines that the knowledge, skills, and judgment of the midwife are unsatisfactory, the QAC may decide to do one or more of the following:

- Require the midwife to participate in a specified continuing education or remediation programs (SCERP).
- Direct the Registrar to impose terms, conditions or limitations (TCL) for a specified period to be determined by the Committee on the certificate of registration of a midwife.
- Disclose the name of the midwife and allegations against the midwife to the Inquiries, Complaints, and Reports Committee (ICRC) if the QAC is of the opinion that the midwife may have committed an act of professional misconduct or may be incompetent or incapacitated.

The outcomes of the QAC panel review are documented in a decision that is issued to the midwife. If it is the committee's intention to give direction to the Registrar on any of the above-mentioned actions, the midwife has 30 days to make a written submission to the committee.

All information collected by the peer assessor is confidential. Information from peer and practice assessments can be shared only with the QAC and not with any other committee of the College except in limited circumstances.

Under the following limited circumstances, information provided by a midwife as part of the QAP could be shared:

- The QAC can disclose the name of a midwife and allegations against the midwife to the Inquiries, Complaints, and Reports Committee (ICRC) if the QAC is of the opinion that the midwife may have committed an act of professional misconduct, or may be incompetent or incapacitated, or
- The QAC can disclose information that demonstrates the midwife knowingly gave false information to the QAC. An example of this would be if a midwife submits a declaration of completion regarding the QAP but a random selection of their report shows that they have not actually completed all the activities, the information provided to the QAC could be shared with the ICRC or the Discipline Committee.

Questions about the Peer and Practice Assessment program can be directed to the Quality Assurance Department at qap@cmo.on.ca.

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PROFESSIONAL DEVELOPMENT PORTFOLIO

QUALITY ASSURANCE PROGRAM

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

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INTRODUCTION

The College of Midwives of Ontario's Quality Assurance Program is a requirement set out in the College's Quality Assurance Regulation (O. Reg 669/20). The Quality Assurance Program is defined as a *program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members.*

An important part of the College's Quality Assurance Program is the Professional Development Portfolio. The Professional Development Portfolio, informed by midwives and approved by Council, is designed to encourage and support midwives to continually engage in self-assessment, continuing education, and professional development.

The Professional Development Portfolio is comprised of a self-assessment, continuing education, and professional development activities and a declaration of completion every three years. This document describes the Professional Development Portfolio, how midwives will meet their Professional Development Portfolio requirements, and the College's process for reviewing midwives' participation in the Professional Development Portfolio portion of the Quality Assurance Program.

PARTICIPATION

Completing the Professional Development Portfolio (Appendix A of this document [to be attached once finalized]) is a requirement for all midwives registered in the General, Supervised Practice, Transitional, and Inactive classes. All midwives must submit evidence of a completed Professional Development Portfolio three years after they become registered with the College and every three years thereafter. The requirements for midwives change slightly depending on how long a midwife is registered in the General class during their three-year reporting cycle. These details can be found in the section Participate in case reviews (peer and interprofessional).

MAINTAINING RECORDS

Midwives are required to keep their Professional Development Portfolio (i.e., Self-Assessment, Learning Plan, and Case Reviews in the formats specified by the College), as well as any supporting documentation for their CE/CPD activities for the previous two reporting cycles. This means a midwife submitting their Professional Development Portfolio will still retain their two previous Professional Development Portfolios but may discard any records prior to that. Midwives may be asked to submit their Professional Development Portfolio to either the College or an assessor as part of the College's Professional Development Portfolio review (see below) or a peer and practice assessment. There is always the possibility that a midwife's Professional Development Portfolio will be reviewed by the College, therefore it is essential that they are complete.

A complete Professional Development Portfolio is one where the following is evident:

- Learning Plans and Reflections are descriptive
- The required number of peer case reviews have been attended and documented
- Supporting documentation about CE/CPD activities are maintained by the midwife (e.g., evidence of course completion, references for journal articles reviewed).

Since the Professional Development Portfolio is designed for midwives to stay engaged in the midwifery profession by participating in ongoing learning, midwives may want to keep their records for their own files to document the changes to their practice throughout their professional careers.

REPORTING CYCLE

Midwives are required to report on their Professional Development Portfolio every three years, by October 1 of their reporting year (i.e., midnight on September 30). A midwife's reporting year is determined in the following way:

A midwife's first reporting cycle begins on the date of their first registration renewal or the third October after initial registration with the College. This means completion of the first Professional Development Portfolio for midwives is likely to be longer than three years. For example, if a midwife registers on July 7, 2019, their first renewal will be on October 1, 2019. Thus, the midwife's first Professional Development Portfolio report will be due on October 1, 2022.

A midwife's reporting cycle does not change if they change classes. This means that a midwife's reporting cycle will always be three years from the date of their first registration renewal or the third October after initial registration with the College and does not go on hold if they register as inactive.

Only activities a midwife participates in during their reporting cycle Professional Development Portfolio cycle are eligible as reportable activities. Any Professional

Development Portfolio activities completed between the date of submission and the actual submission deadline cannot be carried forward to the next reporting cycle.

SUBMISSION TO THE COLLEGE

All reporting midwives will be required to submit a declaration of completion in the Member Portal of the database by the reporting deadline.

Falsely declaring completion of the Professional Development Portfolio is an act of professional misconduct. Should a midwife submit a declaration of completion for the Professional Development Portfolio and a College review of their records finds they do not have the supporting evidence to demonstrate completion, the midwife may be referred to Inquiries, Complaints, and Reports Committee (ICRC) under s. 80.2 of the Code.

COLLEGE REVIEWS

Each year, 20% of reporting midwives will be selected by the College to have their Professional Development Portfolio reviewed for completion. Midwives who have been selected for a College review will have 30 days to submit their Professional Development Portfolio and any supporting documentation. Professional Development Portfolios must be submitted on the College's template. Supporting documentation includes certificates, diplomas, conference proceedings, and other forms of documentation that demonstrate participation in learning activities when such evidence exists. Not submitting the required records for review is considered non-compliance. Details about non-compliance are described below.

COMPLIANCE

Midwives submitting a declaration only

Midwives who submit their declaration of completion and are not randomly selected for review are considered compliant with the Professional Development Portfolio requirements.

Midwives selected for review

Midwives who submit their declaration of completion **and** are randomly selected for review **and** submit complete CE/CPD records by the assigned deadline are considered compliant with the Professional Development Portfolio.

Midwives who are considered compliant will receive a notice of compliance.

NON-COMPLIANCE

Midwives who fail to submit a declaration

Midwives who do not submit a declaration of completion or who are selected for review and do not submit a completed Professional Development Portfolio will receive a notice of non-compliance and must pay an administrative fee pursuant to Article 11 (9) of the College's Fees and Remuneration By-Law. Midwives marked non-compliant may make a written submission regarding their non-compliance to the Quality Assurance Committee (QAC) within 30 days of receiving the notice. Submissions will be reviewed by a panel of the QAC.

Outcome of non-compliance

Following a review of a midwife's documents, a panel of the QAC may make the following decisions:

Take no Action

The panel may choose to take no action

Peer and Practice Assessment

The panel may order the midwife to undergo a peer and practice assessment. The midwife will bear all costs (not more than $2,500) for the peer and practice assessment pursuant to Article 7(2) of the College's Fees and Remuneration By-Law.

Remediation

After considering the assessor's report of the peer and practice assessment, the QAC may choose to do one or more of the following, listed in subsection 80.2 (1) of the Health Professional Procedural Code:

- Require individual midwives whose knowledge, skill, and judgment have been assessed and found to be unsatisfactory to participate in specified continuing education or remediation programs (SCERP).
- Direct the Registrar to impose terms, conditions, or limitations (TCL) for a specified period to be determined by the Committee on the certificate of registration of a midwife.
    - where the midwife's knowledge, skill, and judgment are assessed and found to be unsatisfactory;
    - if, following a SCERP and reassessment, the midwife's knowledge, skill, and judgment is still deemed to be unsatisfactory; or
    - if the midwife does not comply with the direction to participate in, or successfully complete a SCERP
- Disclose the name of the midwife and allegations against them to the Inquiries, Complaints and Reports Committee (ICRC) if the QAC is of the opinion that the midwife may have committed an act of professional misconduct or may be incompetent or incapacitated.

EXEMPTIONS

Midwives who are unable to meet their Professional Development Portfolio requirements due to exceptional circumstances such as illness, parental leave, or any other circumstance the Committee considers appropriate, can apply for an exemption from any or all of the program requirements under Section 4 of the Quality Assurance Regulation. Midwives requesting an exemption must complete a Professional Development Portfolio Exemption Request Form and submit it to the QAC where it will be reviewed to determine if the midwife's circumstances warrant an exemption. All exemption requests must be received by the College by the Professional Development Portfolio reporting deadline.

Midwives may request and be granted either partial or full exemptions. A full exemption means the midwife has no reporting obligations for the full three year Professional Development Portfolio cycle for which the exemption is being requested. A partial exemption means the midwife has to report on some, not all of the Professional Development Portfolio requirements. If the QAC determines an exemption is not warranted, the midwife will be considered non-compliant with the Professional Development Portfolio if they remain unable to meet the requirements.

CONFIDENTIALITY

The Code has special confidentiality requirements that protect information gathered by the College as part of the Professional Development Portfolio. The purpose of these special confidentiality requirements is to encourage midwives' candid participation in the program.

According to the Code (s. 83), information that midwives provide to the College as part of their Professional Development Portfolio is confidential and cannot be shared with other committees such as the Registration Committee. This means that midwives can be forthright in their Professional Development Portfolio knowing that the QAC generally cannot share this information.

There are, however, exceptions to the confidentiality provisions and the QAC can disclose information to the ICRC under the following circumstances:

- if the QAC is of the opinion that the midwife may have committed an act of professional misconduct or may be incompetent or incapacitated
- if the midwife knowingly gave false information to the QAC.

PROFESSIONAL DEVELOPMENT PROGRAM COMPONENTS

Midwives in Ontario have a professional responsibility to ensure that they are competent to practise. At entry to practice, midwives' competence is assured by the entry to practice requirements but maintaining competence requires ongoing learning. The Professional Development Portfolio is designed to support midwives maintain competence by encouraging ongoing learning through self-assessment and participation in continuing education and professional development activities that include self-reflection and attendance at case reviews.

The following components of the Professional Development Portfolio are designed to support midwives maintain competence.

1. Self-Assessment

Self-assessment is "... the ability of a health worker to reflect on his or her own performance strengths and weaknesses to identify learning needs, conduct a review of his or her performance, and reinforce new skills or behaviors in order to improve performance."[1]

The self-assessment built into the Professional Development Portfolio is designed to assist midwives identify their learning needs and can serve as the foundation for creating their Learning Plan.

Unlike other components of the Professional Development Portfolio (e.g., case review reports), the self-assessment is designed for the midwife only and will not be accessible to, or reviewed by, the College.

Although midwives are only required to complete and report on completion of their self-assessment every three years, annual completion is recommended as a way of continually assessing their knowledge and skills related to the standards of the profession.

[1] Bose, S., Oliveras, E., & Edson, W. N. (2001). How can self-assessment improve the quality of healthcare. *Operations research issue paper*, *2*(4), 1-27. Page 4

2. Continuing Education and Professional Development

There are two sections that must be completed in this part of the Professional Development Portfolio:

i. **Develop and complete a Learning Plan**
ii. **Participate in case reviews (peer and interprofessional)**

i. Develop and complete a Learning Plan

Midwives will develop a Learning Plan based on areas that have been identified as in need of updating or expanding. These areas, or learning needs, can be identified in a number of ways including the self-assessment, issues brought up during a peer case review, challenges during a client interaction, or a breakdown in communication with another health care provider. Any area of a midwife's professional life that requires extra attention can be a learning need. These identified learning needs then become learning goals which will form the basis of the Learning Plan. Midwives may benefit from asking colleagues for information and feedback about this part of the Professional Development Portfolio.

A minimum of one learning goal will be met per year. Setting one learning goal per year means midwives can select short term goals to be met the first year and long-term goals to be met in years two and three of their reporting cycle. In the Learning Plan, midwives will be asked to demonstrate how they will meet their learning goals, dates for expected completion and the ways in which those goals will be achieved. There should be at least one learning activity for each goal and some goals will require different types of activities.

Goals should be SMART which is an acronym for:

- **S**pecific – what it is you want to learn
- **M**easurable – quantify the goal
- **A**ttainable – make sure the goal is achievable and realistic
- **R**elevant – make sure the goal is relevant to your practice of midwifery
- **T**ime-limited – put a time limit on the goal so it doesn't go on indefinitely

More information on SMART learning goals is included in the Learning Plan section of the Professional Development Portfolio.

The College does not specify the types of learning goals required. Midwives are encouraged to choose goals that include technical skills and non-technical skills. Technical skills are tangible skills that can be objectively measured, such as measuring a blood pressure or performing the maneuvers in a shoulder dystocia. Non-technical skills are the cognitive and social skills that complement technical skills such as having an informed choice discussion with a client about the benefits and risks to a clinical intervention or coordinating the care and assigning tasks during an emergency. Non - technical skills tend to be more difficult to define, so the College is sharing the following table with examples of non-technical skills[2] that could be included as a learning goal or as activities in a Learning Plan.

Non-technical	Description
Communication	The exchange of information, feedback or response, ideas and feelings
Teamwork	The collection of skills required to work in a team (e.g., conflict resolution)
Leadership	Directing and coordinating the activity of team members, encouraging them to work together, assessing performance, assigning tasks, developing team knowledge, skills and abilities
Situation awareness	Knowing what is going on around you
Decision making	The process of reaching a judgment or choosing an option, sometimes called a course of action to meet the needs of a given situation
Managing stress and fatigue	A particular relationship between a person and the environment that is appraised by the person as taxing or exceeding their resources and endangering their well-being

[2] Flin, R., & O'Connor, P. (2017). Safety at the sharp end: a guide to non-technical skills. CRC Press.

Participate in activities that meet the chosen learning goals

Midwives are required to meet their learning goals by identifying and participating in learning activities. Midwives should choose learning activities that meet their own individual learning style as well as activities that are delivered in a way that meets their goal.

Some learning goals may require only one learning activity. For example, attending a fetal health surveillance workshop may be all that is required to meet a learning goal about intermittent auscultation.

Other learning goals will require more than one activity. For example, a reviewing the recent literature about communication methods and attending a communication workshop may be required for a learning goal about communicating in emergency situations.

Examples of learning activities that can be used to meet learning goals

- Participating in workshops, webinars, teleconferences
- Completing courses
- Reading recent primary research studies or reviews
- Developing protocols and practice guidelines
- Teaching, mentoring, precepting
- Research, project work, publication, presentation
- Reflecting on feedback and keeping a practice journal
- Active participation in a relevant College or Association board, council or committee
- Undertaking relevant undergraduate or graduate courses
- Participation or certification in quality assurance/improvement committees
- Peer mentoring.

Note: Participating in an obstetrical emergency skills program, a neonatal resuscitation program, and a cardiopulmonary resuscitation program are continuing competencies required for registration and so cannot be used as a learning activity for meeting a learning goal.

Reflect on learning

After all learning activities are completed, midwives must engage in a reflection of their learning. Reflection involves drawing on the activities that were undertaken to understand how they met the learning goals. *Reflection is a deliberate and structured process of drawing on past events to understand what has happened and ... is the basis of reflective learning and reflective practice*[3]. More information about reflective learning and practice can be found in the Learning Plan section of the Professional Development Portfolio.

ii. Participate in case reviews (peer and interprofessional)

Case reviews are formal gatherings to discuss specific clinical cases with the goal of learning. The learnings from clinical scenarios should be applicable to midwifery practice. For the purpose of the Professional Development Portfolio, case reviews must be held with at least two midwifery practice groups or among a group of interprofessional colleagues. Each year, midwives who are registered in the General, Supervised Practice, or Transitional class for 12 months or more are required to attend four case reviews per year of registration in the General, Supervised Practice, or Transitional class for a total of 12 case reviews attended over the three year cycle. This means that midwives registered in the General, Supervised Practice, or Transitional class for less than three years report on fewer case reviews.

The requirement for attending and obtaining evidence of attendance at case reviews is specified below (please note that the time registered in General, Supervised Practice, or Transitional class need not be consecutive).

Midwives who are registered in the General, Supervised Practice, or Transitional class for less than 12 months of the reporting period are not required to participate in, or obtain evidence of, attendance at case reviews. This part of the program was designed to address the barriers to attending peer case reviews that may be experienced by midwives who are not associated with a clinical setting attending case reviews as well as the limited relevance for inactive midwives working only in non-clinical roles.

An important component of any case review is establishing parameters around conducting the review. The College does not specify the details of how to conduct a case review, however it is expected that case reviews be conducted in accordance with a framework that is agreed upon by the participants. There are numerous resources that can be used to provide guidance to midwives about participating in case reviews. More information on conducting and tracking participating in case reviews is included in the case review section of the Professional Development Portfolio.

Note that case reviews conducted as part of the College's Professional Development Portfolio are distinct from quality of care reviews conducted at hospitals and birth centres pursuant to the *Quality of Care Information Protection Act, 2016* (QCIPA); however, midwives may count their attendance at QCIPA reviews toward satisfying the required case reviews for the College's Professional Development Portfolio. QCIPA contains specific rules

[3] Andre, K., & Heartfield, M., & Cusack, L. (2017). Portfolios for Health Professionals. Third edition. Elsevier Australia.

relating to quality of care reviews and what information from QCIPA meetings and reviews must be protected as confidential.

Confidentiality of case reviews

Midwives have both legal and ethical responsibilities to protect the confidentiality and privacy of clients' personal health information. For more guidance, see to the *Personal Health Information Protection Act (PHIPA), 2004* and the College's *Guide on Compliance with the Personal Health Information Protection Act*, both available on the College's website.

Unless a client has provided their express consent[4] to disclose their personal health information as part of a case review, midwives should remove all client identifiers from cases that are presented. This may require modifying details about the client, health care providers, and anyone else with information that is discussed. In some situations, some of the extraneous details of a case should be changed to protect the client's identity. It should be made clear at the case review that all identifying features of the client have been removed or changed.

The information discussed as case reviews should be treated as confidential and midwives should not disclose information learned at a case review unless required by law. More information about reporting obligations can be found in the College's Guide on Mandatory and Permissive Reporting.

Questions about the Quality Assurance Program's Professional Development Portfolio can be directed to the Quality Assurance Department at qap@cmo.on.ca.

[4] Express consent is an unequivocal expression of consent that is direct and clear. It can be given orally or in writing (Guide to the Health Care Consent Act)

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

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Regulatory Performance Review 2020/2021

Background:

As part of the College's commitment to regulatory excellence, a Regulatory Performance Measurement Framework was developed to objectively evaluate our regulatory performance. While not legislatively mandated, we made a voluntary commitment to evaluate our performance and to demonstrate our success in regulating in the public interest.

This framework allows us to review, evaluate and report on our performance using a set of standards that are based on our legislative mandate and expected outcomes. The framework describes the outcomes the College is expected to achieve in four broad domains: Regulatory Policy; Suitability to Practise; Openness and Accountability; Good Governance. It was approved by Council in June 2019.

We completed a pilot year to test the framework in 2019/2020.

Key Considerations

Refer to the attached report.

This is the first performance review that will be posted publicly after the June Council meeting.

The same framework will be used to conduct regular performance reviews at the end of each fiscal year. We will compare the results of each year's review with the results from previous years in order to determine how its performance has improved or worsened over time. Where differences are noted, an explanation will be provided. The results of the performance review will be presented to Council every year at its June meeting and will be posted to the website.

Recommendations

The following motion is submitted to the Council for approval:

That the report be accepted as presented.

FOR APPROVAL

Implementation Date

N/A

Legislative and Other References

N/A

Attachments

Regulatory Performance Review 2020/2021

Submitted by: Marina Solakhyan, Director, Regulatory Affairs

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

Regulatory Performance Review
2020/2021

Executive Summary

As the regulator of the midwifery profession in Ontario, we have important outcomes to achieve, including ensuring that midwives registered in Ontario possess and maintain the relevant knowledge, skills and behaviours to provide safe, ethical and effective care and taking action when risks are identified. An important part of the work we do is evaluating our performance and publicly reporting on the execution of our core regulatory functions. This review is not legislatively mandated; it is a voluntary commitment on the part of the College to continuously demonstrate that the College effectively regulates in the public interest and to help us improve our performance.

This report provides the results of our 2020/2021 performance review where we assessed our performance against the standards set in our Regulatory Performance Measurement Framework approved by Council in June 2019.

The framework measures our performance in four broad domains: Regulatory Policy, Suitability to Practise, Openness and Accountability, and Good Governance. Each domain comprises a number of performance standards that form the basis of the performance measurement framework. A "performance standard" means a level of performance that we aim to achieve when fulfilling our regulatory functions. The performance standards include statutory standards set out in legislation and regulations that we are mandated to meet as well as voluntary standards that we set to meet as part of our ongoing commitment to regulatory excellence, public reporting, and accountability.

In developing the performance standards, we gave a balanced overall picture of what we, as the regulator of the midwifery profession in Ontario are required to do, covering all functional areas of the College including policy-making, registration, investigations and hearings, and quality assurance. Operational questions, such as budgeting and human resources, are beyond the scope of this framework. Qualitative and quantitative data are used to demonstrate that the College has met each standard. Different review procedures are used to test compliance with each standard, including file audit.

The framework was piloted in the 2019/2020 reporting period; this is the first formal review of our performance and an important part of our commitment to openness, accountability and public reporting. The performance review took place between April 2021 and May 2021 and drew primarily on evidence of performance during the 2020/2021 fiscal year that covers the period from April 1 to March 31 each year. In 2020/2021, we fully met 15 of 20 standards and partially the remaining five. Our findings are summarised in the below sections of the report.

Domain 1: Regulatory Policy

The College has a rigorous approach to policy-making based on a proper evaluation of risk, evidence, purposeful engagement, and a thorough analysis of options and impacts. This approach ensures that regulation is not adopted as the default solution but rather is introduced to mitigate risk when non-regulatory options are unable to deliver the desired results.

Due to the interconnectivity of Standards 1 and 2, they were reviewed together. The results are provided below.

STANDARD 1. Regulation is proportionate to the risk of harm being managed

Evidence of compliance:	Data source(s)
Regulatory impact assessments are conducted for all new regulatory initiatives to ensure that actions undertaken by the College are based on evidence of risk and are proportionate to the regulatory risk being managed.	New regulatory initiatives or proposals considered by Council or a committee in the reporting period
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

STANDARD 2: Regulation is evidence-based and reflects current best practice

Evidence of compliance	Data source(s)
1. Work undertaken to take into account: - Findings from the literature review - Developments in the area of professional regulation in Ontario and other jurisdictions - College data (investigations and hearings data; learnings from quality assurance and registration; surveys with midwives and members of the public) 2. Evidence that regulatory policy is reviewed and revised at regular intervals.	1. New regulatory initiatives or proposals considered by Council or a committee in the reporting period 2. Schedule for reviewing public facing documents.
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standards

1. Review all regulatory proposals brought to Council or a committee in the reporting period to verify that risk assessment was conducted in all cases
2. Review all regulatory proposals brought to a committee or Council to verify that policy proposals were informed by a variety of sources including College data
3. Review the policy revision schedule to verify that policies were reviewed in the reporting period in accordance with internal procedures (within a period not to exceed four years from the date of first issue or the date of the last review).

Comments/observations

Every College policy proposal designed to introduce a regulatory tool (e.g., a standard of practice) must be accompanied by a regulatory impact assessment (RIA) statement designed in a way that allows for risk identification and assessment of impacts to ensure that any regulatory intervention is proportionate to the risk being managed. This analysis is the first mandatory step in our policy development process. Once risks are identified, the second step is to ensure that the proposals themselves are based on evidence, including that they reflect public expectations and current best practice. We gather information by reviewing research and published literature, applicable legislation and positions adopted by other health regulators in Ontario and across Canada as well as College data.

All College documents, including policies, standards of practice and other guiding documents that are approved by Council or a committee must be formally reviewed within a period not to exceed four years from the date of first issue or the date of the last review. The formal review of a policy may result in no change to the policy, rescinding the policy or revisions to the policy. All revisions must follow the same consistent process described above including first determining if the problem is about risk of harm and then ensuring that recommended revisions are evidence-based. The College's policy review schedule, last updated in February 2021 can be viewed here.

In the period from April 1, 2020, to March 31, 2021, the following regulatory proposals were considered and approved by committees and Council:

1. Standards Review: Phase 2, including the proposals to:
    a. Rescind
        i. The Consultation and Transfer of Care Standard (CTCS)
        ii. When a Client Chooses Care Outside Midwifery Standards of Practice
        iii. Delegation, Orders and Directives
    b. Implement
        i. The Midwifery Scope of Practice
    c. Amend
        i. The Professional Standards for Midwives to set minimum expectations for midwives after a transfer of care and include additional standards on delegation
        ii. The Guideline on Ending the Midwife Client Relationship to provide guidance to midwives in situations when a client chooses care that falls below a standard of the profession.

    These proposals were approved by Council in December 2020 and came into effect on June 1, 2021.

2. Proposed changes to the Registration Regulation under the Midwifery Act, 1991, including:
    a. Clinical currency recommendations
    b. New registrant conditions
    c. Classes of registration: issuance and ongoing registration requirements

    The Registration Committee and Council will continue their work in 2021/2022 with the aim of submitting the proposed draft to the Ministry of Health in March 2022.

The below tables shows that appropriate steps were taken in compliance with our policy development process.

Number	Policy Proposal	Risk-based & proportionate / evidence based
1	Standards review – Phase 2	The regulatory impact assessment for this initiative, including risk identification and evidence gathering, was conducted in 2016 as part of the College's comprehensive standards review. It was not included in the review process. The last step of the process that started 5 years ago, including a public consultation and final approval by Council, was completed in 2020/2021. All proposals came into into effect in June 2021.
2	Clinical currency	The regulatory impact assessment for clinical currency was conducted in 2020. The initial recommendations by the Registration Committee were reviewed by Council in December 202o. This proposal is still in progress and will be finalized in 2021.
3	New registrant conditions	The regulatory impact assessment for new registrant conditions was conducted in 2020. The initial recommendations by the Registration Committee were reviewed by Council in March 2021. This proposal is still in progress and will be finalized in 2021.
4	Requirements for issuance and ongoing requirements for classes of registration	The regulatory impact assessment for classes of registration was conducted in 2020. The initial recommendations by the Registration Committee were reviewed by Council in March 2021. This proposal is still in progress and will be finalized in 2021.

Based on the review, we are satisfied that these standards are met.

Recommendations/comments (if the standard is not met): N/A

STANDARD 3: Regular and purposeful engagement is undertaken with stakeholders, midwives, and the public throughout the policy making process

Evidence of compliance	Data source(s)
1. Engagement and discussions with relevant partner organizations on all regulatory changes is undertaken 2. Proposed changes are circulated to the public, stakeholders and the membership for consultation before they are approved 3. The College allows a reasonable period for genuine comment	1. Number of formal and informal consultations conducted in the reporting period 2. Responses provided to all consultations and survey findings are shared with midwives and the public as appropriate 3. Average consultation length

4. The College provides a written response to all consultations. Where a survey was conducted, evidence that results & analysis were formally circulated	
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standard

1. Review all regulatory proposals brought to a committee or Council to verify that partner organizations were consulted; all proposed changes were circulated to the midwives and the public; and response was provided in all cases.

Comments/observations

Open and effective consultation is a critical part of our policy-making. Effective consultation allows us to identify any potential unintended effects and to hear alternative suggestions and perspectives on our proposals to achieve the best possible policy outcome. In addition, there is a growing body of evidence that shows that regulated professionals are more likely to comply with standards when they understand why those standards exist and believe such standards are legitimately improving their practice. This is why the College's consultation process is designed to not only seek input on our policy proposals but to engage in discussions with midwives to ensure that midwives understand how a new proposal impacts their practice.

We take a flexible approach to each consultation to ensure that we yield the best response in each set of circumstances. Some of the forms of consultation we use include surveys and focus groups, and in-person discussions with key partners. These more targeted forms of consultation alongside or ahead of a written consultation generally generate a higher response rate and provide an effective way to gather views on College proposals, particularly at the earlier stages of policy development.

While a formal written consultation in itself may not always be the best way of generating meaningful responses or gathering evidence, it plays a very important role in our policy-making process especially at a stage where the proposals are already formulated and can be presented in their final form. Publication of written consultation documents that set out the College's rationale and the outcomes it is trying to achieve is transparent and easy to share with the wider stakeholder community. This is particularly important when there may be unintended or unforeseen impacts. As a mandatory element of our process, we provide a formal response to all written consultations, including reporting on the feedback received and setting out our position regarding the issues raised in the consultation. Where surveys and focus groups are conducted, findings are shared with the respondents.

The following consultations took place in 2020/2021[1]:

<u>Formal written consultation on the Standards Review: Phase 2</u>

[1] A by-law consultation took place in 2020/2021. Due to the administrative nature of the proposed changes, this consultation was not reviewed as part of the College's regulatory policy-making.

The College launched a formal written consultation on the Standards Review: Phase 2 on August 13, 2020. It ran for nine weeks closing on October 17, 2020. More targeted consultations, including a survey with midwives and in-person meetings with our partner organizations, took place in previous reporting years. This last consultation with midwives and the public before Council's approval in December 2020, involved feedback gathered in two different ways: comments on the website and e-mails sent directly to the College. We also engaged directly with a wide range of stakeholders during this last phase of the initiative to discuss our final proposals, including the Association of Ontario Midwives, the Midwifery Education Programs, and the International Midwifery Pre-registration Program.

As part of the consultation the following was provided:

- Consultation Paper – August 2020 (when the consultation was launched)
- Proposed final drafts of the Professional Standards for Midwives and the Guideline on Ending the Midwife-Client Relationship, and the Midwifery Scope of Practice document
- Platform to provide feedback and share ideas freely and openly (from August-October 2020)
- Response to consultation (February 2021)
- Opportunity to engage with the College using other channels (email/phone)

Survey with midwives who have been in practice for five years or less

In October 2020, staff conducted a survey to understand more about the experiences of new midwives and what the College could do to support them to develop confidence and competence as primary care providers as they transition to independent practice. This survey was open to all midwives or resigned midwives who practised in Ontario for five years or less. It was sent to 437 midwives and former midwives. The survey ran for three weeks closing on November 8, 2020. The information collected from the surveys has been analyzed and informed the Registration Committees initial new registrant recommendations (considered by Council at its March meeting). The results of the survey will be shared with midwives in the summer of 2021 when a consultation on the Registration Regulation is scheduled to take place.

Practice environment survey with midwives

The survey about midwifery practice environments was conducted in October 2020 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 information from the survey will be analyzed in 2021. Any recommendations will be brought to the Quality Assurance Committee and Council as needed.

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

STANDARD 4: Policy decision-making is open and transparent

Evidence of compliance	Data source(s)
1. Council briefing materials, including the rationale and evidence supporting any	1. Dates and links to Council materials 2. Notices and implementation dates

recommendations, are posted on the College website in advance of every Council meeting 2. Council meetings are open to the public 3. Notice of all new regulatory initiatives given to midwives and the public prior to the implementation date.	
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standard

Website audit

Comments/observations

All materials provided to Council are generally available online two weeks prior to the meeting. Briefing materials clearly identify the public interest rationale and the evidence supporting a decision for any issue brought to Council for review, discussion or approval. As noted above, a mandatory regulatory impact assessment is conducted for all regulatory proposals that is designed in a way that allows for risk identification and assessment of impacts and regulatory options considered to mitigate the identified risks. Once the proposals are approved, and prior to the implementation date, midwives receive a notice from the College. Depending on the initiative, all regulatory proposals and how they apply to midwifery practice are also discussed in our publications and on the website.

The following proposals were brought to Council for review and approval in the reporting period:

Initiative	**Briefing Materials Available to the Public**	**Notices to midwives (also posted to the website)**	**Other activities to help midwives understand the new standards/requirements**
Standards Review: Phase 2	March 2020 (agenda item 7) December 2021 (agenda item 10)	- Notice sent to midwives on February 25, 2021 - Webpage created for midwives to help them understand the changes and impact on their practice	- Two webinars with midwives - Practice advice - Presentations to midwifery students
Clinical currency	December 2021 (agenda item 11)	Not approved/In progress	N/A
New registrant Conditions	March 2021 (agenda item 9)	Not approved/In progress	N/A

Classes of registration	March 2021 (agenda item 9)	Not approved/In progress	N/A

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

Domain 2: Suitability to Practise

The College regulates midwifery in the public interest to ensure that midwives are qualified, skilled, and competent in the areas in which they practise and promote and maintain public confidence in the midwifery profession in Ontario. We achieve these objectives by registering qualified midwives, setting requirements for continuous education and professional development, and investigating complaints and reports about midwives' competence, professional conduct, and fitness to practise.

STANDARD 5: Midwifery applicants and non-practising midwives demonstrate suitability to practise before they are permitted to practise midwifery in Ontario

Evidence of compliance	Data source(s)
1. Checks are carried out to ensure that only those who meet the College's entry to practise and class change requirements are allowed to practise.	1. Number of total applications (initial and class change) 2. Number applicants/non-practising midwives who met the requirements/did not meet the requirements 3. Action taken (i.e., referral to panel for initial applicants; requalification program for inactive) where the requirements for registration were not met
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Select and review 20% of initial applications and 20% of class change applications received by the College to verify that all applicants who became registered and non-practising midwives who moved into a practising class met all registration requirements outlined in the College's Registration Regulation and policies.
2. Review all initial applications for registration and 20% of class change applications that were referred to a panel of the Registration Committee to verify compliance with the College's regulations, policies, and internal procedures.

Comments/observations

The College receives applications for registration directly from applicants. Before an applicant can practise and use a title protected under the provincial law, applicants must provide evidence that they are eligible to hold registration. All applicants must satisfy specific academic qualifications and other requirements, including good character and clinical experience requirements, set by the government and the College. Similarly, non-practising midwives must satisfy certain requirements, including active practice requirements, before they are permitted to move to the practising class. Due to the conditions caused by the pandemic, the College adapted its class change and application process and registration requirements to facilitate the timely registration of applicants and re-entry to active practice for non-practising midwives in 2020/2021, while continuing to ensure that applicants and midwives re-entering the profession are suitable to practise.

Staff considers every application for registration and class change carefully and assesses it against requirements for registration set by the regulations and College policies. A file is created in the system for the applicant/non-practising midwife moving into a practising class when an application form is received by the College. A requirements checklist is used by staff to keep track of all documents received or outstanding as an application is not complete unless all required pieces of information are included. Once the application is complete, registration staff reviews the application against the list of registration requirements. If requirements have been met and no issues are noted, the manager then does a final approval and sign-off. Applicants and non-practising midwives moving into a practising class who meet all College requirements receive a formal notice that they have been registered. Applicants who do not meet the requirements for registration in the General class, Supervised Practice class or the Transitional Class, are referred to a panel of the Registration Committee in accordance with section 15 of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991* (Code). Non-practising midwives who do not meet the requirements are required to complete a requalification program specified by a panel of the Registration Committee, which may include a period of supervised practice.

<u>Initial applications for registration</u>

In 2020/2021, the College received and processed 64 applications, down 28% from 2019/2020 when we registered 89 midwives. This likely can be attributed to a smaller graduating cohort in 2020 with some of the graduates registering outside of Ontario. Of these, 81% were registered in the General class, with 17% receiving registration in the Supervised Practice class and 2% in the Inactive class. One application for registration was referred to a panel of the Registration Committee.

Table 1: New Midwives by Class of Registration

General	52
Supervised practice	11
Inactive	1
Transitional	0
Total	64

Table 2: New Midwives by Route of Entry

Laurentian University graduates	22
McMaster University graduates	20
Ryerson University graduates	14
International Midwifery Pre-registration Program (IMPP) graduates	4
Out of province certificate holders (midwife applicants) from other Canadian regulated midwifery jurisdictions	3
Former midwives	1
Total	64

No issues were identified during the audit; all applicants whose files were randomly selected and reviewed demonstrated that they met the requirements set out in regulations and College policies before they were issued a certificate of registration. The results of the file review also showed that appropriate regulatory action was taken in all situations where the requirements were not met.

Class change applications

In 2020/2021, we received and processed 195 class change applications. Of these, approximately 33% (65 midwives) requested to move from the Inactive class to the General class. Of these, 17 midwives were referred to a panel of the Registration Committee for approval of a requalification program because they were not able to meet the requirements for class change outlined by the Registration Committee, with all 17 resulting in the issuance of a certificate of registration in the General class.

No issues were identified during the audit; all non-practising midwives whose files were randomly selected and reviewed demonstrated that they met the requirements set out in regulations and College policies before they were issued a certificate of registration. The results of the file review also showed that appropriate regulatory action was taken in all situations where the requirements were not met, in accordance with the Registration Regulation and College by-laws.

Based on the results of the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

STANDARD 6: Midwives continually demonstrate suitability to practise

Evidence of compliance	Data source(s)
1. Checks are carried out to ensure that clinical currency and other ongoing requirements (*renewal, active practice, NR conditions/supervised practice/QAP) are met 2. Action is taken in cases where midwives are not able to meet ongoing suitability to practise requirements or if concerns are identified 3. Mechanisms used to regularly assess how midwives are performing beyond annual	1. Number of members who met all requirements at registration annual renewal and action taken where the requirements were not met 2. Number of midwives who met active practice requirements and action taken where the requirements were not met

registration renewal and quality assurance program reporting.	3. Number of new registrants and supervised midwives whose conditions were lifted / supervised practice was complete 4. quality assurance program compliance rate and action taken in all cases of non-compliance 5. Number of peer assessments undertaken, and action taken where a midwife's knowledge, skills and judgment were found unsatisfactory
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Select and review 50% of midwives who did not complete renewal by October 1 to confirm that appropriate actions were taken by the College in accordance with internal policies and procedures
2. Select and review 5% of midwives who met their active practice requirements to confirm the requirements set out in the Registration Regulation were met.
3. Select and review 50% of midwives who did not meet their active practice requirements to confirm that appropriate actions were taken by the College in accordance with the Registration Regulation
4. Select and review 5% of new registrants and supervised midwives who completed their new registrant year or supervised practice in the period from April 2020 to March 2021 to confirm adherence to College internal policies and procedures.
5. Select and review 50% of midwives who did not submit their QAP reports to confirm that appropriate actions were taken by the College in accordance with the governing legislation
6. Select and review 50% of midwives who did not satisfactorily complete a peer and practice assessment program to confirm adherence to internal procedures.

Comments/observations

Once registered, midwives must meet ongoing conditions of registration, including renewing their registration each year and being reassessed against registration and other requirements.

There are three ongoing reporting requirements that all practising midwives must comply with:

1. Annual registration renewal (including good character disclosures and evidence of competency in CPR, ES and NRP) by October 1
2. Annual quality assurance reporting by October 1
3. Active practice reporting by October 1[2]

[2] Midwives are required to report each year based on the births they attended in the reporting period of July 1 – June 30. 2 or 5-year active practice due dates are communicated to midwives in the member portal. The first active practice due date is the 2-year due date, which is two years from the date a midwife is registered with the College, adjusted to coincide with the October 1 reporting period. Subsequently, a 5-year active practice reporting due date applies.

Other mechanisms in place to ensure suitability to practise after registration that apply to some midwives include:

1. Completion of a period of supervised practice as directed by a panel of the Registration Committee (this is in place for midwives who are registered in the Supervised Practice class)
2. New registrant conditions (these conditions are in place for midwives in their first year of practice after receiving their initial certificate of registration in the General class)
3. Peer and practice assessments

Annual renewal

Each midwife's renewal form submitted via the online portal is reviewed by staff.
If after a review it is determined that a midwife is not in compliance with the requirements, their certificate of registration may be suspended (for non-payment of fees, after a 30-day default period) or they may be referred to the Inquiries, Complaints, and Reports Committee (ICRC) for failure to provide information.

We continue to see a high renewal rate, with approximately 97% of midwives renewing their registration online by the October 1 deadline. In 2020/2021 we made renewal campaign improvements, including publishing a renewal guide with step-by-step instructions on how to navigate the online portal and "helpful hints" published on the website. The below table shows renewal outcomes for 2020/2021. The results of the file review showed that appropriate regulatory action was taken all situations where the requirements were not met, in accordance with the Registration Regulation and College by-laws.

Table 3: Renewal 2020/2021

Total Number of midwives required to renew by October 1, 2020	1033
Successfully completed renewal as of October 1	1005
Did not complete renewal	28
Met the requirements by the default deadline	23
Did not meet the requirements by the default deadline	5
Outcomes	
Suspended for non-payment of fees	5
Referred to the ICRC for failure to meet the continuing competencies requirements	0

Quality Assurance Program (QAP) Reporting

Midwives track and report their annual QAP activities through the online portal. Each report submitted is reviewed by staff. If after a review it is determined that a midwife is not in compliance with the QAP requirements, they are referred to a panel of the Quality Assurance Committee for further review and possible action. In making their decision, panel members assess risk by applying a risk assessment tool to determine if a matter has no or minimal, low, moderate or high risk. In each situation there can be aggravating factors and mitigating factors, which will be considered by the panel. Depending on the level

of risk, a recommended outcome will inform the panel's decision-making. The Committee's risk assessment tool can be found here:

As in previous years, we see a high compliance rate (98% which is slight increase of approximately 1% compared to last year). The results of the file review showed that appropriate regulatory action was taken in all situations where the requirements were not met. Refer to the below tables for the QAP reporting for 2020/2021

Table 4: Outcomes for 2020/2021 QAP reporting

Total Number of midwives who met the requirements	789
Total Number of midwives who did not meet requirements (non-compliant)	14
Total Number of midwives who were granted exemption from requirements	11
Total Number of midwives subject to QAP requirements	814

Table 5: Exemptions from the QAP requirements[3]

Granted	11
Not granted	0
Total	11

Table: 6 QAP Non-compliance Outcomes

Explanation accepted/no further action required	14
Advice/recommendation	0
Required to participate in a Peer & Practice Assessment	0
Referral to ICRC	0
Total	14

Active Practice Reporting

Each midwife's active practice report submitted ~~via~~ online is reviewed by staff to ensure compliance with the requirements set out in regulations and College policies. Midwives who meet their active practice requirements are notified and their subsequent active practice reporting due date becomes available in the online portal. If after a review it is determined that a midwife has a shortfall, they are referred to a panel of the Registration Committee for consideration of a shortfall plan, existence of extenuating circumstances or the need for a term, condition or limitation to be imposed on their

[3] Under the Quality Assurance Regulation (made under the *Midwifery Act, 1991,* the QAC may grant an exemption to a midwife from any of the requirements of the program because of illness, disability, maternity leave or any other circumstance the Committee considers appropriate.

certificate of registration. The level of risk will inform the panel's decision-making and panels use a risk assessment tool to ensure consistency in decision-making. The results of the file review showed that appropriate regulatory action was taken in situations where the requirements were not met.

Table 7: Active Practice Reporting for 2020/2021

Met the requirements	146
Were referred to a panel of the Registration Committee for not meeting the requirements	12[4]
Total Number of midwives required to submit an APR report	159

Table 8: Panel Outcomes for Active Practice Requirements Shortfall

Exception granted – extenuating circumstances demonstrated	9
Shortfall plan required	0
Shortfall plan and undertaking imposing terms, conditions and limitations	0
Total	9[5]

Monitoring new registrant conditions and completion of supervision plans

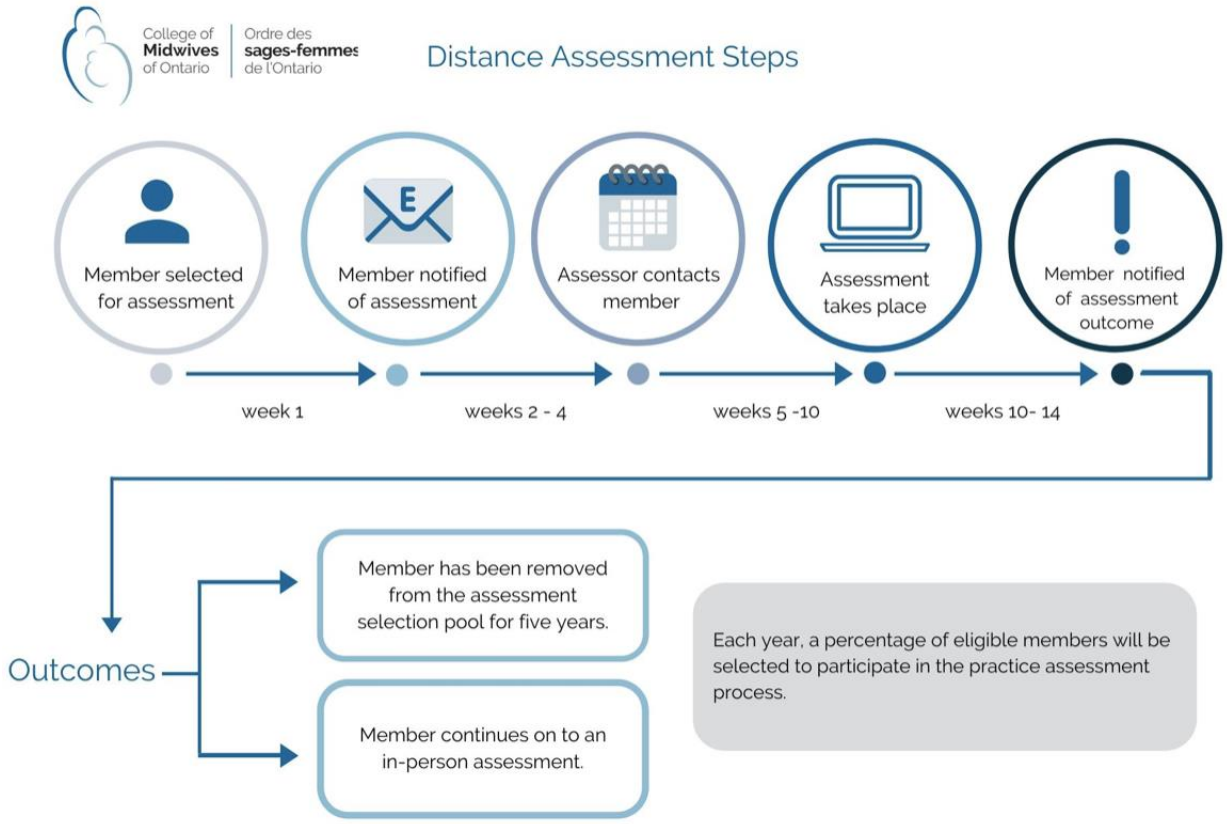
As noted above, midwives have certain conditions imposed on their certificate of registration in their first year of practice, after receiving their initial certificate of registration in Ontario. Similarly, some midwives are required to complete a period of supervised practice (e.g., a short period of supervised practice may be required if a midwife did not meet the clinical experience requirements at entry to practice). Based on the results of the review in all cases where new registrant conditions were lifted and midwives in the supervised practice class moved into the general class, evidence was provided to the College to demonstrate that the new registrant conditions were met, and that the supervision plan approved by the College was satisfactorily completed.

Peer and Practice Assessments

The College's new peer and practice assessment program implemented in January 2020 is grounded in the assumption that midwives are practising competently while recognizing that the changing dynamic of practice environments and best practices create the need for continued learning and development. This approach emphasizes the non-punitive nature of the quality assurance program in line with the clear intent of our governing legislation. The assessments are completed in a fair and consistent manner and are based on the College's competency framework that addresses the full spectrum of midwifery professional practice, including non-technical competencies such as communication and interprofessional care.

[4] Initially, 13 files were referred– one file was withdrawn from the panel process as the midwife provided evidence of meeting the requirements.
[5] Three files referred to a panel of the Registration Committee (as noted in Table 7) were not finalized in 2020/2021 and were carried over to the next fiscal.

The College's new assessment program uses objective and valid tools and is laddered or tiered meaning that it uses longer follow-up assessments only where risks are identified after a short distance assessment. College-trained assessors use the information gathered during the assessment process to summarize the midwife's knowledge and their application of midwifery legislation, standards and best practices in the provision of client care. All information is submitted to the Quality Assurance Committee for review and determination of outcome. For distance assessment steps, refer to Figure 1:



In 2020, 10% of practising midwives (81) were randomly selected to participate in a peer and practice assessment. No in-person assessments took place in 2020/2021. This means that all midwives indicated scores of 75% or above in the distance assessment and were not required to participate in an in-person assessment.

Table 9: Peer and Practice Assessments

Assessments completed	76

Deferred [6]	5
Total	81
Assessment outcomes	2020/2021
Satisfactory completion of distance assessment	76
Completion of an in-person assessment	0
Total	76

Based on the results of the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

STANDARD 7: Complaints made to the College about the professional misconduct, incompetence or incapacity of a midwife are acted upon

Evidence of compliance	Data source(s)
1. Evidence that all complaints filed with the College were acted upon 2. Evidence that risk assessment is conducted in a timely and effective manner at intake and throughout the investigation.	1. Total number of complaints received and status of each complaint 2. Number of complaints that were considered eligible for ADR 3. Internal procedures/framework for assessing risk at intake and throughout the investigation and at the ICRC level.
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standard

1. Review 20% of all complaints received from April 1 to March 31, 2020, and their status to confirm that they are either closed or open/in progress.
2. Review 20% of complaints that were considered eligible for ADR to verify that they met the eligibility criteria outlined in the ADR Eligibility policy

Comments/observations

Under the framework set out in legislation, we must investigate every complaint filed with the College. Once a complaint has been received in an appropriate form, it is immediately assessed for any risks to the public that need to be acted upon expeditiously by making an interim order and as to whether it could be referred to the College's Alternative Dispute Resolution (ADR) program. The criteria for

[6] Deferral of an assessment occurs when a midwife goes inactive after the date of selection and remains in the inactive class for the duration of the assessment program cycle.

identifying cases that warrant an interim order at intake and throughout the investigative process are set out in the College's ICRC Procedures Manual. The eligibility criteria for ADR are set out in the Alternative Dispute Resolution Eligibility Policy. Based on the results of the review, we are satisfied that the complaints considered eligible for ADR met the eligibility criteria.

Table 10: Alternative Dispute Resolution Program in 2020/2021

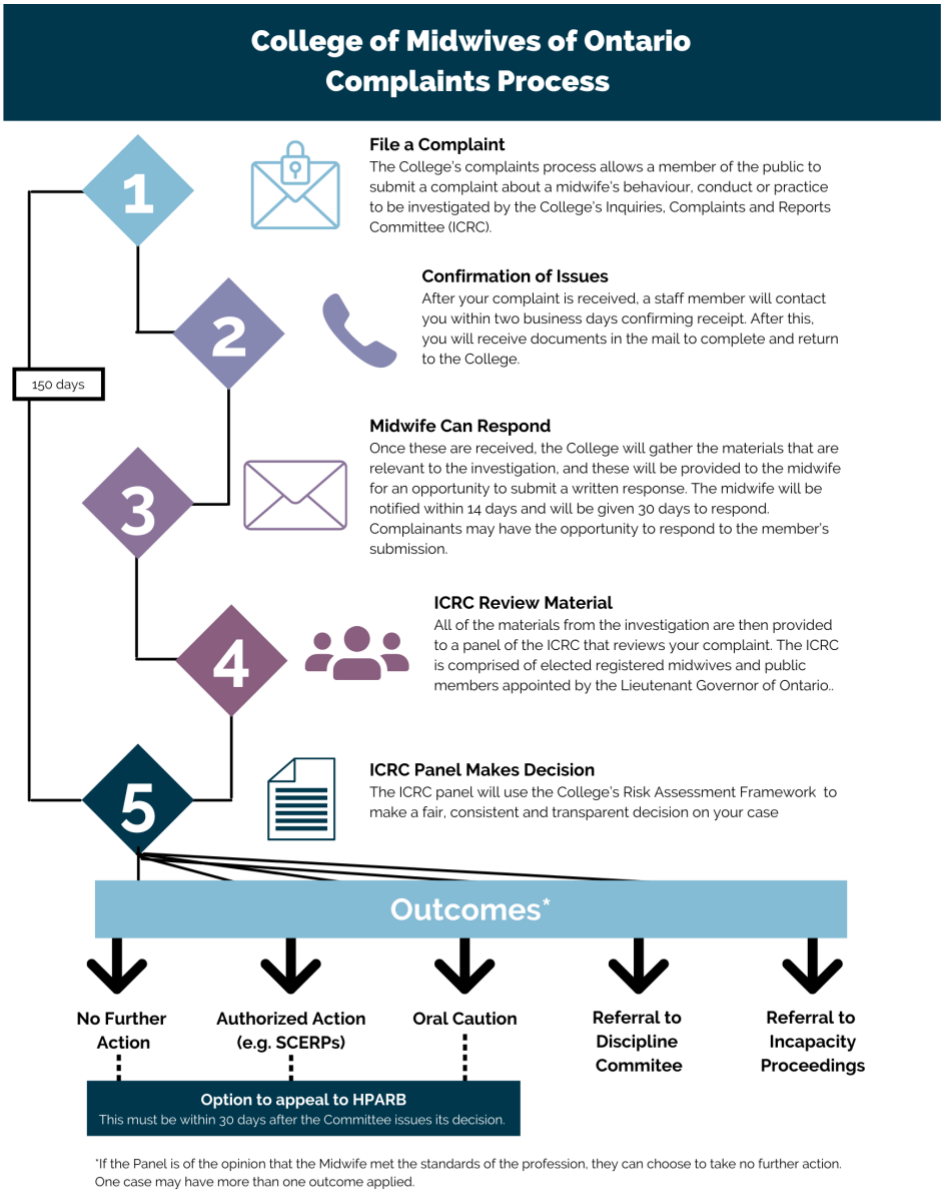
Open files with ADR (Files carried over) as of April 1, 2020	o
Open files referred to ADR	0
Closed files within 60 days	0
Closed files within 120 days	5
Files returned to ICRC due to timeframe	0
Files returned to ICRC due to unsuccessful mediation	0
Files returned to ICRC - Registrar did not ratify the agreement	0
Open files as of March 31, 2021	0

Table 11: Other ADR-related information

Total Number of Complaints Received	45
Number of complaints that were not ADR eligible	26
Number of Complaints that were ADR eligible	19
Number of Complaints ELIGIBLE that proceeded to ADR upon consent of all parties	5
Number of midwives who agreed to participate in ADR	12
Number of complainants who agreed to participate in ADR	6

Risk assessment is built into into our complaints and reports processes. Staff take risk into account in every decision, and every new piece of information triggers a risk assessment and consideration of whether action is a necessary response. This might be to prioritize the case, seek legal /expert advice, to interview a new witness, or to consider making an interim order. When a matter is brought to the ICRC, they also assess risk by applying a risk assessment tool to guide their decision-making.

Figure 2: How the College manages complaints about midwives



This year, the College received and closed the highest number of complaint matters[7] received in a single fiscal year in the College's recent history. This equates to 45 complaint matters received, 55% more than the number of complaint matters received in 2019/2020 (29 new complaints). Similarly, the ICRC closed 51 complaint matters this year, 155% more than last year (when 20 complaint matters were closed). This is because we were able to resolve more of our older, more complex cases in 2020/2021. For our complaints' caseload in 2020/2021 and other complaints-related information, refer to the below tables.

[7] One complaint may involve more than one midwife. When this happens, a separate file is opened for each matter which is handled individually by the College. The College received 27 complaints in 2020/21 which resulted in 45 complaint matters (ten complaints involved more than one midwife).

Table 12: Complaints' caseload in 2020/2021

Open files as of March 31, 2020	31
New files	45
Closed files	51
Open files as of April 1, 2021	25

Table 13: Who made a complaint in 2020/2021

Client	35
Family Member	5
Health Care Provider	3
Another Midwife	2
Total	45

Based on the results of the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

STANDARD 8: Reports made the College about the professional misconduct, incompetence or incapacity of a midwife are acted upon

Evidence of compliance	Data source(s)
1. All reports received by the College were acted upon 2. A decision to launch a formal investigation is proportionate to the risk of harm caused to current or potential clients.	1. total number of reports received by the College 2. total number of preliminary inquiries made and the total number of investigations launched
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standard

Selected and reviewed 20% of reports received by the College in 2020/2021 to confirm that preliminary inquiries were made in each case and a formal investigation was launched in all cases where probable and reasonable grounds existed.

Comments/observations

Mandatory reporting obligations legally require a midwife to self-report (e.g., findings of professional negligence and malpractice) and provide information about other midwives or other healthcare practitioners to relevant regulators. It is in the public interest that this important information be provided to relevant authorities on a timely basis. Midwives are also allowed to make permissive reports

which refers to those instances where midwives are not required to make a report under legislation but choose to do so, in the public interest. Finally, information also comes to our attention through other sources, e.g., from the Office of the Chief Coroner (Coroner's Reports); information received from a client that did not result in a formal complaint; or information received from other regulators.

Upon receipt of credible information, the Registrar conducts "preliminary inquiries" to determine if there are reasonable and probable grounds that the midwife engaged in professional misconduct or is incompetent. Determining whether reasonable and probable grounds exist requires assessing the alleged conduct to determine how risky the midwife's behaviour is to clients and the public. Assessing risk can be complex and requires consideration of a variety of factors. A formal investigation is launched only if the risk to the public warrants the report being investigated. Once the decision to investigate the report is made, the Registrar brings the concerns to the attention of the ICRC with a request to approve the appointment of an investigator. When this step is reached, the procedures in a complaints matter are followed (see Figure 2).[8]

In 2020/2021, the College received 62 reports (mandatory and other reports). The review showed that all reports received by the College were acted upon with almost 11% of the reports resulting in a formal investigation. For more information, refer to the below tables.

Table 14: Mandatory & Other Reports in 2020/2021

Self-reports by midwives	41
Other mandatory reports	7
Permissive reports by midwives	3
Information received from other sources	11
Total	62

Table 15: Preliminary Inquiries made in 2020/2021

Open inquiries as of March 31, 2020	22
New inquiries started	62
Inquiries closed	61
Open inquiries as of April 1, 2021	23

Table 16: Preliminary inquiry outcomes in 2020/2021

Reports resulting in a formal investigation by the Registrar	7
Reports resulting in an educational letter	20
Reports resulting in no action	35

[8] With the only difference that ICRC decisions in a report matter cannot be appealed to Health Professions Appeal and Review Board (HPARB)

Total	62

Table 17: Total number of reports under investigation in 2020/2021

Open as of March 31, 2020	8
New in 2020-2021	7
Closed in 2020-2021	10
Open as of April 1, 2021	5

Based on the results of the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): While we consider that this standard is met, to be able to better demonstrate that a decision to launch a formal investigation is proportionate to the risk of harm caused to current or potential clients, a recommendation was made to develop a decision tree/tool for risk assessment to simplify risk assessment and to achieve greater consistency in decision-making. This recommendation will be implemented in 2021/2022.

STANDARD 9: RISK OF HARM TO THE PUBLIC BY INDIVIDUALS ILLEGALLY PRACTISING MIDWIFERY IS MANAGED APPROPRIATELY

Evidence of compliance	Data source(s)
1. Evidence that the public and midwives have information to identify and report those engaged in unauthorized or illegal practice 2. The process of dealing with non-registrants who hold themselves out as midwives is proportionate to the risk being managed. 3. Evidence that the College is transparent about those engaged in unauthorized or illegal practice	1. Website information 2. Number of unauthorized practice reports received by the College and action taken 3. average length from the receipt of report to final action.
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the standard

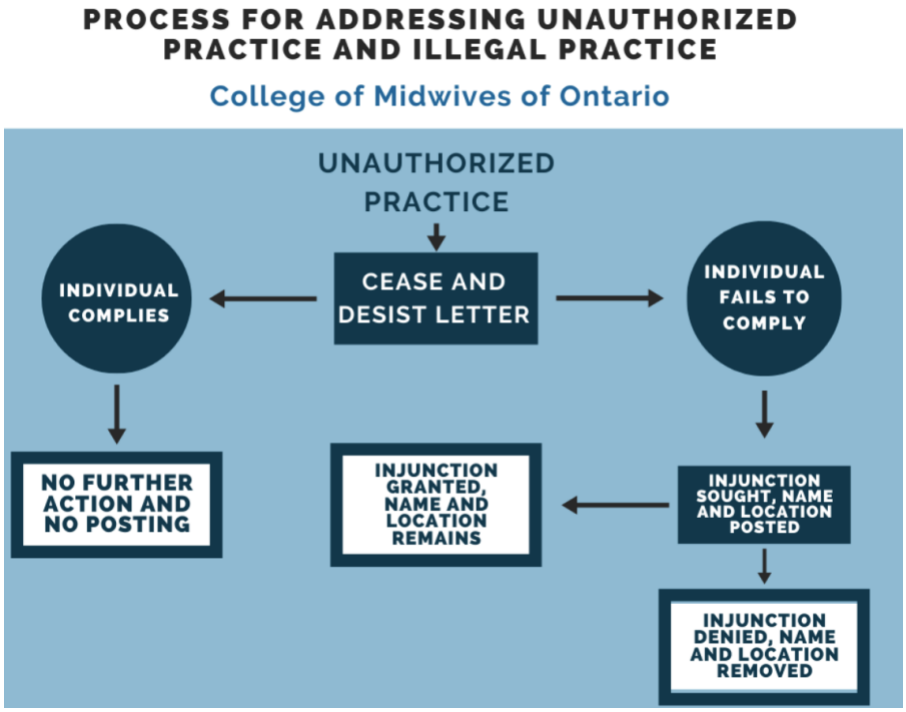
1. Website audit
2. Review all reports of unauthorized practice received from April 1 to March 31, 2020 to ensure that the internal process was adhered to.

Comments/observations

The *Midwifery Act, 1991* restricts the use of both professional titles and representation of midwifery qualifications. This is because there is a risk to client safety when unqualified individuals hold themselves out as midwives. We, as the regulator of the midwifery profession, have a duty to ensure protection of midwifery clients and the public, and tackling title misuse is an important part of this.

The College takes action, including legal action, to protect the use of professional titles in situations where title misuse has been identified. For further details, refer to Figure 3.

Figure 3: How the College addresses unauthorized practice



The College has a dedicated webpage that defines what unauthorized/illegal practice means and details the College's process for addressing the reports made to the College or if information comes to the College's attention through other means. We also post the names and locations of individuals that the College is in the process of seeking an injunction against (i.e., currently "unauthorized practitioners" with the potential to be deemed "illegal practitioners") and those individuals that have had an injunction successfully brought against them (i.e., "illegal practitioners"). In addition, the College encourages members of the public to use the College's public register to verify their midwives' membership status and to contact the College if they cannot find their midwife's name on the public register.

No reports of unauthorized practice were made to the College in 2020/2021.

Based on the results of the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

Domain 3: Openness and Accountability

The College fulfills its mandate of serving and protecting the public interest by acting with fairness, impartiality, timeliness and consistency, by providing access to information and transparency in decision-making, and by publicly reporting on the execution of its regulatory functions.

Standard 10: Clients and the public have access to information to understand what it means to regulate in the public interest and how the College makes decisions that affect them

Evidence of compliance	Data source(s)
1. There is accurate, accessible information available about the College's role and its public protection mandate and how decisions are made 2. There is practice advice available to address questions from the general public about midwifery standards.	1. Public facing documents and information on the website 2. Practice advice data
Conclusion against this standard: Met ☐ Partially met x Not met ☐	

Review procedure to test compliance with the standard

Website audit

Comments/observations

The College's website clearly states that the College regulates midwifery in the interests of public safety and confidence. Information about the College's complaints and investigations is clearly set out through relevant links and downloadable documents. There is detailed information on the College's Sexual Abuse Prevention Program, including how the College investigates all allegations of sexual abuse and how individuals who were, or may have been, sexually abused by a midwife while they were a client, can obtain funding for therapy and counselling.

Our What to Expect from Your Midwife brochure outlines the role of the College in regulating midwifery in the public interest, as well as what clients can expect from their midwives. The College sends brochures (in both English and French) to all Midwifery Practice Groups across the province for client distribution.[9] The brochure order form is available on the College's website. In 2020/2021, we created a COVID-19 webpage for the public to provide first-hand information (by way of frequently asked questions) about how the pandemic has changed the way midwifery care is being provided, and to assure midwifery clients that their safety remained our priority. In addition to resources available on the College's website, our Practice Advisor is available to provide practice advice to midwifery clients and the public about midwifery standards. While the vast majority of individuals who contact the College for practice advice are midwives (almost 78%), others approach the College for information, including

[9] In addition to providing information to midwifery clients, this brochure distributed by the College enables midwives to meet standard 52 in the Professional Standards for Midwives that requires midwives "provide appropriate information to [their] clients about how the midwifery profession is regulated in Ontario, including how the College's complaints process works".

midwifery clients (8% of total inquiries made in 2020/2021), some of whom are also complainants as well as hospitals, midwifery students, consultants and insurance providers.

We note that there is less information available to the public about the College's other core functions (registration and quality assurance) to help the public understand how the College regulates midwives to ensure suitability to practise. There is also limited information on the website about the governance arrangements that are in place to ensure regulatory integrity and objective and impartial decision-making. Finally, we do not currently engage directly with the public to measure their understanding of the College's public protection mandate and our decision-making and to assess the overall accessibility of College information. Based on our overall performance against this standard, it is only partially met.

Our new 2021-2026 Strategic Plan identified managing increased expectations of information (both about midwifery practice and College procedures), openness in decision-making and demonstrating our value as the regulator as one of our strategic priorities. As part of this priority the following initiatives will be completed.

1. Rebuilding the content of the website as it relates to educating the public about the role of the College and our complaints and discipline processes, and
2. Creating materials to better educate the public about the standards of the profession and other requirements midwives are held to, including translating materials into other languages.
3. Conduct a series of qualitative surveys with midwifery clients and the broader public who went through our complaints process to assess their perceptions of the College so we can better understand the impact of our work and how we can support, provide guidance, and communicate more effectively with the public.

We will be able to report on the progress of the above initiatives in 2021/2022; however, progress in this area will be gradual with full implementation expected by 2026.

Standard 11: Public register provides access to information about midwives

Evidence of compliance	Data source(s)
1. The public register is up to date and in compliance with the legislation and by-laws that set out what should be public 2. The public register search is prominently displayed on the website and is accessible at all times 3. The public has information to understand how to navigate the public register and how to interpret the information provided 4. Information deemed as public is posted within 5 days after the midwife has been notified of the decision 5. Non-College information (e.g., charges) is made available within 5 business days after the members has been notified of the College's obligation to post to the register.	1. Register profiles 2. Committee orders (ICRC/discipline, registration and quality assurance) that include information designated as public 3. Public register-related webpages, including the glossary of terms

Conclusion against this standard: Met ☐ Partially met x Not met ☐	

Review procedure to test compliance with the standard

1. Select and review 20 random register profiles to verify their accuracy (in addition all midwifery files reviewed as part of standards 5 & 6 were also reviewed against this standard)
2. Select and review 5% of committee orders issued in the reporting period that include information designated as public to verify that they were posted to the register within five days after the midwife has been notified of the decision or of the College's obligation to post to the register (for non-College information) and were accurate.

Comments/observations

According to the *Regulated Health Professions Act, 1991*, the College is required to publish and maintain a publicly accessible register of midwives so that important information about their registration is easy to find.

To establish whether a midwife is registered with the College, the "Find a Midwife" function is clearly displayed on the website home page which allows midwifery clients and the general public as well as other interested parties to search for a midwife by their registration number, first and last name, practice location, and clinic name.

The content of the public register is determined by section 23 of the Code and Article 14 of the General By-law. It includes the following categories of information:

1. Information generated as a result of a College proceeding [10], and
2. Personal, practice and other information

Information generated as a result of a College proceeding

This information must be updated by staff within five days after the midwife has been notified of the decision. Midwives are not responsible for verifying the accuracy of information generated as a result of a College proceeding. For example, if the Quality Assurance Committee directed the Registrar to impose terms, conditions and limitations on a midwife's certificate of registration, it is staff's responsibility to ensure that this information is available on the register and is accurate. We conducted a check of a sample of entries on the register for accuracy. All entries checked were randomly selected, but all related to midwives who either had been subject to an ICRC, Discipline or a Registration Committee decision and whose status changed (e.g., class change; new registrant conditions lifted) in the reporting period. All entries checked were accurate and were posted within 5 days after the midwife was notified of the decision.

[10] "College proceeding" includes decisions to register an applicant or change a midwife's class of registration, registration history as well as all panel orders and other decisions that are designated as public information.

Personal, practice and other information

This category includes a broad variety of information ranging from a midwife's name, current and past practice location and business address to criminal findings of guilt, criminal charges, bail conditions, findings of professional negligence and malpractice and other similar types of information. Midwives are required to provide this type of information by either updating their profiles in the member portal (that is tied to the public register) or contacting the College in writing. Our website outlines which pieces of information midwives can update in the member and which can only be provided in writing to the College. We cannot guarantee that the information that midwives must provide is indeed provided to the College in a timely manner[11], or at all, and we cannot guarantee that the register is always accurate. We must, however, make every effort to ensure that the information is accurate and complete.

We conducted a check of 20 random register profiles to verify that there were no obvious gaps in how the required information displayed on the register. We identified two profiles that had duplicate entries for past practice information. The entries were not identical as they were displaying different start and end dates. We investigated the reasons for these errors. At this stage, it is not clear how these entries were created; further investigation is required to understand the extent of the problem and what caused the issue to be able to reduce the risk of this kind of error happening again.

Despite our overall satisfactory performance against this standard, it is only partially met. While the issues noted above are minor and do not pose a risk of harm to the public interest, they likely could have been prevented. We already have an ongoing program ~~of work~~ to make improvements to the register, including making changes to how the information is displayed to improve user experience, greater use of checks by staff as well as conducting educational webinars with midwives to improve their understanding of notification requirements. Together, these different measures should improve the accuracy of personal, practice and other information that is not easily verifiable by the College. This work will continue in 2021/2022 and will be reported on next year.

Standard 12: The investigations and hearings process is fair, transparent, timely, consistent and focuses on public protection

Evidence of compliance	Data source(s)

[11] Midwives, as regulated professionals are expected to know, understand and comply with their mandatory notification requirements.

1. All parties are provided with information to understand the process and decision-making and are kept informed on the progress of their case. 2. Panel decision-making is proportionate to the risk of harm caused to current or potential clients 3. Decisions are well-reasoned 4. Compliance with committee orders or direction is effectively monitored 5. Defined benchmarks and adherence to those.	1. All files closed in the reporting period 2. Panel decision-making framework/tools 3. ICRC panel outcomes 4. Number of decisions appealed to HPARB and their status 5. total Number of orders made by ICRC, Discipline and FTP that require monitoring and their status. 6. Professional conduct survey findings 7. Data showing that the benchmarks were met
Conclusion against this standard: Met ☐ Partially met x Not met ☐	

Review procedure to test compliance with the standard

1. Select and review 20% of all cases (complaints/reports and discipline/fitness to practise) closed in the reporting period to verify that the statutory requirements and internal procedures were adhered to.
2. Select and review 20% of cases that had a monitoring component to verify that committee orders were completed within the timelines set by the panel.
3. Verify that investigations/hearings benchmarks were met.

Comments/observations

Our investigations and hearings process is the only function of the College that directly involves the public who access midwifery services. It is also one of the most complex functions of the College with multiple statutory and non-statutory procedures that must be followed before a case can be closed.

No procedural issues were identified during the audit; all files that were randomly selected and reviewed were handled in accordance with the requirements set out in the Code and the College's internal procedures.

Information and support

The review showed that all parties (or a midwife in a report matter) are provided with relevant information to understand the process and decision-making and are kept informed on the progress of their case. Staff is available to respond to any inquiries throughout the process. The College has a policy that requires staff to acknowledge all inquiries within two business days and to provide a timeline in which the inquiry can be addressed if it cannot be addressed within that time. All staff of the College are responsible for abiding by this policy and identifying when the standard cannot be met to management. The generic email address: conduct@cmo.on.ca that is used in all formal documents for inquiries relating to complaints, reports, or unauthorized practice and general information about the complaints, discipline or ADR process has an automatic response that indicates the inquiry is received and gives the established timeline of two business days for a response. In addition, practice advice is available at intake and throughout the process if complainants (and midwives) need advice on clinical, ethical, or regulatory issues.

The College's new strategic plan 2021-2026 identified Building Engagement and Fostering Trust with the Public and the Profession as a strategic priority. One of the initiatives undertaken to meet this priority is the development of an online portal to provide complainants and midwives with access to key information about the complaints process and the status of their specific case at each step.

Decision-making

As noted above, once the case reaches the ICRC for deliberation and decision-making, panel members use a risk assessment tool to determine if a matter is no or minimal, low, moderate, or high risk. In each situation there can be aggravating factors and mitigating factors, which will be considered by the panel. Depending on the level of risk, a recommended outcome will inform the panel's decision-making, including a referral to a panel of the Discipline Committee. The ICRC risk assessment tool ensures greater consistency in decision-making.

A summary of the committee's dispositions in 2020/2021 is shown below.

Table 18: ICRC Dispositions [12]

Dispositions	Complaints	Reports
	2020/2021	2020/2021
Number of decisions issued	**51**	**10**
Complaints referred to ADR	5	N/A
Complaints Withdrawn	1	
Frivolous and Vexatious	1	
No Action	29	3
Advice & Recommendations	13	3
Specified Continuing Education or Remediation Program (SCERP)	3	5
Oral Caution	0	1
Referral to Discipline Committee	1	0
Referral to Fitness to Practise Committee	0	0
Acknowledgement & Undertaking	0	0
Undertaking to Restrict Practise	0	0
Undertaking to Resign and Never Reapply	0	0

The Discipline Rules of Procedure as well as the discipline process flowchart, including possible penalties is provided on the website.

Table 19: Results of Discipline Proceedings in 2020/2021 [13]

Reprimands	2

[12] Some decisions contain more than one disposition (e.g., caution and SCERP). So, the total number of decisions may not equal the total number of dispositions.
[13] One discipline case may result in more than one finding of professional misconduct and/or penalty component.

Terms, conditions and limitations on the midwife's certificate of registration requiring the midwife to complete remediation	2
Revocations of certificates of registration	0
Suspensions of certificates of registration	0
Cost awards	2
Total number of discipline proceedings	2

No Fitness to Practise proceedings were held in 2020/2021.

Compliance monitoring

Some decisions made by the ICRC, or a panel of the Discipline Committee, require monitoring to ensure compliance with committee orders. For example, a panel of the ICRC may require that a midwife complete a a Specified Continuing Education Remediation Program (SCERP) or an order can be made that a midwife's practice must be audited after a specified period of time to ensure that they are able to demonstrate the required knowledge, skill and judgment in an area of practice that required remediation. Staff corresponds with midwives to ensure they are aware of their compliance requirements. If the midwife does not comply with any order of the ICRC or Discipline within the prescribed timeline, the Registrar can decide to commence an investigation into the midwife's failure to comply. If this happens, it becomes a new investigation.

Table 20: Compliance Monitoring[14]

Orders carried over from 2019/2020	4
New orders in 2020/2021	34
Complete orders n 2020/2021	31
Orders carried over to 2021/2022	7

No issues were identified during the audit; all files that were randomly selected and reviewed were appropriately monitored to ensure compliance.

Reviews before the Health Professions Appeal and Review Board

In a complaint matter either party can seek a review of the ICRC's decision unless the decision was to refer the matter to discipline or to an incapacity inquiry. There is no right of review before the Health Professions Appeal and Review Board (HPARB) in a Registrar's report matter. In such cases, the only option for a midwife who is dissatisfied with an outcome is to apply for judicial review to the Divisional Court. HPARB reviews focus on two issues: the adequacy of the investigation and the reasonableness of the decision. HPARB has broad remedial powers. In addition to confirming the decision of the ICRC, it can return the matter to the ICRC to make a new decision with recommendations from HPARB or it can require the ICRC to make a specific decision dictated by HPARB. While the mere fact of a review before

[14] Committee decisions may consist of multiple orders with different prescribed timelines. Accordingly, the total number of orders being monitored may not equal the total number of midwives being monitored.

HPARB is not indicative of an issue, we closely monitor HPARB reviews. Any matter referred back to the ICRC or any recommendations made to the ICRC will trigger a review and a possible change to internal procedures.

As of April 1, 2021, there were 10 appeals before HPARB. No appeals were closed in 2020/2021.

Table 21: HPARB appeals in 2021/2022

Open HPARB appeals (appeals carried over from 2019/2020)	2
New HPARB appeals	8
Completed HPARB appeals	0
Open HPARB appeals (appeals carried over to 2021/2022)[15]	10

Appeals to the Divisional Court

No discipline decisions were appealed to the Divisional Court in 2020/2021.

Timely resolution of matters

According to 28(1) of the Code, a complaint is expected to be completed within 150 days of it being filed with the College. After the 150-day period expires, a letter must be sent to both parties informing them that the deadline will not be met and providing an expected date of disposition that is no more than 60 days from the 150-day deadline. After the 210-day period expires, a letter must be sent by the Registrar to both parties (and to HPARB) every 30 days explaining why the ICRC was not able to complete the matter and providing an estimate of the expected date of disposition that is no more than 30 days from the date of the previous letter. Unlike the process for complaints investigations, according to the Code there is no set deadline to complete an investigation in a report matter and render a decision. Nor is there a requirement to send letters to the midwife notifying them of the reasons for any delays. However, according to our internal procedures, staff will update midwives on the status of the investigation at the 150-day, 210-day, and subsequent 30 days after, until the decision is issued. The below table shows timelines from receipt of complaint or appointment of an investigator in a report matter until the date of the decision and reasons.

Table 22: Timelines: complaint matters and reports

	Complaint matters	Reports
Files closed <150 days	6	2
Files closed between 150 days and 210 days	11	1
Files closed >210 days	34	7

The 150-day timeframe set out in legislation is ambitious as there are multiple steps that must be taken to close a case, including giving notice to the midwife along with 30 days to make written submissions (extensions are regularly sought by a member's legal counsel), completing an investigation, bringing the case before a panel of ICRC, their deliberations, and the writing of reasons. Additional steps may be

[15] The ten appeals are representative of six complaint matters. Five complaints involve more than one midwife. All appeals are by complainants.

required in complex cases, such as, for example, getting an expert opinion. As shown in Table 23, less than 12% of complaints and 20% of reports were closed within the 150-day timeframe in 2020/2021. Providing meaningful and timely resolutions to complaint and report matters is a key factor in assessing not only the operational efficiency of any system, but also its accessibility, and its ultimate effectiveness. A key metric for many regulators is processing times for regulatory approvals and other processes. Indeed, decisions rendered a year or years after the events in question may no longer be meaningful to the parties involved. At the same time, the quest for simplicity and timeliness cannot be pursued to the detriment of procedural fairness and other principles that we are held to. As an administrative agency we have a duty to ensure that any exercise of power can be justified to the public and midwives in terms of rationality and fairness. Although there may at times be a trade-off between simplicity of process and procedural fairness (and arguably a simpler system that is more accessible and timelier could lead to greater fairness, particularly for cases that are themselves simpler), this is not always the case.

Despite our overall satisfactory performance against this standard, we only partially met it because we were unable to demonstrate evidence of defined benchmarks and adherence to those. The work to set timelines for resolving our complaints and reports matters to be able to benchmark our performance against those was planned for 2020/2021 but due to increased workload in the department, we were not able to complete it as planned. We note that because the benchmarks have not been set yet, we will not be able to assess our performance against this aspect of the standard in 2021/2022. However, we will be able to present our benchmarks for conduct matters in the 2021/2022 report.

Standard 13: Midwives and midwifery applicants have access to information and guidance to understand College requirements

Evidence of compliance	Data source(s)
1. Availability and accessibility of information about regulatory requirements and how those will be monitored and enforced 2. The College supports midwives in understanding new or revised standards and other College requirements 3. Practice advice is available.	1. Website 2. Number of practice advice inquiries made and responded to 3. Other engagement activities undertaken in the reporting year
Conclusion against this standard: Met ☐ Partially met x Not met ☐	

Review procedure to test compliance with the standard

Website audit

Comments/observations

<u>Information provided to applicants and midwives</u>

Full information is provided on the website about what an applicant must to do in order to become registered as a midwife. Information for internationally educated midwives and midwives coming to Ontario from other Canadian jurisdictions is provided in the “Applicants” section of the website and includes frequently asked questions and links to other relevant websites.

The “resources” section of the website provides information and downloadable guidance documents for midwives, including on the various pieces of provincial legislation that apply to healthcare practitioners, including midwives. All College standards and policies are published on the website (including documents archived after 2018). The “midwives” section of the website provides information about the ongoing requirements that midwives must meet (such as quality assurance requirements and active practice requirements). This section also includes practice advice (in the form of frequently asked questions) and links to relevant documents that midwives must be aware of. In addition, a practice advisor is available to respond to any questions that midwives may have regarding midwifery standards, policies, and regulations.

The website audit indicates that the College provides sufficient information about its requirements and processes in a matter which appears accessible but we have not surveyed midwives to assess their perception of the College’s website, including its usability and accessibility.

Practice advice

In 2020/2021, our practice advisor received 184 inquiries (phone calls and email) in total. Table 23 shows broader categories, such as scope of practice, broken down further into subcategories. For example, there were 84 inquiries about scope of practice and of those 84, 18 were specific to controlled acts and 23 were specific to the Designated Drugs Regulation. Table 24 describes who the inquiries came from.

Table 23: Type of Inquiries Received by the Practice Advisor in 2020/2021

Category	
Scope of practice	84
• Controlled Acts	18
• Laboratories Regulation (i.e., access to laboratory tests)	10
• Designated Drug Regulation (i.e., access to Drugs)	23
• Providing care that is not normal or outside pregnancy – postpartum/newborn (i.e., client condition)	4
• Providing care to non-midwifery clients	3
• Practising a narrower scope than the full legislative scope	3
• Providing care that is not midwifery care	7
• Client or non-midwife clarifying midwifery scope (e.g., masking requirements during the pandemic, writing a sick note)	7
• Working under Delegation	9
Inactive registrants and the practice of Midwifery	7
College Standards	50
• Professional knowledge and practice (e.g., what training does the College require)	7
• Person-centre care/informed choice	1
• Integrity/Conflict of Interest	11
• Record Keeping	9
• Second Birth Attendants	6

• Ethical (Conflict over care/Termination of care).	16
Other Regulations and Guides (e.g., PHIPA, Health Protection and Promotion Act)	4
Midwife looking for information on website or seeking clarification of standard	16
Miscellaneous	23
TOTAL	184

Table 24: People Who Made Inquiries in 2020/2021

Midwives	143
Clients	15
Hospital administrators	7
Other healthcare professionals (physicians/paramedics)	5
Others (midwifery students, consultants, insurance provider)	14
Total	184

Support provided to midwives when changes are made

Our consultation process is designed in a way that not only seeks input on our policy proposals but also enables us to engage in discussions with midwives throughout the process to ensure that they understand how the standards apply to their practice and what is expected of them before, during, and after implementation. In 2020/2021, the following activities were undertaken to support midwives' understanding of the changes regarding College standards of practice coming into effect in June 2021.

- Response to consultation that reported on the feedback we received but also set out our response to all the issues raised in the first consultation, including how the proposed changes will affect midwifery practice
- Meetings with midwifery students (spring 2021)
- Mass communication through website/ practice advice
- Webinars with midwives and senior midwifery students

The College's main focus in previous years was on developing new and revising old standards as well as on developing documents to guide midwifery practice. A significant amount of work was accomplished on this front, but we were less effective in building engagement and fostering trust with the profession. In our new 2021-2026 Strategic Plan, we have made it a priority to listen to and engage with midwives and midwifery students. We committed to establishing new and better channels for digital and face-to-face engagement with midwives and midwifery students and to taking a broader, more open approach to consulting on policy and other issues. Some of the initiatives to be undertaken to meet this priority include:

1. Continuing to make information about our ongoing requirements, standards and guidelines available to midwives in an engaging and accessible format.
2. Introducing orientation workshops to help midwives who are new to practice, or new to the province, understand professional issues that will affect them on a daily basis and what it means to be a regulated professional in Ontario.

3. Continuing to 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. Surveying midwives and midwifery students to track their perceptions of the College so we can better understand the impact of our work and how we can communicate more effectively with them.

Because of the reasons noted above, this standard is partially met. We will be able to report on the progress of our initiatives in 2021/2022; however, progress in this area will be gradual with full implementation expected by 2026.

Standard 14: Registration processes are fair, transparent, impartial and objective

Evidence of compliance	Data source(s)
1. Evidence that all registration files referred to a panel of the Registration Committee are managed in accordance with the requirements set out in legislation and regulations and internal procedures o All midwives and applicants who are subject to a registration proceeding are provided with information to understand the process and make submissions /provide information to support their case o Panel decision-making is proportionate to the risk of harm and reasonable 2. Evidence of defined benchmarks for all registration processes and adherence to those 3. Satisfactory completion of the Office of the Fairness Commissioner: o Annual Fair Registration Practices Reports o Most recent Registration Practices Assessment Report.	1. All files closed in the reporting period 2. Panel decision-making framework/tools 3. Registration panel outcomes 4. Data showing that benchmarks are adhered to 5. Number of decisions appealed to HPARB and their status 6. total number of orders made by the Registration Committee that require monitoring and their status
Conclusion against this standard: Met ☐ Partially met x Not met ☐	

Review procedure to test compliance with the standard

1. Select and review 20% of registration cases closed in the reporting period to verify that statutory requirements and internal procedures were adhered to
2. Review the Office of the Fairness Commissioner (OFC) report(s) to verify that all recommendations made by the OFC were addressed
3. Review data to confirm that registration benchmarks were met

Comments/observations

A comprehensive file review was conducted to test compliance with this standard. Of the reviewed files, 50% included a referral to a panel of the Registration Committee. No issues were identified during the audit; all files that were randomly selected and reviewed were handled in accordance with the requirements set out in the Code and the College's internal procedures.[16]

Reviews before HPARB

An applicant who has received an order of a Registration Committee refusing to issue a certificate of registration or giving a certificate of registration that has some limits or conditions can require the Health Professions Appeal and Review Board (HPARB) to review their application for registration. HPARB has the authority to return the matter back to the Registration Committee or require the College to issue a certificate of registration with any terms, conditions and limitations the Board considers appropriate if the Registration Committee is determined to have exercised its powers improperly. We closely monitor HPARB reviews of our registration matters as any matter referred back to the Registration Committee or any order made by HPARB that is different from the initial decision made by a panel may trigger a review of our internal procedures.

One registration matter was appealed to HPARB in 2020; however, it was later withdrawn by the applicant.

Office of the Fairness Commissioner (OFC) Reports

We submit a Fair Registration Practices Report to the OFC yearly. The 2020 report can be reviewed here.

Timeliness

The comments made above under Standard 3.4. (timely resolution of matters) apply to registration matters as well. While they are less procedural and legalistic than conduct matters, it is equally important to ensure, as a matter of procedural fairness, that registration files move through the system in a timely manner. The below table shows our timelines from referral of a case to a panel of the Registration Committee to a written decision.

Table 25: Timelines: registration matters

Files closed within 30 days	13
Files closed within 60 days	13
Files closed beyond 60 days	3
Average: (reported in number of days)	96

Despite our overall satisfactory performance against this standard, we only partially met it because we were unable to demonstrate evidence of defined benchmarks and adherence to those. We also note that four registration files referred to a panel of the Registration Committee in December 2020 (for active practice shortfall) were not completed by the end of this fiscal (they were all at a decision drafting

[16] The files were assessed against the requirements that were temporarily in place in 2020/2021 to address the impact of the pandemic on the ability of midwives and midwifery applicants to meet our registration requirements (e.g., cancellation of the Canadian Midwifery Registration Examination in May 2020).

stage as of March 31, 2021). Immediate changes will be implemented to ensure timely drafting of panel decisions. The work to set timelines for closing registration matters to be able to benchmark our performance against those was planned for 2020/2021 but due to the pandemic and its effects on the registration department, this work was not complete in 2020/2021 and was moved to 2021/2022. We note that because the benchmarks have not been set yet, we will not be able to assess our performance against this aspect of the Standard in 2021/2022. However, we will be able to present our benchmarks for registration matters in the 2021/2022 report.

Domain 4: Good Governance

The College has governance arrangements that ensure effective functioning, preserve a high degree of regulatory integrity to help us deliver our mandate and achieve decision-making that is objective and impartial, and avoids conflict of interest, bias, or improper influence.

Standard 15: Council meetings are open to the public, and Council and committee decision-making is transparent and accessible to the public.

Evidence of compliance	Data source(s)
1. Council meetings and briefing materials are available to the public 2. Council decisions are publicly available 3. Committees report to Council on a quarterly and annual basis.	1. Council packages 2. Council meeting minutes 3. Quarterly and annual committee reports provided to Council
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

Website audit

Comments/observations

All Council meetings are open to the public. As per s. 7.01 of the General by-law, notice of every Council meeting is posted on the College's website at least 2 weeks before a regular Council meeting and as soon as reasonably possible before a special Council meeting. The notice is provided in English and French and include the intended date, time and place of the meeting.

In 2020/2021, all notices were provided to the public in accordance with the requirements set out in the by-law. All Council meetings in the reporting period were held remotely and the meeting link was provided to all interested parties upon request.

All Council materials are available to the public along with the agenda and approved minutes. They can be viewed here. All committees provide their quarterly and annual reports to Council. They can be viewed in Council packages.

Based on the review, we are satisfied that this standard is met.

Standard 16: Council is structurally separated from inappropriate stakeholder or other influence to support regulatory integrity

Evidence of compliance	Data source(s)
1. Eligibility criteria for election to ensure independence of decision-making 2. Council member terms on Council are appropriately imposed 3. Policies, procedures and criteria for selection and terms of appointment of the governing body are documented and readily available to aid transparency and attract appropriate candidates. 4. College by-laws and policies are adhered to and monitored.	1. By-laws and governance policies 2. Election and other information available to midwives to understand the requirements 3. Candidate nomination forms including declarations that they met eligibility criteria set out in College by laws 4. Council terms document
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Website audit
2. Review nomination forms for all candidates who stand for election to verify that internal procedures were adhered to.

Comments/observations:

Criteria to support regulatory integrity

There are systems in place to ensure Council and committees are protected from inappropriate stakeholder or other influence and to support regulatory integrity. Under the College's current by-law (ss. 5.06 and 6.12) a midwife may be eligible for election to Council or appointment to a committee if they:

1. have not been a director, board member, officer or employee of a Professional Association in the previous 12 months
2. have not been a director, board member or owner of a midwifery educational institution in the previous 12 months
3. have not been disqualified from Council within the preceding three years

All candidates who stood for election in 2020/2021 submitted a nomination form to the College declaring that they met the above criteria.

Terms

Under ss. 4-5 of the Code, the term of a Council member who is elected (i.e., professional member) should not exceed three years. In addition, a professional member's term should not exceed nine consecutive years. In general, imposing terms is considered a good governance principle as term limits

bring new perspectives to the overall work of Council. The review showed that Council member terms are appropriately monitored and enforced.

Transparency of College governance

The College General by-law that sets out the majority of the College's governance procedures (including elections, qualifications and terms of office) and all governance policies as well as the Governance Manual are available on the website. Detailed information is provided on the website about Council elections, including the Elections Guide, eligibility criteria, time commitment, and other relevant information.

Based on the review, we are satisfied that this standard is met.

Recommendations: As noted above under Standard 13, it is worthwhile considering providing information to the public and midwives in a more accessible format to educate them about the governance arrangements that are currently in place to ensure high degree of regulatory integrity and objective and impartial decision- making.

Standard 17: There are systems in place to protect the independence of Council and committee decision makers from any interests other than the public interest

Evidence of compliance	Data source(s)
1. The College has a conflict of interest policy 2. A training around conflict of interest is provided on an annual basis 3. All Council and committee members declare a conflict of interest before joining Council, annually and before each Council, committee or panel meeting. 4. There is a disqualification procedure in place for acting in a conflict of interest 5. Governance by-laws and policies are adhered to and monitored	1. By-laws and governance policies 2. Conflict of interest training dates for Council and non-Council committee members 3. Annual conflict of interest declarations (for Council and committee members) and conflict of interest forms filled out before each meeting (including panel meetings)
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Review the training calendar for the reporting period to verify that a conflict-of-interest training was provided to Council and committee members
2. Verify that all Council and committee members have a signed conflict of interest form on file for the reporting period.
3. Select and review 5% of panels (all committees) held in the reporting period to verify that a conflict of interest was declared in each case

Comments/observations:

Conflict of interest

The College has a conflict of interest by-law (ss. 8.01-8.15) that governs the conduct of Council and committee members, including a disqualification procedure for members who acted in a conflict of interest. In addition, s. 5.08w of the General by-law states that any candidate that stands for election must complete a conflict of interest form declaring that they do not have a conflict of interest to serve as a member of Council. The same applies to midwives and members of the public who apply to be appointed to College committees as non-Council committee members. Finally, all Council and committee members are required to complete a conflict-of-interest questionnaire on an annual basis. They also declare any conflicts as they arise in between the meetings and before each Council and committee meeting. All Council and non-Council members must declare a conflict of interest before they can be appointed to a panel to deliberate on/hear a particular case. The review showed that all Council and committee members have a signed conflict of interest form on file for the reporting period. Similarly, in all cases that were randomly selected and reviewed, Council and committee members declared a conflict of interest before they were appointed to a particular panel.

Training:

The annual conflict of interest training session covering common conflict-of-interest situations and situations that may be specific to midwifery, and the circumstances in which they may arise was held in October 2020.

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

Standard 18: There are systems in place to ensure that Council and its committees fulfill their duties professionally and ethically

Evidence of compliance	Data source(s)
1. Midwives who stand for election successfully complete the College's training program relating to the duties, obligations and expectations of Council and committee members prior to the date of nomination 2. Council and committee members attend a mandatory orientation session and receive ongoing training about expectations pertaining to their role and responsibilities on Council and statutory committees 3. The College has a Code of Conduct for Council and committee members & a disqualification procedure for contravention of duties and expectations.	1. Governance modules completion data 2. Annual training calendar for Council and committees 3. Annual code of conduct acknowledgments made by all Council and committee members
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Verify that all midwives who stood for Council and non-committee members who submitted an application to the College successfully completed governance education modules
2. Review Council and committee training calendar for the reporting period
3. Verify that all Council and committee members have a signed annual code of conduct acknowledgment on file for the reporting period

Comments/observations:

Completion of governance education modules prior to nomination

Currently all candidates running for election must complete the College's governance education modules, including completion quizzes. There are three modules that each have their own learning themes. The first module focuses on the legislation and regulations that provide the governance framework for regulating midwifery as a profession, the second module focuses on the College as a regulatory institution, and the last module focuses on the role of the College Council and its committees. The Governance Manual accompanies the modules and is provided to all candidates. This manual provides an overview of governance and its meaning and purpose as it applies to the regulation of midwifery. It also provides detailed information relating to the duties, obligations and expectations of Council and committee members, including time commitment expectations. Evidence of completion is obtained once final quizzes are successfully completed and automatically submitted to the College. All candidates who stood for election in 2020/2021 satisfactorily completed the governance education modules.

Code of conduct – training and acknowledgments

All Council and committee members have a signed code of conduct acknowledgment on file for 2020/2021. Relevant training was provided to Council and committee members in October 2020.

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

Standard 19: Collectively, Council and its committees have a diversity of skills and experience tailored to the functions of the College and are appropriately trained to ensure robust decision-making

Evidence of compliance	Data source(s)
1. The College has pre-defined competencies for Council and committee members	1. Competency matrix for current Council and committee members

2. Council and committee members self-assess their competency and skill level on an annual basis 3. The annual training plan for Council and committees is informed by the needs of Council and its committees and reflect current best practice in governance (including the governance of regulators).	2. Schedule of annual trainings developed by the Executive Committee (note in the narrative)
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Verify that all midwives who stood for Council and non-committee members who submitted an application to the College met the eligibility criteria outlined in the by-law, including successful completion of the governance education modules
2. Verify that Council and committee members were assessed on their competency and skill level in the reporting period.
3. Review minutes by the Executive Committee (in its role as the College's governance committee) to verify that the annual training plan for Council was informed by the needs of Council and its committees as well as by developments in the area of professional regulation.

Comments/observations:

Meeting pre-determined eligibility criteria

All professional Council members (midwives) are elected by their peers in elections that take place annually. There are minimum requirements in place (s. 5.08 of the General by-law) that outline the eligibility to stand for election, including meeting all the requirements set out in the by-law (e.g., no discipline finding in the previous 3 years, no notation on the register of a finding of guilt made by a court in relation to any provincial or federal offence, no term, condition or limitation imposed by a panel of the discipline committee) and successful completion of the College's training program relating to the duties, obligations and expectations of Council and committee members prior to the date of nomination. All three candidates who stood for election in 2020 met the eligibility criteria outlined in the by-law.

Orientation before the first meeting

Generally, a comprehensive Council orientation session is delivered in-person before the first meeting of Council (generally held in October). Both professional and public members are required to attend. In addition, public members who join Council mid-year, receive an individualized orientation by the Council chair and Registrar/CEO. In 2020, due to the pandemic, the orientation session was held remotely. External speakers are generally invited to speak. There is no knowledge testing built into these sessions.

A full day training session was held in October 2020 and included an introduction to Council roles and responsibilities, fiduciary duties, the legislative framework that exists in Ontario and the regulatory framework specific to the midwifery profession as well as an introduction to the concepts of

professionalism and competence and how the College should ensure those. In addition, two individualized orientation sessions were held on June 17 and September 25 for four new members (two attended each session), in advance of their first Council meeting held in October 2020.

Competency self-assessment and training

An effective Council relies on the skills and experience of its members. It is not necessary for Council members to be experts in all competencies. What is important is that the Council has the collective expertise in the competencies that are necessary to provide oversight and strategic guidance to staff.

Competency self-assessment for Council was done in October 2020. Council members were asked to review the list of essential competencies and personal attributes and skills (approved by Council) and indicate their level of competence in accordance with the provided competency level descriptions. The results of the 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. The results of the evaluation were used to create a competency matrix unique to the College's current Council and, in combination with training suggestions put forth by Council members, a training plan for 2020/2021 Council was proposed as follows:

March 2021

- Personal check in
- International Midwifery Pre-Registration Program
- Regulatory journey of a midwife
- Platform and application tips

June 2021

- Personal check in
- Anti-Bias/Anti-Racism training
- Discipline training (this will happen in a separate training in July)
- Chair training

October 2021

- Personal check in
- Re/Orientation to good governance
- Indigenous Cultural Safety and Humility training

December 2021

- Personal check in
- Risk-based regulation
- Future of midwifery
- Government organizational structure and regulation/legislation making

The list of essential competencies was developed by the Executive Committee in 2017. It will be reviewed and updated in 2021/2022 to ensure that it is aligned with the evolving strategic needs of the College and the sector more generally.

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

Standard 20: Council regularly evaluates its effectiveness to ensure improved leadership, better decision-making and greater accountability as well as more efficient Council operations

Evidence of compliance	Data source(s)
1. Council evaluates its effectiveness on a regular basis 2. Findings are presented to Council and that Council discusses the areas identified for improvement and approves an appropriate action plan as needed	1. Council performance evaluation dates 2. Action plan developed to address areas for improvement
Conclusion against this standard: Met x Partially met ☐ Not met ☐	

Review procedure to test compliance with the above standard

1. Verify that Council's effectiveness was evaluated in accordance with internal procedures
2. Review the Executive Committee's report to Council, including an action plan as needed.

Comments/observations

The Council evaluation framework first developed in 2015, was reviewed and revised in 2020. In 2020/2021, Council performance was evaluated in 3 different ways:

1. Council Performance Evaluation Survey: Anonymous online survey was conducted in October 2020. The survey asked Council to focus on and assess key areas that affect the Council's performance as a whole and its key responsibilities for governance of the College, including Strategic Governance; Operational Oversight, Council-Registrar/CEO Relationship, Council Governance Processes, Council Engagement and Interpersonal Skills, Chairing Skills, Chair Evaluation, and General Strengths and Improvement Needs. The results were reviewed by Executive in November 2020 and presented to Council in December 2020.

2. Peer Review: This survey was conducted to assess individual member's effectiveness and help them develop and bring value to their roles. The survey was sent out by the Chair to all Council members in October 2020 (responses are received on a confidential basis). Thematic analysis was presented to Executive in November. The Chair emails "unfiltered" responses to individual Council members and holds one-on-one teleconference meetings with Council members to discuss feedback provided by peers. The responses to this questionnaire and subsequent discussions with the Chair are held in complete confidence.

3. Post-Council Meeting and Training Day Evaluations: This form of evaluation was introduced in 2020. An online survey is conducted after each Council meeting to evaluate the effectiveness of Council meetings and trainings and identify any gaps that must be addressed. The Council Chair is provided with the results and discusses any action items with the Registrar at their weekly meetings.

The results of the 2020 evaluations were presented and discussed at the December 2020 Council meeting (agenda item 6: Council Annual Evaluation Presentation).

In accordance with the Council Evaluation Policy (GP10), a third-party assessment of Council's effectiveness must be conducted at least once every three years. The first third-party assessment of Council's effectiveness is scheduled for the fall of 2021.

Based on the review, we are satisfied that this standard is met.

Recommendations (if the standard is not met): N/A

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

☑ **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

*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,

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)

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_____

Edan Thomas  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,

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,

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)

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Judith Murray — Judith Murray — 26-11-20

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,

Jan Teevan

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 Teevan | Jan Teevan | 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.

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

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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,

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

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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,

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)

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

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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,

Sarah Baker

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)

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

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